Suicide Mortality
**Review Committee**

# Understanding deaths by suicide in the Asian population of Aotearoa New Zealand

## Te whakamārama i ngā mate whakamomori i te taupori Āhia i Aotearoa

newzealand.govt.nz

Health Quality & Safety Commission New Zealand
*Kupu Taurangi Hauora o Aotearoa*

Kei roto i te pōuri te māramatanga e whiti ana.

The potential for enlightenment can be found glimmering in the dark.

[Ringatū prayer]

Citation: Suicide Mortality Review Committee. 2019.
*Understanding death by suicide in the Asian population of Aotearoa New Zealand.*
Wellington: Health Quality & Safety Commission.


PO Box 25496, Wellington 6146, New Zealand.

ISBN 978-1-98-859903-8 (online)



This document is available online at
www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources.

Enquiries to: info@hqsc.govt.nz

Health Quality & Safety Commission New Zealand
*Kupu Taurangi Hauora o Aotearoa*

# Acknowledgements | He mihi

The Suicide Mortality Review Committee (the SuMRC) would like to acknowledge:

- whānau, family and friends bereaved by suicide
- the experiences shared in this work by staff of Victim Support, Age Concern, Asian Wellbeing Services staff in the Asian Family Services, Sahaayta, East Health Trust, the Grief Centre, Police and Te Pou
- the advice and stories provided by Asian Family Services
- the advice and support of members of the Asian Suicide Prevention Advisory Group, Dr Elsie Ho, Dr Gary Cheung, Patrick Au, Kelly Feng and Ivan Yeo
- Dr Shyamala Nada-Raja (senior research fellow, Department of Preventive and Social Medicine, University of Otago) for advice
- the work of the SuMRC secretariat – Dr Carlene McLean (writer of this report), Dr Clive Aspin, and the support of the mortality review committee group secretariat.

Finally, and most importantly, the Committee acknowledges with respect that the information and intelligence given in this report represent the lives of individuals who died by suicide.

# Suicide Mortality Review Committee | Komiti Arotake Mate Whakamomori

Prof Rob Kydd (Chair)
*Professor of psychiatry at the University of Auckland*

Dr Sarah Fortune (Deputy chair)
*Consultant clinical psychologist and academic, University of Otago*

Taimi Allan
*Chief executive, Changing Minds Trust*

Tania Papali'i, Ngāpuhi/Ngāi Tai ki Tāmaki
*Programme lead resilience, Northland District Health Board*

David Cairns
*Suicide prevention coordinator, Pegasus Health*

Dr Maria Baker, Ngāpuhi me Te Rarawa iwi
*Chief executive, Te Rau Ora*

Denise Kingi-'Ulu'ave
*Clinical psychologist, Le Va*

Prof Roger Mulder
*Professor of psychology, Department of Psychological Medicine, University of Otago, Christchurch; Consult Liaison Service at Christchurch Hospital*

# Document purpose | Kaupapa o te pukapuka

This report by the Suicide Mortality Review Committee focuses on the impact of suicide on the Asian population of Aotearoa New Zealand.

In reviewing death by suicide affecting Asian people, we aim to reinforce previous work and highlight areas requiring action in policy development.

## Reading this report on suicide

If any of the issues in this report are personal for you and you want to talk to someone, please contact any of the agencies and services below.

If you need immediate help, please call:

- Need to Talk? 1737 call or text (mental health, depression, and anxiety counselling)
- Lifeline: 0800 543 354
- Suicide Crisis Helpline: 0508 828 865 | 0508 TAUTOKO; 12 noon to 12 midnight (those in distress, or those who are concerned about the wellbeing of someone else).

Other services available that offer support, information and help:

- Le Va: www.leva.co.nz
- LifeKeepers: www.lifekeepers.nz
- Waka Hourua: www.wakahourua.co.nz
- Aunty Dee: www.auntydee.co.nz – free online tool for anyone who needs some help working through a problem or problems; a systematic approach to decision-making based on structured problem-solving
- Depression Helpline: www.depression.org.nz | 0800 111 757, text 4202, 8am–12 midnight
- Suicide Prevention Information New Zealand | www.spinz.org.nz
- What's Up: www.depression.org.nz | 5–18-year-olds | 0800 942 8787 | 1–11pm
- The Low Down: www.thelowdown.co.nz | team@thelowdown.co.nz | text 5626 | 12 noon–12 midnight
- OUTLine NZ: 0800 688 5463 for support related to sexual orientation or gender identity
- Mental Health Foundation: www.mentalhealth.org.nz | list of resources (including videos) | download the bereavement handbook with updated support information
- Kidsline: (up to 14 years) 0800 543 754 (0800 kidsline) | 4–6pm weekdays
- Youthline: 0800 376 633 | free text 234 | talk@youthline.co.nz
- Samaritans: 0800 726 666
- Healthline: 0800 611 116
- Supporting Families (can provide support for whānau, bereaved by suicide) | http://supportingfamilies.org.nz
- Skylight (also gives contacts for people who hold local suicide bereavement support groups) | https://skylight.org.nz

You can also talk to your GP, local health professional, whānau or someone you trust.

## Guide for reporting on suicide

The Suicide Mortality Review Committee provides useful guides for journalists and the media when on reporting suicide. We recommend reviewing this guidance before reporting data and discussion included in this report: www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/3612.

# Contents | Ngā ihirangi

## Figures | Ngā tatau



## Tables | Ngā tūtohi

# Language used to talk about suicide | Te reo e whakamahia ana ki te kōrero mō te whakamomori

It is important to understand the language used to talk about suicide. Having a shared understanding helps us make better decisions together and reduces the potential for misunderstanding each other. Please consider the terms below when discussing suicide, whether you are collecting and analysing data or discussing prevention or interventions.[1]

Table 1: Preferred and undesirable language for talking about suicide

| Preferred term(s) | Undesirable term(s) | Reason for avoiding undesirable term(s) |
|---|---|---|
| Died by suicide | Committed suicide | Suggests suicide is a criminal act. |
| Suicide | Completed suicide, successful suicide | Suggests someone has achieved a desired outcome. |
| Suicide attempt; suicidal self-directed violence; non-fatal attempt | Failed attempt; non-fatal suicide | 'Failed attempt' gives a negative impression of the person's action, implying an unsuccessful effort aimed at achieving death.<br>'Non-fatal suicide' presents a contradiction: 'suicide' indicates a death, while 'non-fatal' indicates that no death occurred. |
| Suicidal thoughts and suicidal behaviour | Suicidality | Refers simultaneously to suicidal thoughts and suicidal behaviour, yet these phenomena are vastly different in occurrence, associated factors, consequences and interventions so should be addressed separately. |
| Non- or suicidal self-directed violence | Suicide gesture, manipulative act, suicide threat | Gives a value judgement with negative impression of the person's intent; usually used to describe an episode of non-fatal, self-directed violence. |
| People living with thoughts of suicide | Suicidal | Contributes to stigma of suicide; preferred term focuses on the person rather than the potential actions. |

Table 2: Glossary of terms used in this report

| Term | Meaning |
|---|---|
| Acculturation | Assimilation to a different culture, typically the dominant one |
| Deliberate self-harm | A deliberate act of self-inflicted injury without the intent to die; however, some people who self-harm are at increased risk of suicide. |
| Lived experience | A lived experience of mental distress and recovery. |
| Suicidal behaviour | The range of behaviours related to suicide and self-harm, including acute self-harming behaviours not aimed at causing death and suicide attempts; some also include deliberate risk-taking behaviours as suicidal behaviours. |
| Suicide | A person's deliberate and conscious act to end their life. |
| Suicide attempt | A range of actions where a person makes an attempt at suicide but does not die. |
| Suicide cluster | Multiple deaths in a community linked by geographical and/or social connections. If suicides have no obvious social connections, evidence of connection by area and time is required to define them as a cluster. |
| Suicidal contagion | Spreading of suicidal thinking, statements and behaviours through a community; where suicidal contagion occurs, a suicide cluster can also occur |
| Suicide ideation | When a person has thoughts about ending their life. |
| Suicide rate | A measure of how often a suicide occurs relative to the number of people in the population. Rates are more meaningful than numbers when comparing suicide data over time and between different populations. |

# Chair's introduction | Te kupu whakataki a te manukura

Each week in Aotearoa New Zealand, around 14 people die by suicide. Each day a much bigger number will deliberately harm themselves and even more will contemplate suicide.

Suicide is a complex issue; addressing death by suicide in Aotearoa New Zealand is complicated. Signs that it may occur can begin to appear in an individual, or community, many years before it happens. And its impact extends way beyond the individual with a devastating ripple effect.

But much of it is preventable.

For the remarkably diverse group of Asian people living in Aotearoa New Zealand, suicide and mental distress are compounded by issues related to their ethnicity and length of residence in this country. Both have profound effects on feelings of belonging and connectedness, which in turn affect mental health.

Mental distress and suicide affecting Asian people in this country have been a relatively hidden issue. The Government has appropriately focused its concern with inequity mainly on its Te Tiriti o Waitangi partner, tangata whenua Māori and, to some extent, on our Pacific neighbours. However, health and social policy should not ignore Asian mental health.

Like Māori and Pacific peoples, Asian people draw strength from family and whānau whakapapa, and their connectedness to their culture, beliefs and language. We should acknowledge these strengths and support Asian communities to build on them.

Tackling racism in all its forms, along with social disadvantage, isolation and exclusion, will have a large impact on suicide rates.

Building a health and social system that is compassionate, connected and equitable will mean that communities are resourced, no one is left alone, and help is there when and where it is needed. Ultimately, when we create a safe environment for children, help will not be needed in the first place.

It is our collective responsibility, across all social, justice and health agencies, to act now on what we know and fill the gaps in what we don't know. We cannot wait any longer.

There is hope. We are beginning to listen to whānau, to those with lived experience and to communities. We need to learn from those who are working effectively for individuals and communities, and against suicide. A knowledge of what is working for Māori, Pacific and Asian communities is out there. We just need to hear it – and act on it.

**Professor Rob Kydd**
*Chair, Suicide Mortality Review Committee*

# Executive summary | Whakarāpopototanga matua

The number of suicides in the Asian population in Aotearoa New Zealand is low relative to the number across indigenous and other ethnic groups, and the total population. However, this report highlights suicide within this group because the increasing number of Asian people in Aotearoa New Zealand combined with challenges of their integration and settlement in this country, has implications for social services and the mental health system. Key understandings framing this report are that:

- the rate of Asian suicide fluctuates but has been slowly rising, from 5.93 per 100,000 in 2007/08 to a high of 8.69 in 2017/18; in 2018/19 the rate was 7.63
- the Asian population in Aotearoa New Zealand is the third largest behind European and Māori, and is projected to increase to 22 percent by 2038, surpassing Māori and Pacific population groups
- even one suicide in any ethnic or population group is one too many
- action taken now to understand the factors contributing to suicide among Asian people and address the common and unique needs of this diverse and growing population group will prevent them from becoming a more significant group in our suicide statistics, prevent unnecessary distress for Asian communities and reduce the growing demand on health services.

To varying degrees, research and policy efforts have aimed to address the inequities and impact of colonisation for Māori, and inequity and immigration and settlement issues for Pacific peoples in Aotearoa New Zealand. However, while the Government has a responsibility to focus on the tangata whenua of Aotearoa New Zealand and the will to understand and support our Pacific neighbours, policies for Asian and refugee communities are under-developed.

In contrast, those bereaved and those with lived experience, frontline workers, analysts and academics have conducted sound research over the past few decades in Aotearoa New Zealand around Asian health issues and suicide. In 2006, the Ministry of Health reported that, 'policy settings needed to address broader structural issues relating to the social determinants of health for Asian people, including racial and institutional discrimination in the housing and labour markets, and in health care'.[3]

It is unethical that more has not been done with this collective wisdom and rich source of local knowledge that policy and practice change makers can access easily.

This report seeks to bring the issues around suicide for our Asian population to the forefront of conversations by government policy makers, practice change leaders and the communities that are both affected and can help. This work is especially important given the growth of the Asian population and the pressing needs of refugee communities.

This report provides significant insights into the:

- impact of racism on mental health, accessing support and receiving high-quality services
- effect of shame and stigma on asking for help
- need for culturally appropriate services – with increasingly culturally and linguistically diverse groups challenging our mental health system
- need to raise community awareness around mental health – Asian communities are still unaware of our general health and mental health system and of how to recognise mental distress.

# Defining 'Asian' | Te whakamārama i te 'Āhia'

Of the nearly 5 million people who live in Aotearoa New Zealand, more than a quarter were born in other countries. Many new residents in the 21st century have migrated from Asia. Between 2001 and 2013, the Asian population of Aotearoa New Zealand grew from 6 percent to 12 percent.[4] In 2018 Asian people were an estimated 15 percent of the population, compared with Māori at 16 percent.[5] The Asian population in Aotearoa New Zealand is projected to increase to 22 percent by 2038, surpassing both Māori and Pacific population groups.[6]

The Auckland region is home to the highest proportion of people born overseas. In 2013 almost 66 percent of the population of Aotearoa New Zealand who identified with at least one Asian ethnic group lived in Auckland.[7] Auckland District Health Board (DHB) provides health services for the largest Asian population in Aotearoa New Zealand: an estimated 27 percent of its consumers identify as Chinese, Indian or Other Asian. Asian groups are also a substantial part of the population that other DHBs in the Auckland region serve: 18 percent of Waitematā DHB's and 19 percent of Counties Manukau DHB's population.

Asian migration and settlement have been an integral part of forming the society of Aotearoa New Zealand. Organised Chinese migration into Aotearoa New Zealand began in 1866, with the arrival of Chinese miners to the goldfields in Otago, and people from India, Pakistan and Bangladesh started arriving here in the late 19th century as British subjects.[8] In 1899 the Immigration Restriction Act limited the diversity of immigrants by requiring anyone not 'of British birth and parentage' to fill out their immigration application in a European language. Since the 1990s, however, Asian groups have consistently contributed the greatest net migration to Aotearoa New Zealand with an average of over 15,000 people per year from 1996 to 2002. This trend has made Asian people the fastest-growing population in Aotearoa New Zealand, after Pacific peoples.

The Ministry of Health has previously reported that Asian people generally have health that is comparable with the total population of Aotearoa New Zealand, but some differences are evident. For example: Chinese and Indian people who have lived here for less than five years are more likely to be living in the most deprived quintile of small areas, and less likely to own a home; Asian people on average are more likely to have higher educational qualifications, lower incomes and lower employment rates than the Aotearoa New Zealand population in general; and recent or first-generation migrants have better health status than those born here, or who have lived here for a long period.[9]

Taking a strategic approach to addressing suicide by Asian people is complicated by the need to understand the cultural context in which suicide occurs – and that context will vary for the many different ethnicities drawn together under the collective umbrella of 'Asian'. Those identifying as Asian share some common beliefs and experiences, but come from diverse ethnic, religious and political backgrounds; their cultural values and beliefs vary depending on their particular subculture and the individual's own degree of acculturation to Western values.[10] Asian, Māori and Pacific communities share a common collective approach to family and social structures, but each community also has unique factors that contribute to deaths by suicide, none of which will be captured in an analysis of factors contributing to suicide events based on a mainstream, invariably Eurocentric perspective.

Through its work on the Living Standards Framework to assess the impact of government policies on intergenerational wellbeing, the Treasury has looked at the perspective of Asian people living in Aotearoa New Zealand.[11] It found the Asian population is experiencing issues that can reduce wellbeing, including issues related to mental health, access to health services, immigration, employment and experiences of discrimination.

First-generation Asian migrants tend to be healthier both directly because of immigration health screening and indirectly because they are screened for education, wealth and occupation.[12] Yet, as time goes on after they have migrated to Aotearoa New Zealand, their positive health status generally deteriorates towards the national average. Refugees, on the other hand, generally have poorer physical and mental health than the average but it improves over time. Analysing different groups within the broad Asian population also shows differences in health status. For example, Indian migrants have the highest rate of self-reported diabetes of all ethnic groups, and Chinese have a relatively high risk of stroke.[13] The patterns of suicide among new

migrants tend to be similar to those in their country of origin, but as their length of residence grows and as new generations are born and acculturate here, the suicide patterns tend towards those of the general population. Given these suicide patterns may differ from patterns in the general population, especially among new migrants, unique approaches and policies that target this group are necessary.[14, 15]

> *I was born and grew up in Lower Hutt, so I describe myself as a Hutt boy. I say that ironically because people don't really think of me as a Hutt Boy because I don't match their expectations of what a Hutt boy looks like. My ancestry in Aotearoa goes back five generations.*
>
> *When I was small, I felt like I was like any other kid at school, but other kids quite regularly pointed out that I was Chinese, you know making slanty-eyed gestures and calling me Ching Chong and putting on fake accents. Unfortunately, this is what kids do. Unfortunately, as I later discovered, this is what adults do, too.*
>
> *At school, the only non-white kids were me and my brother, a Samoan family and a Māori family. The reality is if you weren't white and middle class in the 1970s and 1980s, you were thought of as foreigners, even Māori, and that's what they thought of us.*
>
> *We didn't speak Cantonese at home; as recently as in my parent's generation, people were beaten for speaking Chinese. But it was something that was never really talked about; we just put our heads down, get on with life and take it on the chin.*[16]

.

# Background | He whakamārama

The reasons behind a death by suicide are complex and involve many layers. Although it may sometimes appear to be triggered by a single distressing event, as the media often simplistically describe it, in reality suicide is influenced by many risk factors, which often contribute over a lifetime, and by significant events in a person's life. These can include their social interactions (separation or lack of connection), physical (drug and alcohol, chronic pain, adverse childhood experiences), and cultural, economic and environmental factors,[17] including the ongoing impact of colonisation.[18] We see most of these factors appearing in the lives of those who have died by suicide in Aotearoa New Zealand across all ethnicities.

While greater access to high-quality mental health services is needed to address suicide,[19] suicide is not always, or simply, a mental health issue; not everyone who experiences depression has thoughts of suicide, and not everyone who dies by suicide has a mental illness.[20] To achieve the system change that is required to impact on suicide and self-harm rates, we need to understand and address the impact of the broader social determinants of mental health, such as education, employment, housing, social connectedness, discrimination and poverty. This work includes improving cross-government collaboration and achieving collective ownership.[21]

Although suicide has a wide and devastating impact, it is a relatively uncommon event at a current rate of 13 individuals per 100,000 people, and death by suicide in the Asian population in Aotearoa New Zealand is relatively low. However, the Suicide Mortality Review Committee (the SuMRC) believes these deaths are avoidable and create unnecessary suffering for those bereaved by suicide, peers, friends, colleagues and society on emotional, spiritual and material levels.

Suicide in Aotearoa New Zealand affects some ethnic groups more than others. The biggest inequity is evident in Māori suicide rates; the SuMRC is currently looking into the factors behind suicide among Māori young people (rangatahi) and women and girls (wāhine and kōtiro). This report focuses on the impact of suicide on the Asian population of Aotearoa New Zealand.

Asian people have been making Aotearoa New Zealand their home for over 150 years. The population designated 'Asian' has grown significantly in recent years. Despite this growth, the lack of suicide prevention strategies for Asian people living in Aotearoa New Zealand is a concern.

While many causes, risks and protective factors impacting on the Asian population are relevant to other ethnic groups, addressing the unique nature of death by suicide in each group requires separate analysis. Some features of suicide more specific to Asian individuals and communities include:[22]

- families and communities attaching stigma to suicide, based on their cultural views
- lack of linguistically and culturally appropriate services
- the potential role of collectivism, while it can also be protective, as a barrier to engaging with agencies and clinicians. When an Asian person needs help, another tends to speak on their behalf because of the collective nature of the family. This behaviour is not always compatible with the Western medical approach, which treats the patient as an individual and protects their right to confidentiality; the result is often that Asian patients will not speak up for themselves or openly disagree with the family member speaking for them.

This report does not review self-harm; but notes that suicide and self-harm have a complex relationship. Some of those who self-harm do not have suicidal thoughts at the time of harming.[23] However, this is a complex issue because people who self-harm have a higher risk of further self-harm and later suicide.[24]

A single death by suicide will impact on many people. Although it is not possible to know exactly how many, the impact may be more pervasive than previously thought and associated with significant adverse outcomes. One study estimated that over 100 people are exposed to a single suicide, with 20 percent reporting that it caused a major life disruption.[25]

In reviewing death by suicide affecting Asian people, this report aims to reinforce previous work and highlight areas requiring action in policy development. It raises some significant issues relating to suicide among the Asian population and also touches on a key factor contributing to suicide – racism. This report seeks to 'shine a light' in this area because:

- the population rate of Asian suicide has been resistant to a decrease and, with the projected growth in the Asian population, the rate may rise[26]
- a proactive approach is required now to address the needs of this diverse and growing population group, before it becomes a group that is represented more significantly in the suicide statistics.

# The extent of suicide | Te whānuitanga o te mate whakamomori

***Nā te hiahia kia titiro, ā, ka kite ai tātou te mutunga***

***You must understand the beginning if you wish to see the end***

## Data from around the world

Suicide is increasingly publicised as a global problem socially, economically and politically. In 2016 approximately 800,000 deaths around the world were by suicide.[27] Yet, despite its increasing media profile as a growing issue, the total global mortality rate from suicide actually decreased by almost a third from 16.6 deaths per 100,000 in 1990 to 11.2 deaths per 100,000 in 2016.[28]

China and India, the two most populated countries in the world, accounted for 44 percent of the world's deaths from suicide in 2016. India's contribution to global suicide deaths in 2016 increased in 1990 from 25 percent to 37 percent for women and from 19 percent to 24 percent for men,[29] and was the leading cause of death for those aged 15–39 years. A large drop in the suicide rate in China has contributed to the global reduction in suicide. The benefits of China's significant economic growth, higher employment and higher levels of education may have contributed to the overall decrease across the population. However, the rate of suicide among older adults in China increased,[30] which may be linked to the stress of these rapid changes as urbanisation brings with it a more individualistic society in which people experience lower levels of social integration.

Males globally have higher mortality rates from suicide than females.[31] However, female suicide rates have been higher in Asian countries (5.7–9.5 per 100,000) than in English-speaking countries (4.0–5.6 per 100,000).[32] Worldwide, young females have lower rates of suicide than males but higher rates of suicide ideation and attempts, although this ratio is much lower for countries across the group of Asian countries that extends from southern India to China.[33] A common explanation for the higher ratio of male suicides is that males have multiple risk factors, for example, having both mood and alcohol abuse disorders, and using more lethal suicide methods.

Although the reported global suicide rate has fallen, data indicates a worldwide trend of increasing mental distress, anxiety and depression. In total, an estimated 264 million people in the world were living with anxiety disorders in 2015, a 15 percent increase since 2005.[34] However, despite the high burden of mortality of suicide and morbidity of mental illness, relatively little evidence is available on the link between suicide and depression across Southeast Asia.[35]

## Data in Aotearoa New Zealand

Aotearoa New Zealand's suicide rate is often compared with rates in other countries. However, in comparing suicide data, it is important to remember that rates are affected by how countries produces their statistics. Countries differ in the standards and processes they use to decide whether a death is suicide; and coronial services differ in the level of proof they require to classify a death as suicide. Other differences lie in: the approach to identifying a person's intention of killing themselves; who is responsible for completing the death certificate; whether a forensic investigation is carried out; the provisions for confidentiality over the cause of death; the level of independence of coronial review processes; and cultural practices and beliefs around suicide.

In Aotearoa New Zealand, the total rate of suicide over the past decade has been considered 'relatively stable'.[36] However, recently the rate has increased each year between 2014 and 2019.[37] Suicide is the eighth-highest cause of death in Aotearoa New Zealand (1.6 percent of all deaths in 2015), which is higher than motor vehicle accidents (1.1 percent) and below influenza/pneumonia (2.4 percent).[38]

The Chief Coroner's annual report on suspected suicides in Aotearoa New Zealand in the 2018/19 year recorded the number of deaths as 685 and a rate of 13.93 per 100,000.[39] This was an increase in number and rate on the previous year (2017/18) of 13.67, and on the five years earlier.[40] The Aotearoa New Zealand-reported suicide rate is similar to those in other countries – in 2016, the rate was 11.9 per 100,000 in Australia and 13.9 for USA, 9.3 in Ireland in 2015, 10.4 in England and 13.4 in Scotland.[41, 42, 43]

Overall, suicide rates in Aotearoa New Zealand have been higher for males and Māori; lower for people aged 65 years and over, and slightly higher for people aged 13–24 years, compared with those aged 25–64 years; slightly higher for people living in rural areas; and increasing with increasing deprivation (although the extent of that difference depends on ethnicity).

Provisional coronial data showed Asian suicide deaths rose from 5.9 to 8.7 per 100,000 between July 2017 and June 2018, and dropped slightly to 7.63 in 2018/19. Between 2016 and 2017 provisional suspected self-inflicted deaths increased by 50 percent.[44] Of the self-inflicted deaths within the 'Asian' group, the ethnicities were 33 percent Indian, 28 percent Chinese, 15 percent Southeast Asian and 24 percent Other Asian. In 2018/19, 50 percent of the Asian group who died by suicide were employed, 25 percent were unemployed and 25 percent were students at the time of their death.[45]

In Aotearoa New Zealand, suicide rates for the Asian ethnic group have been low compared with other main ethnic groups, but higher than for Pacific peoples.[46] Chinese and Other Asian youth have had lower suicide rates than the total population, but Indian youth and Other Asian females have had similar rates to the total population. Chinese and Other Asian youth had significantly lower intentional injury hospitalisations than the total population; however, Indian female youth had a higher rate than the total population.[47] For Asian youth and middle-aged adults (those younger than 65 years), suicide rates were less than 7.0 per 100,000; rates were highest among those living in the most deprived areas, as with other ethnic groups.[48]

For the overall population in Aotearoa New Zealand, the male to female ratio of suicides is around 3:1. For Asian populations in particular, the average ratio has been around 2:1.

The age distribution of confirmed suicides in the Asian population was similar to the population average. Since the mid-1990s, suicide in middle-aged and older (45+ years) adults in Aotearoa New Zealand has been increasing.[49] As the population ages, suicides in this age group will become increasingly important, especially for those ethnicities with older populations – European and Asian. Declining physical health has already been shown to contribute to suicide among older Asian people in Aotearoa New Zealand.[50] Among the Asian population, the factors contributing to suicide appear to differ between youth, the middle-aged and the elderly, so different approaches are needed to address the needs of each age group.

The Asian population in Aotearoa New Zealand is relatively young: the median age is 30.6 years and a high proportion (31 percent) is aged between 15 and 29 years.[51] Of all groups affected by suicide, youth in Aotearoa New Zealand receive the most media attention because youth suicide rates here have been the highest among countries in the Organisation for Economic Co-operation and Development (OECD).[52] Rates for suicide by all those aged 15–24 years peaked in 1995 at 29 deaths per 100,000. Since 2012 (with 24 deaths per 100,000), the overall rate has been declining.

Asian Family Services have been working to improve the mental health and wellbeing of Asian families since 2016, and have been providing psychological interventions and psychoeducation and therapy workshops for Asian individuals and families. The organisation also provides a national support helpline.[53] Of the callers, 7 percent were international students. Apart from gambling, the main issues people were calling about were mental health issues (51 percent), interpersonal relationships (15 percent) and family violence (11 percent); gambling calls also related to mental health issues and interpersonal relationships. Observations have indicated that consumers of Asian Family Services, as well as Asian consumers of the services of district health boards (DHBs) and primary health organisations (PHOs), are following the trend of increasing distress and suicide in the Asian population in Aotearoa New Zealand. This mirrors increases in the rates of distress and suicide observed among Asian people and other ethnic groups in the United States of America.[54]

# Factors contributing to suicide | Ngā āhuatanga tautoko i te whakamomori

## Disadvantages of an individualistic approach to death by suicide and resilience

An individualistic view focuses on the personal behaviours and risk factors that contribute to or protect against suicide. While such factors are one area to consider, this approach draws attention away from the need to address systemic inequities through changing public policy.[55] Broader factors outside an individual's control that contribute to suicide include, for example, the economic environment, precarious employment, trauma and abuse, racism, poverty and social exclusion.[56] Ethnic minorities face the compounding issue of experiences of racism and deprivation; some experience a combination of gender, gender identity and ethnicity impacts – an experience we need to understand better in order to address it effectively.

This section provides an analysis of both system-mediated risk and protective factors over the various life domains. Taking this more holistic approach to understanding suicidal thoughts and behaviours[57] will help to develop more impactful and sustainable policy change.

## Discrimination and racism

Around the world and in Aotearoa New Zealand, researchers have long recognised that racism and colourism – discrimination based on race and skin colour – are a determinant of health and promote inequalities in health, mental health and social outcomes.[58,59,60, 61, 62, 63]

The impact of racism in Aotearoa New Zealand is shared across many ethnicities. Māori experience the greatest inequity in health outcomes in Aotearoa New Zealand, in part because of their loss of autonomy and sovereignty, and alienation from land, language and resources, due to colonisation.[64, 65, 66, 67]

The White New Zealand League, established in 1926, was opposed to both Chinese and Indian immigration because its members saw these immigrants as a threat to the racial integrity and economic prosperity of European New Zealanders. Its supporters included grower associations of market gardeners, labour organisations and the Royal New Zealand Returned and Services Association, and open racial tensions persisted until the late 1950s.[68, 69]

Many more Asian people report being affected by racism than all other groups. A 2018 study of national survey data found the Asian ethnic group experiences the most racism (15 percent), followed by Māori and Pacific peoples (both 10 percent), and Europeans (4 percent).[70] For Asian participants, those born overseas were twice as likely to experience racism compared with those born in Aotearoa New Zealand.

Ethnic discrimination, which students from indigenous and minority groups report more often than other groups, is associated with a range of adverse health and wellbeing outcomes for young people.[71, 72, 73] In Aotearoa New Zealand, these outcomes include reduced access to health care, poorer experiences as patients and adverse impacts on physical and mental wellbeing.[74, 75] These kinds of negative impacts result from entrenched social structures and policy frameworks that support racism.[76, 77, 78] For example, Asian people on average consume less fruit and vegetables and engage in less physical activity than the general population.[79] However, when they access primary care, their general practitioner (GP) is less likely to give them a 'green prescription' for free physical activity and nutrition support, compared with Europeans.[80]

Media in Aotearoa New Zealand portray the diverse group of international students from Asia as a single homogeneous identity, with stereotypical social and economic characteristics. This representation makes the students' interaction with the host population difficult by making them appear separate from other New Zealanders. It also leads to both open racism and unconscious bias, which gain support from the power imbalances that arise from having the dominant, Eurocentric culture.[81, 82]

Ethnic bias occurs at personal, interpersonal and institutional levels. Sometimes that bias is overt and conscious; at other times it is implicit, unconscious and automatic.[83]

## Implicit and unconscious racism

Public and social policy in Aotearoa New Zealand has not kept pace with the changes in the country's ethnic profile. The increasing cultural diversity of the population in Aotearoa New Zealand is challenging clinicians and practitioners.[84] Racial discrimination by health professionals has been associated with negative patient experiences.[85] A survey of DHBs and PHOs in 2011 found equity was embedded in policy for Māori, but not for other ethnic groups.[86] Generally, these health organisations struggled to put equity principles into practice, indicating that they had the will but were not acting on it, and that the strategic intent existed but was not applied.

The five types of racism related to health policy arise from:

- tyranny of the majority (policy makers are predominantly European)
- privileging biomedical Western evidence over indigenous knowledge
- cultural competencies and political values of the policy writers
- the consultation process (wrong questions, wrong people, wrong timeframe)
- organisational sign-off processes that mask or eliminate ethnic content.[87]

## Explicit and conscious racism

Asian people encounter explicit physical and verbal abuse specifically because of their ethnicity. Their reported experience of racial discrimination increased from 28 percent in 2003 to 35 percent in 2007, while it remained largely the same for other ethnic groups – Māori 29 percent, Pacific peoples 23 percent and Europeans 13.5 percent.[88]

Action Station research in 2018 found that 32 percent of Māori, 22 percent of Asian people, and 21 percent of Pacific peoples experienced racial abuse and harassment online.[89] Online racially directed abuse is a significant issue for Asian groups, and the impact is likely to see them withdraw from social media and potential sources of social support.

No treaty in Aotearoa New Zealand gives Asian people any protection or rights as they are not Tangata Tiriti. Instead, they are exposed to additional racially based stressors related to the view that they do not belong in the country. Other people reinforce this idea by directing hate speech at them such as, 'I was born here you were not', 'go home' and 'taking over the country'.[90, 91, 92, 93]

Although laws,[94] supported by an international treaty,[95] make it possible to prosecute someone for using speech designed to hurt or harm another, this rarely happens. Such cases are lacking because the threshold to meet the legal test is high and, as a group, Asian people in this country are less likely to complain about being exposed to racism. The British Government is implementing a system of hate crime legislation, policy, monitoring and community support for victims. British law uses terms broader than Aotearoa New Zealand's laws, requiring prosecutors to prove only an 'element' of hostility.[96]

## Stigma and shame around mental illness

To many Asian people, suicide is stigmatising and shaming both to the individual and to the collective esteem of the family. Due to traditional cultural and religious values, they may disapprove of divulging private or shameful information to people outside of the family, especially to a person of another culture.[97] It can also be difficult to find a suitable professional interpreter not known to the person or their family who will not contribute to the person's sense of shame and stigmatisation.[98] For this reason, many Asian people are more reliant on informal help with translation.[99]

> *Many Asians experienced survivor guilt when their loved one took their life. In the context of completed suicide, a feeling of shame which prevented family members from seeking emotional support. Consequently, the family usually carries the guilt and with no one to talk to and feels distressed, they are holding a secret. The secret further isolates the individual.*
> (Counsellor, Grief Centre)

A study on family violence and female Asian immigrants in Aotearoa New Zealand considered that reluctance to use services could be related to lack of awareness and access to resources.[100] Women were more likely to use prayer and faith to recover from sexual assault and intimate partner violence.[101, 102]

> *Many of our Asian clients do not differentiate between psychological distress and mental health,*

> *to them they think it is a weakness if you don't know how to deal with your own emotional problem. It takes a lot of sitting, listening and talking through with them to understand that, before we can begin to move on to support or treatment.* (Counsellor, Asian Family Services)

Self-reported depression has been less common in Asian ethnic groups compared with European and Māori.[103] However, Asian recent immigrants who experience difficulties in settlement show feelings of depression, hopelessness and isolation, and their feelings are intensified when they also experience discrimination. At the same time, cultural factors – including fear of failure, fear of returning home or losing visas, and having families in their countries of origin who depend on them financially – make it less likely that they will engage with mental health services or support services.

> *Many Asian patients are referred to me primarily suffering from stress, symptoms of depression; and emotional problems; presenting problems are related to couple relationship, parenting, adjustment to New Zealand culture. Asian people do not think psychological distress is an issue that needs help. To Chinese people, talking therapy means that you are gossiping about your problem, which goes against face-saving. They believe that support is only required when someone is experiencing a severe mental disorder.* (Asian service community coordinator, Age Concern)

Services may intensify the sense of shame. An Australian review of documents found that the risk and biomedical discussion in those documents had the effect of constructing people living with thoughts of suicide as 'dangerous', 'lacking coping skills' and 'burdensome'. This influence was particularly evident for people from ethnic minorities.[104]

Studies of Asian populations in their native countries show that they do not access mental health professional support to a great degree there either, largely based on cultural and/or religious stigma around mental health issues.[105] Therefore, developing culturally responsive services in Aotearoa New Zealand is only part of the solution.

Shame around addictions impacts on suicidal behaviour and support seeking. In the United Kingdom, for example, 19 percent of problem gamblers had thought about suicide in the past year, compared with 4 percent of non-problem gamblers and non-gamblers, and 5 percent of problem gamblers had made a suicide attempt in the past year, compared with 0.6 percent of the other group.[106] Gambling poses a unique risk to suicide because it is linked to a person's sense of extreme shame at their personal failure in meeting their responsibilities to their family.[107] Suicide is further linked to a history of substance or alcohol abuse or misuse, along with gambling.[108]

> *Mr L, in his mid-30s is married with two young children, and he is a gambler. He had previously been supported for his gambling addiction but was hesitant to contact the counsellor after his relapse. However, increasing pressure from his debtors led him to eventually divulge that he had lost a huge amount of money and was at a loss as to what he could do but did not want to let his family know. When the counsellor screened him with the Patient Health Questionnaire (PHQ-9), the results suggested that he was undergoing severe depression. He did not accept his feelings of fear, anxiety and hopelessness could be related to depression. He dismissed the counsellor's advice to see his general practitioner. A few days later, when the counsellor followed up, he had deteriorated and was distraught, and divulged his plan to kill himself. He engaged with the Asian Family Services team and a supportive cultural connection was made. The service walked sensitively alongside him and his family on the journey. The stigma and guilt eventually lifted, and his depression was acknowledged and treated.* (Asian Family Services)

The South Korean population has significant issues with poor mental health but has the lowest rate of antidepressant use in the OECD. Instead, people tend to see self-medication through alcohol use as more socially acceptable than psychiatric visits to treat mental illnesses. Around 40 percent of those who attempt suicide in South Korea do so while intoxicated. Of Chinese living in Wellington who needed help for dealing with psychological stress, only 5 percent chose to seek professional help,[109] while nearly 50 percent chose alcohol and 8 percent chose gambling as a coping mechanism.[110] Asian students with high expectations about academic performance and no close support also misuse alcohol and drugs.

> *Korean clients are hesitating to engage with services due to stigma and discrimination related to being perceived as weak when seeking professional*

*psychological intervention. Psychological distress is a sign of personal weakness instead of a natural human response to suffering. Many Koreans are Christian and have a strong affiliation with a local church. In a religious context in South Korea, people who show psychological distress are perceived as spiritually weak and are often advised to have faith in God and pray more as coping mechanism for dealing with emotional distress.* (Counsellor, Grief Centre)

## Poverty and deprivation

To address suicide, we need to change from a disease-specific focus to one based on a public health model, which involves a multipronged, population-oriented approach built on known best practices.[111]

It is well established that suicide and mental distress are linked with socioeconomic deprivation. They can contribute to inadequate living and working conditions and have a role in limiting resources, access to the fundamental building blocks of wellbeing, and opportunities to participate in society, which in turn impacts on social relationships, connectedness and support.[112]

Economic insecurity is an emerging socioeconomic determinant of mental health.[113] The insecurity that precarious employment creates is more damaging to mental health than realised previously. It is also more damaging for men and is not related to amount of income. In Aotearoa New Zealand, the suicide rate is higher for males than females of all ethnicities.

In Aotearoa New Zealand, a range of socioeconomic factors contribute to the pattern of suicide rates.[114] For example, being married is protective for both men and women, whereas employment is not protective for men aged 18–44 years and women aged 18–24 years. Lower socioeconomic position is linked with higher suicide rates, especially for young Māori men. Suicide rates are also higher among more educated women than among less educated women.

For Asian people in Aotearoa New Zealand, along with poverty, the main socioeconomic determinants of mental health are English-language competence, unemployment, education and home ownership.[115] Research shows Asian people are less likely to own their home, and those who have lived in Aotearoa New Zealand for less than five years are more likely to live in areas that belong to the most deprived quintile (the areas in the country ranked in the lowest 20 percent for socioeconomic deprivation). Despite having higher educational qualifications than average, Asian incomes were lower than those of the total population, suggesting that language proficiency and personal and institutional discrimination contributed to these results.

## Pressures on young people

Young people generally tend to be more impulsive and more prone to suicidal thinking and behaviours. When combined with mental illness, difficult relationships and stressful life events, those tendencies exacerbate distress and suicide ideation.[116]

*I am a 1.5 generation. I came to New Zealand 20 years ago as a teenager. As a 1.5-er, I experienced all the internal and external racism. Coming to New Zealand as a teenager put us in the role of being a translator for your family and learning how to be independent very quickly while you are still a child.*

*My first language is Cantonese, but I have been speaking English since I was 5.*

*At school and with peers, even til this day, I am expected to behave the 'Kiwi way', and at home, the 'Chinese way'. I am supposed to speak English at work and Chinese at home.*[117]

Most refugee youth experience bullying in their first 12 months of living in Aotearoa New Zealand.[118] Bullying occurs most commonly in schools, followed by public and social settings. Youth have identified the reason for the bullying as their ethnicity, religion or being 'a refugee', and it made them feel stressed and unsafe.

Asian young people face increased social complexities in their relationship with their parents when they migrate. They need to respect their parents' culture while trying to integrate into a new culture, as well as uphold conflicting identities and feelings of not belonging anywhere, all of which impacts on their mental health.[119] A study of Asian parents in Aotearoa New Zealand found that the qualities they prized in their children were obedience, respect and politeness.[120] Freedom and independence for their children were both

aspirational and problematic, and created conflict through the clash between parents' expectations and children's demands for the independence they observed among their Kiwi friends. While the younger generation adapts to the country through the New Zealand education system, the parents do not assimilate as well. As a result, family tensions develop through the conflict between a traditional collective society and the adopted individualistic society.

> *Young international students often feel they're not understood by parents while parents push them to study harder. Although they know parents care, expressing feelings of love from Chinese parents is not common. Often this might be the most needed thing – to hear that their parents care. Feeling unloved, not being heard or understood, internalises the stigma.* (Psychologist, Te Pou)

Asian students often work in an achievement-oriented and competitive atmosphere where stress is considered normal and inevitable. Acceptance of this attitude prevents them seeking help. This type of stress combined with isolation can lead to mental health issues and anxiety disorders, poor physical health and interpersonal conflicts.[121] The terms 'culture shock' and 'sojourner adjustment' describe the significant anxiety international students go through trying to adjust to a new culture.[122]

> *There has been an increasing trend of international students' death by suicide based on the cases that were reviewed by our Auckland DHB's suicide review group. There has been a lack of pastoral care, especially that comes with a social work or counselling background. Instead, most schools hire support from the student body, who speaks the same language, but not professionals who have knowledge and skills in psychological intervention.*
>
> *There are often signs, such as dropping grades, absenteeism, before the suicide, but these were not addressed.* (Auckland DHB)

Young students generally are often subject to additional pressures on top of academic ones, such as unrealistic parental expectations, relationship issues, and sexuality and identity crises. International students in Aotearoa New Zealand experience additional challenges of adjusting to a new culture,[122] new language and different education system, while also being detached from close family support.

> *Failure to perform leads to psychological distress when combined with social isolation, hopelessness and without adequate support from their immediate environment. This has led to some of the international students believing that their lives do not matter.* (Counsellor, Grief Centre)

## Older people and isolation

Immigration to Western countries can exacerbate the breakdown of the traditional Asian family unit. The experience can leave older Asian people with feelings of worthlessness and guilt, which may lead to a sense of isolation if they feel they are no longer valued, productive members of their family or of society.

> *For the older Chinese, their main issues usually relating to psychological abuse and neglect by closed family; older Chinese are lacking social support, which limits their opportunity to bond emotionally outside of their family. They also feel embarrassed about getting help from people which reflects poorly on their own parenting skills. I found older people tend to have difficulties in living with their children/ grandchildren as their lifestyle is quite different, ie, west vs east; old vs young; time vs work... It brought stress to all parties in the family as they lack mutual understanding and communication skills for all parties. So, these referrals mainly come through from police, DHB, friends/ neighbours and family; not much self-referral.* (Social worker, Age Concern)

For Asian families, the ethos of relationships and the importance of others maps onto kaupapa Māori views of health, whānau and identity. From a kaupapa Māori perspective, personal development and resilience sit within the context of values such as whanaungatanga, which is a sense of belonging to and holding a collective identity with others. Rather than being a property of the individual, resilience is built through social support and being accepted by others.

Migrants who have been in Aotearoa New Zealand longer, who have good English and friends outside their ethnic community, as well as migrants who came here at a younger age, express a greater sense of belonging. Being tangibly welcomed

by tangata whenua helps; refugees have found that participating in a pōwhiri gives them a much stronger sense of belonging in their new country.[123]

> *When I entered the marae they said, 'You are welcome, this is your home, everyone is free to do anything.' It makes you feel happy, you feel accepted to the community.*
>
> *We liked it [pōwhiri] – it means something when welcomed by the owners of the land, the speeches, the way food is given. You feel accepted in this country.* (Asian immigrant)

## Health system

When the health system loosely classifies people as belonging to the general group of 'Asian', it averages out the different health needs of different ethnicities within this group. The result is to make some high-needs groups invisible and mask the inequities between particular groups.[124] It also restricts appreciation of the diversity of the cultural practices, languages, migration patterns and family dynamics, and how these differences affect an individual's engagement with services and compliance.[125]

Engagement with health also varies due to diversity in customs and religious beliefs in Asian countries that influence responses to mental health, serious illness, family and gender roles, end-of-life care issues, and death and funeral practices.[126] The current approach to policy is to further classify the Asian group as three more specific ethnic groups – Chinese, Indian and Other Asian – as one attempt to minimise the drawbacks of overgeneralising ethnicity.

## A Eurocentric system

The Western biomedical model of health is concerned with the biological construct of human bodies; the way that Asian people understand mental wellbeing and illness can be fundamentally different to this.[127, 128] Among Asian cultures, traditional medicine sees health as based on harmony, while illness is based on factors both external and internal to the body and is therefore more connected to the mind and emotions.[129] To meet the needs of Asian people, therefore, the health system should focus less on improving access for the Asian population to Western medical models and Eurocentric services and more on encouraging clinicians to respect Eastern views of mental health and wellbeing, working with the consumer.

Mental health is often the single biggest contributor to life satisfaction, with a greater influence than physical health, income and unemployment.[130] Chinese people surveyed in Wellington had little knowledge of broader health determinants and paid less attention to their mental wellbeing than their physical health. They often sought medical treatment for physical symptoms, such as fatigue, abdominal pain and headaches, but were unwilling to link physical symptoms with underlying mental health issues.[131] The results showed two main sources of psychological pressure: cultural adaptation (eg, linguistic barriers) and environmental pressures (eg, academic, financial).

The reasons for needing to consult with multiple specialist practitioners in the Western model are often unclear to Asian families. They find they have to repeatedly explain their mental health conditions to many different clinicians and providers, which creates a growing sense of embarrassment and 'loss of face', and can lead to them dropping out of the process. Mental health providers start inappropriate interventions through misunderstanding cultural perceptions. Added to that, when Asian consumers have confidentiality concerns and do not trust the system, they completely disengage from it.

> *Services are not responsive to unique Asian needs, including ACC, Corrections, Justice and family violence services. Asian clients present with multilayer issues... services are prescriptive with a compartmentalised approach that does not suit new migrants to address complexity of their experiences and impact.* (Director, Saahaayta)

Researchers have observed that Western models of counselling, therapy and support are unsuitable in assisting Asian families following suicide attempts.[132] Asian people are less likely to access talking therapy and, among those who do, many drop out.[133] A study of clinical records of Asian patients in Western medical care found that dominant Western understandings of suicidal behaviour underpinned clinicians' cursory explanations for suicide attempts,[134] limiting further access to culturally appropriate professional supports. Te Pou reviewed the increasing use of Western forms of talking therapies among Asian people in Aotearoa New Zealand. It found that cultural, linguistic, communication and religious factors, in addition to presenting symptoms, needed to be considered when deciding on goals, communication and type of therapy.[135]

## Access barriers

In Aotearoa New Zealand, Asian people generally have lower rates of health service use than other ethnic groups across all measures.[136] The SuMRC trial found Asian people were less likely to access services than other ethnicities.[137] Data from the Integrated Data Infrastructure showed Asian people were half as likely as non-Asian people to have seen secondary mental health services in the three months or 12 months before their death by suicide.[138] In addition, 20 percent had contact with their GP in the three months before their suicide and three in five in the 12 months before. As to contact with secondary mental health services, 10 percent of Asian people had contact with a service in the three months before their suicide.

Among the services Asian people had lower rates of access to were screening services, mental health services, disability support and aged residential care.[139, 140] Compared with other ethnic groups, Asian people were also less likely to have a primary health care provider, to have seen a family doctor or any other health professional in the past year, and to have used a public hospital in the past year.[141]

While refugees and migrants of all ethnicities bring with them experiences of mental illness, health service use and trauma,[142, 143, 144] the Asian Family Services support team has observed that Asian consumers are usually more reluctant than any other ethnicity to seek psychological help. They hold back because they are concerned about stigma and discrimination, do not see mental health issues as a reason to get support or do not understand how psychological interventions work and their potential benefits.

A survey by Waitematā DHB on late presentation to health services by Asian patients found evidence that its Asian population is delaying seeking mental health services until they are acutely unwell. The reasons survey respondents gave were that they were not aware of the existence of mental health services; preferred to access alternative therapies; believed the services were culturally inappropriate, and lacked family support for entering mainstream services.[145]

Language and cultural issues are the two most widely experienced barriers to service use. Asian people (and those of other ethnicities) do not see mainstream mental health services as culturally sensitive. With health care providers not fully understanding Asian consumers' cultural and religious perceptions, consumers experience stigma and discrimination in these services. Mental health practitioners and consumers do not share the same language and lack access to appropriate interpreters (although it is also not ideal to include interpreters in discussions around mental distress). People in the broad group of migrants and refugees often have limited English language proficiency. Communication difficulties are compounded for those who, based on their past experiences, lack the motivation to communicate due to depression, trauma and/or mistrust of authority.

Young Asian people in Aotearoa New Zealand are less likely to access health care than their European counterparts.[146] Mental health service access rates are increasing for Māori, Pacific and Asian young people, but rates remain below those recommended to meet the needs of these populations.[147] More positively, the access rates for infants, children and adolescents to mental health and alcohol and other drug services have been increasing, and at a faster rate than in the adult population.

Health issues for older Asian adults create additional barriers to access. In 2011, 4 percent of people in Aotearoa New Zealand with dementia were Asian; by 2026, the percentage for European/other people with dementia is expected to drop but for Asian people it is expected to increase to 8.4 percent.[148] Often cultural reasons prevent families from seeking support for dementia. Such reasons include attributing dementia symptoms to 'normal' ageing and seeing it as a mental health issue, which then confers shame. Some cultures also promote the practice of families taking care of their older people themselves rather than asking for external aid.

## Workforce capability and competency

Part of the challenge for the health sector in developing more culturally responsive services for patients, consumers and families is to build a workforce that reflects the cultures they care for. The sector is also challenged by an ageing workforce that is expanding at a slower rate than the population. Among DHB employees in the mental health and addiction areas, 14 percent

identified as Asian, 11 percent as Māori and 7 percent as Pacific peoples; across all DHB staff, 19 percent identified as Asian, 8 percent as Māori and 4 percent as Pacific peoples.[149] These percentages indicate relatively few Asian staff work in mental health and addiction services.

The following case demonstrates how mainstream services with a lack of culturally competency do not have the skill set or understanding of how to approach Asian families and individuals in a way that engages them in the health system.

> *Master J, a late teen, called the Asian Helpline asking for the counsellor that had previously attended his family's case. He was distressed and desperate, saying that he was going to hurt himself with a pair scissors as he felt threatened by his family situation. He said that he did not feel comfortable to call other mainstream helplines and could only bear to call the Asian Helpline which he trusted. He was not confident of his English language ability and did not dare to call other helplines through frustration with being understood and misunderstood. He had locked himself in his own room with barricade to forbid his family members from getting close to him due to trust issues. The district health board youth mental health service was consulted about the case, but its response was that there was nothing they could do as he did not want to engage with them. Due to language difficulties and the nature of help that he needed, the family was isolated as there was no appropriate agency to attend to his case – it required the involvement of two Asian counsellors who would be present with the family, one to attend to the family, and one to engage separately with the teen. The time taken to engage with both in a culturally relevant way, resulted in commitment by both the young man and his family, and a sustainable and effective long-term plan developed.* (Asian Family Services)

The emergency department clinician's role in suicide risk assessment is to provide initial assessment and management of short-term risk. In discussing cultural competency, the 2016 suicide guidelines for emergency departments explicitly state that staff need to understand the stigma around suicide in some cultures[150] (while acknowledging risk factors as predictors are difficult to assess in the clinical setting). The guidelines acknowledge the importance of recognising the role of the family, particularly when assessing Asian or Indian individuals, as while they may appear to be 'westernised', they may still have strong cultural values, including beliefs about the importance of family and shame around mental health issues.

Several factors help to explain why ethnic minorities have an increasing need for effective services. These include that these groups are growing in size and are suffering increasingly inequitable access to services. In addition, communities are advocating more for unique cultural perspectives in services, and health law and policy are increasingly recognising the importance of being culturally responsive.[151, 152, 153] Responsive services need to focus on recovery, reflect relevant cultural models of health and take into account the clinical and cultural needs of people affected by mental illness and addiction. They must listen to service users and give access to full information, use collaborative processes at all levels, encourage feedback and do 'whatever it takes' to support easy and timely access to services.[154]

# A hopeful future | He anamata whai tūmanako

## Protective factors

A protective factor against suicide for Māori is having a strong cultural identity – knowing whakapapa, participating with whānau and at marae, having access to Māori land, associating with other Māori, knowing te reo Māori and identifying as Māori.[155] Similarly, cultural identity – identifying strongly with one's ethnic group and keeping up links with the Asian community and language – may be protective for Asian people.[156] At the same time, it is also desirable for those not born in Aotearoa New Zealand to integrate into and acculturate with the local community, as another factor considered to be protective.[157, 158]

As in te ao Māori, Asian cultures promote the importance of the family, interdependency and collectivism over individualism.[159, 160] Cultivating and maintaining social bonds and healthy family relationships can increase resilience and act as a protective factor against the risk of suicide. However, although collectivism may be protective to a point; young Asian people who have moved to a relatively individualistic culture can find it stressful to having a sense of belonging to one culture while living in and attempting to integrate into another.

Some Asian cultures have views similar to te ao Māori concepts of whakapapa (integrated relationship between ancestry, ethnicity, culture, identity and land), whanaungatanga (relationships), manaakitanga (duties and expectations of care), kotahitanga (collective unity) and wairuatanga (spiritual wellbeing). For their part, Māori have recognised that valuing elders, intergenerational living, customs around food, hosting guests or manaakitanga, and relationships or whanaungatanga are values they share with many Asian cultures.[161]

Embedding Māori concepts in public policy is critical for designing effective mental health and addiction and social support services for Māori but it will also benefit Asian and Pacific whānau. A holistic service approach to wellness, incorporating the Māori health model Te Whare Tapa Whā, will improve outcomes for Pacific and Asian populations with similar cultural views of whānau and community. This approach aims to make kaupapa Māori approaches the preferred service of model of care on the basis that initiatives that are responsive to the need for cultural competency, and holistic in their approach, will be more effective for all.[162]

To understand the complexities of an individual's life, and identify potential protective factors as well as risk, the SuMRC is developing a suicide review methodology based on a kaupapa Māori framework. Kaupapa Māori is a way of working that enables contexts for Māori whānau to be explicitly realised by recognising Māori as experts in their own community and whānau.[163] It privileges Māori knowledge and enhances tino rangatiratanga and self-determination of Māori.[164] This approach to reviewing death will also improve reviews of the suicides of Pacific and Asian individuals by providing a better understanding of cultural context.

## Promising practice

To reduce the stigma of seeking help, Asian Family Services has partnered with Apollo Medical to pilot a programme where a counsellor works one day a week in general practice so the practice can make a direct referral to the counsellor when Asian consumers are showing signs of mental distress and addiction issues, such as gambling. The concept assumes that the GP has built a good rapport and trust with the consumers and usually speaks the same language. Making the referral immediate and from a trusted and culturally similar person significantly reduces the stigma.

The approach has been very successful. Asian Family Services now works with three general practice clinics and a private training establishment to provide counsellors and social workers. The Alliance Health Plus Trust also contracted Asian Family Services to provide psychological services to its registered patients two or three hours weekly at the general practice clinics, which Auckland DHB's primary mental health initiatives support at Avondale Family Health Clinic. Demand for the services is high and there is a long waiting list for all clinics.

The success in enabling more Asian consumers to get the mental health support they need is primarily because they have a culturally appropriate and trusting relationship with their key primary care contact, and direct access to

appropriate counsellors and social workers in the primary care environment. With both a social worker and counsellor available, these professionals together can provide a comprehensive, holistic response to the complexity of Asian consumers' lives. The social worker always follows up with the consumer and checks in with them before an appointment to ensure they feel comfortable about and commit to attending the appointment. After the appointment, the social worker or counsellor provides the consumer with simple, language-appropriate resources. Because of their own cultural background, they approach counselling with the unique sensitivity, caution and respect required for Asian consumers, who usually have never had counselling before and do not understand its purpose. With this model, seven to eight counselling sessions are often enough to establish an ongoing level of trust and engagement in mental health services, so that consumers can access them when needed and before a crisis event.

Peer-led health promotion activities for Asian young people, by Asian peers, have been successful in helping shape attitudes, beliefs, intentions and behaviours.[165]

The following case shows the challenges faced by the 1.5 generation of young Asian people, transitioning between two worlds and cultures.

> *Riki arrived in Aotearoa New Zealand from Mainland China as a child of six with his parents and younger brother. Riki is a '1.5 generation' Chinese; he was born in China, yet his youth has been moulded by a Western environment and culture. Growing up in a foreign environment so young meant he readily adopted his new home and assimilated rapidly into a new, more 'culturally appropriate' way of behaving and being. But this created stress at home through conflicts with his parents, misunderstandings, anger and tears. His parents held onto their traditional values and beliefs, and expectations of the behaviours of children; these increasingly didn't match the behaviours they were seeing in their eldest son. Their need for him to conform created confusion and stress for Riki, and he found it impossible to be two people.*
>
> *At the age of 14, Riki was referred to Carole by his parents for counselling. They were concerned for his health, and for the wellbeing of the family, and tired of trying to get him to change, but things were deteriorating, they were feeling desperate. Riki agreed to see Carole but he knew counselling wouldn't do any good; he had previously seen his school's guidance counsellor, a nice Pākehā man, but it was too hard to discuss his real feelings, for Riki it seemed like another waste of time. But with his parent's insistence, he agreed to meet Carole, to 'get them off his back'. Carole, a Chinese social worker and counsellor in her 60s, was different. She was patient, warm and talked through her own whakapapa. She showed him, through her words, an in-depth understanding of Chinese family dynamics; Carole understood the potential impact of family.*[166] *After a few sessions Riki eventually told Carole that he had been self-harming to cope with his anxiety; he had been feeling that he didn't fit, and his life wasn't worth living. He hadn't made any specific plans to kill himself, but he was increasingly thinking about suicide as his only way out. He made sure he hid his distress and self-harm from his parents; he knew their perspective, and that they could never understand – he didn't really understand it himself. He told her how he felt suffocated in his own home, with no free time, unable to be himself and express himself. His family focused solely on his performance at school; it seemed their only real concern. Knowing the Chinese culture values authority meant Riki's voice was disregarded, but growing up in Aotearoa New Zealand, he had a voice and was desperate to be heard.*
>
> *To shift the balance of the dynamics of his family, Carole proposed a family intervention strategy to support Riki; he agreed, with relief. Together, Carole and Riki developed a plan, with daily actions, to help to ease his anxiety and create breathing space for him, time to be himself. He agreed to stop self-harming while they worked together. Carole also met with his parents separately; she spent time describing to them the cultures and behaviours of the people of Aotearoa New Zealand, the differences from and similarities with home. She also took some time to present Riki's view of his life in this country, life for young people transitioning between cultures, and how his parent's views and actions towards him were making him feel. Riki and his parents sat for hours with Carole, and they listened, cried and talked.*
>
> *The approach Carole used was culturally useful and worked for them because, as a collective society, Chinese individuals do not generally speak up for themselves; instead, authority*

*figures or credible individuals often take the respected role of advocating for the young or the 'weak'. Riki could not 'hear' his parents, and his parents would not hear Riki. The work with Carole gave Riki a new understanding of the perspective of his parents. They had never really talked about life in China, or described their expectations from a cultural perspective, just from a parental one. Through Carole's skill in her ability to gently explain to Riki the traditional worldview of his parents, and to break down the traditional Chinese values and beliefs that had not made any sense to him, he gained a new respect and understanding for them.*

*After some frustration and tears, much querying and clarifying, Riki's parents were able to understand some of the challenges for Riki growing up in another culture, accept that their views would be different, and make some changes to help show Riki he was supported by them, and to give him space to grow.*

*Riki continues talking and learning with Carole. He no longer self-harms, is content living at home and is doing well in school.* (Asian Family Services)

In Auckland, Waitematā DHB's Asian Health Services use cultural support coordinators or health navigators to support and address the need of culturally and linguistically diverse communities. Research shows that this role is effective because health navigators can bridge the gap between health services of primary health, secondary health and non-governmental organisations (NGOs) for the communities they serve.[167] The health navigator aims to build awareness and understanding of the cultural factors of the diverse communities they serve and of the ways such factors influence communities' help-seeking behaviours and health practices and beliefs. Their role is to assess the values, beliefs and practices related to health in the community being served; enhance communication between patients and providers; and advocate for the use of culturally competent practices in delivering services. However, navigators must have a history and experience with cultural groups for which they serve as broker. In particular, they need: the trust and respect of the community; knowledge of values, beliefs and health practices of cultural groups; an understanding of traditional wellness and healing networks within diverse communities; and experience of navigating health care delivery and supportive systems within communities. Other practical interventions suggested included providing services that are multilingual, culturally sensitive and community focused.[168]

Waitematā DHB's Community Child Health cultural case workers provide community and hospital-based support to migrant and former refugee families from culturally and linguistically diverse (CALD) backgrounds. The workers provide cultural support to children with special needs and their families, helping with education for parents about Aotearoa New Zealand health and education systems, coordination and navigation to relevant services/agencies, advocacy, and advice and support for health professionals. Cultural case workers work with different teams of health professionals, dietitians, social workers, nurses and psychologists.

At Auckland DHB, a separate mental health consultation service, which includes suicide prevention, works alongside the mainstream mental health teams. The services, comprising Asian staff, provides assessment and intervention directly to Asian clients, including post-vention work after a suicide in the Asian community, helping the surviving family members to work through their grief process.

In Counties Manukau DHB, the Wellness Support programme is a new model of care that works with and funds mental health and addiction interventions in primary care. It was developed and designed with the local community, with the initial focus on Māori, who, under the previous model had the worse health outcomes. With this new model this is now changing. The focus is now on Asian and Pacific populations. Asian clients expressed that the biggest barrier to accessing services was language. The programme has started a collaboration with a GP, a DHB occupational therapist and an NGO that has staff and groups in Mandarin and other languages. The programme is expanding to include the design of psycho-education workshops that will be delivered in a range of languages – and open to access via GP/attendance without referral.

Counties Manukau DHB also runs a mental health first aid programme for the public that helps individuals deal with challenging life situations and shows how to support others who are going through a difficult time. Two of the facilitators deliver these workshops primarily to Asian and Muslim communities, or groups seeking to better

understand the mental health needs of these communities. The training uses real-life situations, trained instructors teaching how to listen without judging, and it supports and encourages people to seek professional help if needed. 'You will learn a lifelong skill that will make a positive difference to you and others.' Community mental health support also includes Asian mobile support, specialising in services for non-English speaking clients in both Auckland and Counties Manukau DHB. Services recognise the importance of cultural strengths to wellbeing, matching staff to different language needs.

Auckland DHB runs a mental health consultation and liaison service to Asian clients and families. The service has a role in suicide prevention; as a consultation service, it works alongside mainstream mental health teams to provide assessment and intervention for Asian clients. The service has recently developed to include a post-vention approach, helping surviving family members work through their grief process in a culturally appropriate way.

Asian Wellbeing Services offers multi-lingual and culturally appropriate psychological interventions, tailor-made psycho-education and therapy workshops. This service is used by Chinese, Indian, Japanese and Korean clients who are not fluent in English and are not able to access free mainstream psychological services. The team of registered professionals include clinical psychologists, psychotherapists, counsellors, art therapists and social workers. Languages are available in Cantonese, Mandarin, Korean, Japanese and Hindi.

## Opportunities for change

### 1. Opportunities for community

> *Sometimes, talking with different kinds of people will take you out of your comfort zone but you know what, you don't always have to be comfortable. Sometimes being uncomfortable makes us better at working in harmony as humans. This is how you get to know each other, to get on with each other. This should be our goal.* [169]

Communities, not just individuals, can become depressed or anxious, disconnect from each other and lose the sense of trust and the ability to work together. Communities want access to national resources to create local solutions and seek wider powers to take charge of what they perceive to be the main causes of poor mental health outcomes for their communities.[170] Community-led initiatives designed from the ground up are paramount in addressing suicide and self-harm. Most of the support for distressed individuals happens within the community. It often takes a strengths-based approach, builds on what is working and has built-in leadership and collective ownership.

Policy development must recognise cultural differences of communities, such as the collectivist nature of Asian (and Māori and Pacific) communities, the strong identity linked to the harmony-seeking group, and families and communities that are often hierarchical. Policies for community support could include resource to:

- grow awareness of suicide as preventable, de-stigmatise suicide and mental illness, enhance mental health literacy and promote early help-seeking among Asian families and communities
- grow community capacity to prevent re-victimisation of bereaved families
- normalise settlement stress and promote the use of mental health services, and problem gambling and addiction services
- provide community health workers to deliver care in homes and community settings, and promote mental health services at social and sports locations – this approach has been effective through, for example, tai chi, badminton, table tennis, martial arts and religious organisations[171]
- provide culturally appropriate parenting programmes
- provide programmes and resources to help migrants integrate into their new communities
- grow awareness about post-vention services and the potential benefits of post-vention services for suicide prevention.

### 2. Opportunities for different sectors to work together

> *We cannot solve the problems on our own – we need everybody, especially those affected.* (Mental health provider)

Suicide is a complex issue that many social determinants of wellbeing contribute to. For this reason, the health system can provide only part of the response needed to address it. A truly effective response to suicide involves agencies across government to:

- listen to the voices of young people in Aotearoa New Zealand;[173] young people have said they want: access to great mental health services and affordable, accessible, excellent education; well-resourced community spaces to come together to connect across generations and to peers; to be supported to explore their identity, gain a sense of belonging and purpose without feeling pressured; and to learn about other cultures, sexualities and gender identities
- improve information-sharing and service pathways between secondary and tertiary mental health and addiction services and primary health care (general practices and PHOs) and social agencies
- address broader structural issues relating to the social determinants of health; socioeconomic stratification (eg, recognition of overseas qualifications and work experience) and racial discrimination (especially institutional discrimination in the housing and labour markets, and in health care)
- improve the care of people presenting to emergency departments with self-harm injuries, improve their transition and provide appropriate follow-up with social agencies and family
- involve family members in an intersectoral approach to care planning
- take a whole-of-government approach to providing a subsidised national language assistance service so non-English speaking Asian people with health issues can access funded interpreting services when they are dealing with multiple agencies, such as primary care, DHB services, community support services, police, Oranga Tamariki and/or family violence agencies – and align this approach with the development initiative of the Ministry of Business, Innovation and Employment's Language Assistance Service
- categorise 'Asian' mental health and social indicators into more specific ethnic groups – at least Chinese, Indian and Korean – to identify emerging risk groups and appropriate interventions.

## 3. Opportunities for health

*I really think talking with each other, intercultural dialogue, is the answer to a lot of problems we see in our communities. We don't want our own groups just talking to each other: we need the forums to include everybody. Sometimes I will be at a meeting that is supposed to help provide solutions for problems being faced by Asians, but I am the only Asian there.*
(Mental health professional)

In 2006 the Ministry of Health produced a comprehensive review of the health status of Asian people in Aotearoa New Zealand and provided policy advice.[174] The issues it documented then remain relevant at the time of writing this report:

1. Ensure suicide prevention plans and policies recognise and reflect the unique patterns and needs around Asian mental health issues and suicide; and develop specific strategies to address suicide prevention in subpopulations such as refugees.
2. Improve the cultural safety of mainstream health services.
3. Foster growth of Asian-specific health services and of the Asian health workforce.
4. Provide social services for new immigrants to help them build their English-language skills, to reintegrate them into the workforce and support them to acculturate in adaptive ways.
5. For the Ministry of Health – monitor its requirement for DHBs to acknowledge the diversity of patients; make services culturally appropriate, effective and safe; reduce inequities as required by the New Zealand Public Health and Disability Act 2000; and set standards of clinical competence and cultural competence as required under the Health Practitioners Competence Assurance Act 2003.
6. Deliver suicide prevention messages and resources to diverse Asian communities and programmes in Asian communities to reduce social isolation of vulnerable people.
7. Strengthen relationships with different Asian ethnic subgroups to understand specific cultural influences on suicide risk.
8. Establish a one-stop shop for mental health needs, combining social worker and counsellor roles, because Asian people face multi-layered issues that need to be addressed in one setting rather than across multiple settings.
9. Establish an NGO service that offers DHBs, NGOs and primary health care, and their Asian consumers, services to integrate Asian consumers into their recovery journey.

10. Provide bereavement support and follow-up for Asian families affected by suicide, and support Asian families to break down resistance and cultural barriers to accessing bereavement support and related services.
11. Develop a national web health system and health information portal and an 0800 multilingual call centre for new migrants, which provide information on how to enrol with a GP, a list of GPs, when to access emergency services, and culturally competent mental health professionals for early intervention (for an example, see the New South Wales Multicultural Health Communication Service, www.mhcs.health.nsw.gov.au).

## 4. Opportunities for education

*We often see Asian international students who are vulnerable due to social isolation, have complex needs, but are receiving insufficient pastoral care from their private training establishment.* (Area manager, Victim Support)

Many international students are living in isolation, often in inner-city apartments; new arrivals are most at risk. Their suicide methods seem to be similar to those in their home country. Many international students do not have sufficiently detailed knowledge of mental health and psychological distress. Some options for intervention are to:

- provide a wrap-around service to support young students when they first arrive in Aotearoa New Zealand, with a particular focus on coping and problem-solving skills
- provide a low-intensity cognitive behavioural programme for international students of Asian descent, which has proven effective in reducing depression and anxiety, and in improving adjustment to tertiary study in Aotearoa New Zealand[175]
- ensure international students have good health insurance coverage that includes primary care (GP) services so they can access health care for physical and mental health care needs.

## 5. Opportunities for workforce development

To develop the workforce in health and other sectors to respond effectively to the needs of Asian consumers, some options are to:

- develop a toolkit for health professionals on the Asian presentation of suicide risk
- address workforce resource constraints by enabling mental health, addiction and primary health professionals to work together in interprofessional practice, as part of a whole-of-system approach to improving outcomes for Asian consumers[176]
- use CALD cultural competency training and resources to improve cross-cultural interactions and understanding between health practitioners and Asian consumers and their families; and between staff[177]
- support practitioners, counsellors and social workers to understand mental health and suicide prevention, identify warning signs and appreciate cultural differences in the way Asian people may present with suicide risk
- train police, hotline volunteers, Victim Support and interpreters to identify individuals at risk of suicide and bereaved families, and equip them with culturally appropriate intervention skills
- expand mental health first aid training for health professionals with experiences of Asian suicides, and enable the trained to train community leaders and volunteers
- improve talking therapies for Asian consumers, with an approach that explores and respects cultural values around distress, involves families, draws on the support of the community and addresses stigma.[178]

.

# Future questions | Ngā pātai ā muri ake

The immediate next step for the SuMRC is to develop a robust analysis of the data on suicides, across all ethnic groupings under Asian. This will include looking into specific data sets that provide background on systemic issues, for example, education achievement, health service accessibility, social service responsiveness, justice sector engagement, family violence, and also more qualitative data that will underpin this service-focus, with context provided from in-depth analysis of some individual cases, from a life-course analysis. The SuMRC will provide a comprehensive data overview on Asian suicide in Aotearoa in 2020.

Other relevant and important areas the SuMRC will look at over time include:

- why Asians who are born oversees are more likely to experience racism than those born in Aotearoa New Zealand and why Asian people report experiencing racism in Aotearoa New Zealand more than Māori and Pacific peoples do
- the impact of isolation on Asian students or workers who move to Aotearoa New Zealand alone
- the role of social media as a tool that offers a protective factor against discrimination, and as one that supports discrimination
- the role of the family and extended networks, and specific cultural factors among Asian immigrants that influence suicide risk, for example, for Māori, whakapapa and whanaungatanga are supportive, whereas for Asian and Pacific families, home culture may be seen as additional pressure that does not fit with the new culture
- how Pacific and Asian families operate in their home countries and what happens when they migrate to Aotearoa New Zealand.

The SuMRC will also continue to work with stakeholders and those with lived experience to find out more about:

- the potential in our education system for embedding learning in terms of cultural intelligence and inclusion, and international examples of successful inclusivity and social connectedness practices linked to suicide prevention
- understanding the issues around reporting and recording hate speech and the cultural responsiveness of the justice sector.
- how psychological distress and suicide ratios compare among Māori, Pacific and Asian population groups
- best practice examples from overseas in the area of suicide prevention and post-vention in relation to Asian people.
- the impact of being migrants and second-generation New Zealanders – many Asian immigrants have not experienced racism at home and are skilled migrants who do not gain equivalent employment or income here, which does not match their high expectations of gaining good employment and income.

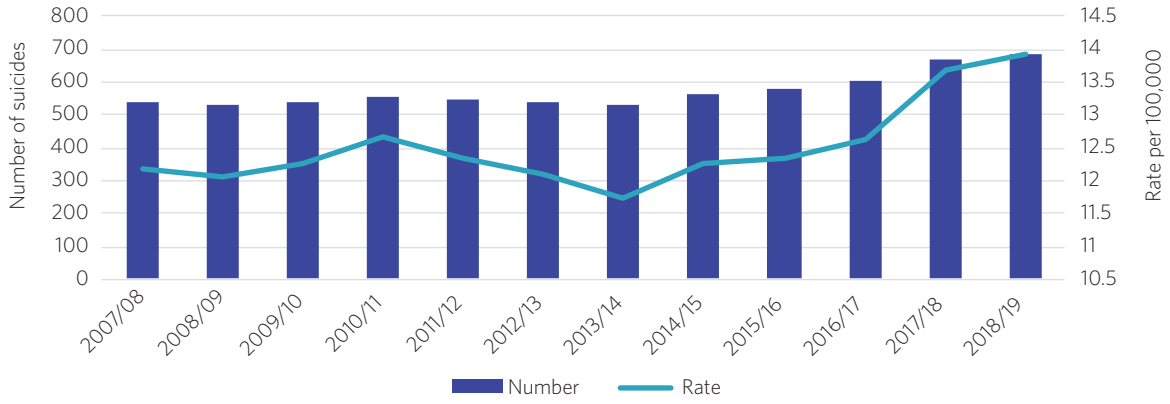
# Appendix: Data | Āpitihanga: Ngā raraunga

This report draws on data from the Chief Coroner's provisional data to 2019, the SuMRC database of suspected self-inflicted deaths, and the Integrated Data Infrastructure, as well as confirmed suicide data to 2017 from the Ministry of Health mortality database.

Suicide in 2016 was the leading cause of death in some countries in the Asia Pacific region. It was also among the top 10 leading causes of death in eastern Europe, central Europe, New Zealand, Australia and North America.[179]

The Chief Coroner's annual report on suicide in the 2018/19 year presented the provisional number of deaths by suicide in this country as 685 and a rate of 13.93 per 100,000 people (Figure 1).[180] This was an increase in number and rate on the previous year 2016/17 of 12.64, and on the five years before that.[181] The 2016/17 suicide rate was similar to the rate in 2010/11 of 12.65 per 100,000. By comparison, in 1995 and 1998 suicide rates reached a peak of about 15 per 100,000.

Figure 1: Coronial provisional suicide rate and number in Aotearoa New Zealand, 2007/08–2018/19

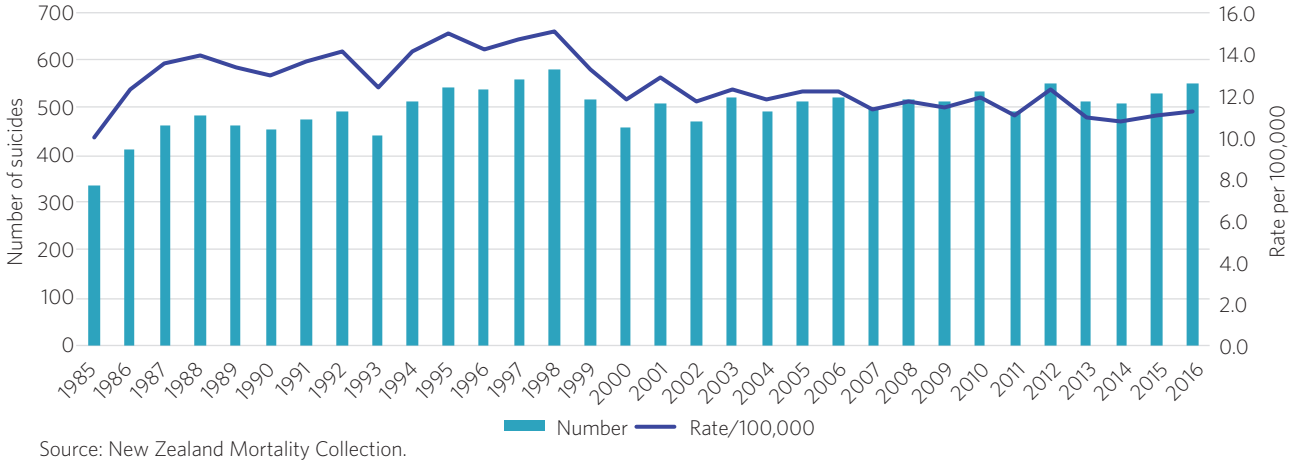



Source: Chief Coroner's provisional suicide statistics for 2018/19.[180]

The New Zealand Mortality Collection data shows a slight decrease in the total suicide rate over the 20-year period from 1996 to 2016. Over the 11-year period from 2006 to 2016, the rate of suicide has remained relatively stable year to year (Figure 2).[182] Over these 11 years, the suicide rate:

- for males has also generally decreased, although it has been at least 2.5 times more than the rate for females
- for youth has been variable (ranging from 14.1 per 100,000 to 23.0 per 100,000), but generally higher than the rates for the other age groups.

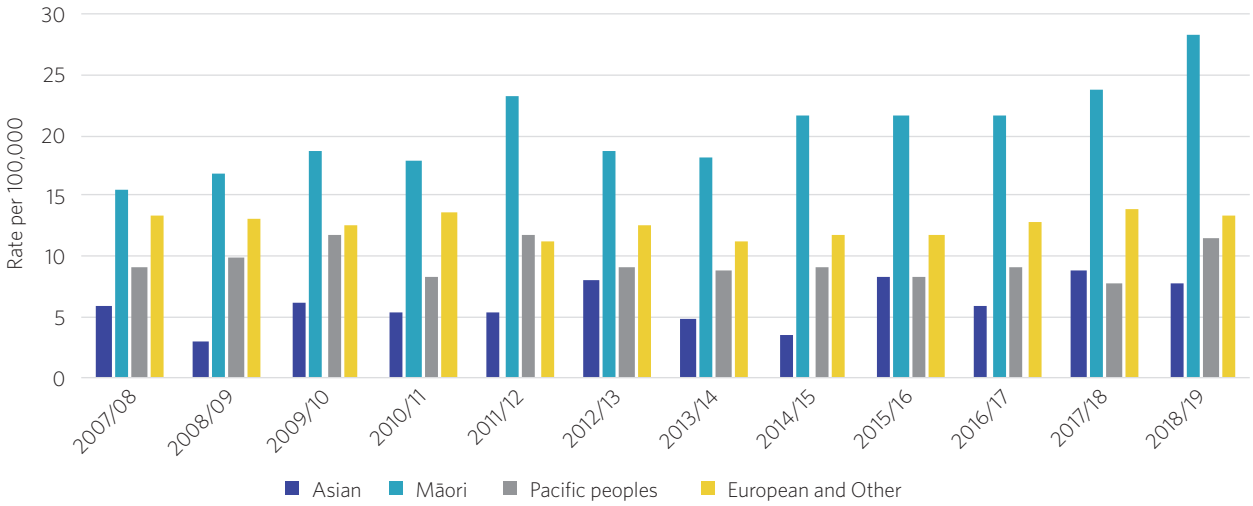
Figure 2: Number and rate of confirmed suicides in Aotearoa New Zealand, 1985–2016




Source: New Zealand Mortality Collection.

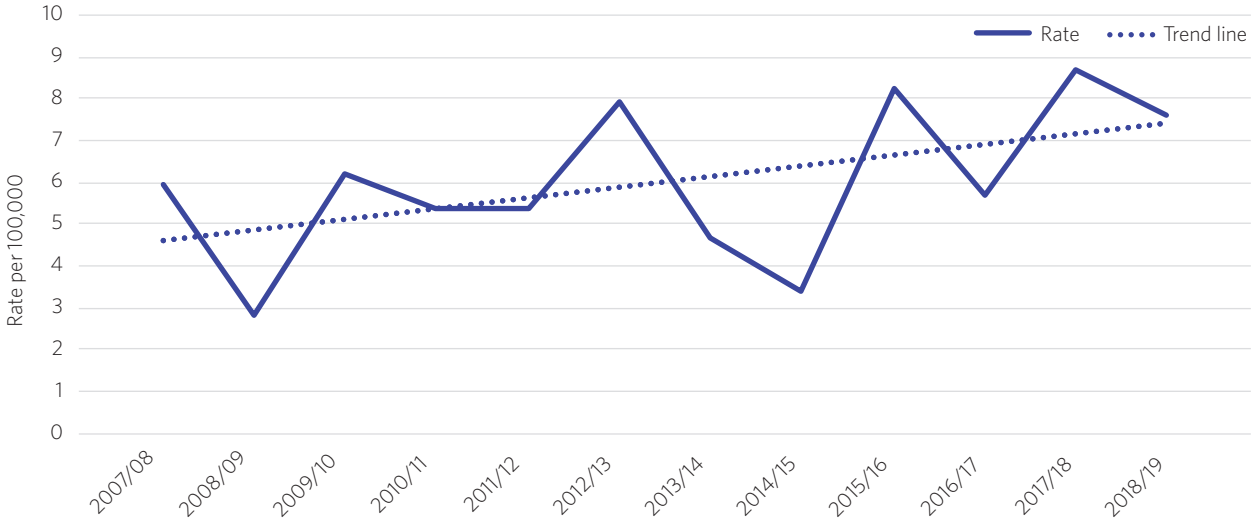
Overall has decreased slightly from the peak of 15.1 per 100,000 (579 deaths) in 1998 to 11.3 per 100,000 (553 deaths) in 2016.

Figure 3: Rate of provisional suicides in Aotearoa New Zealand, by ethnicity, 2007/08–2018/19




Source: Chief Coroner's annual report. [183]

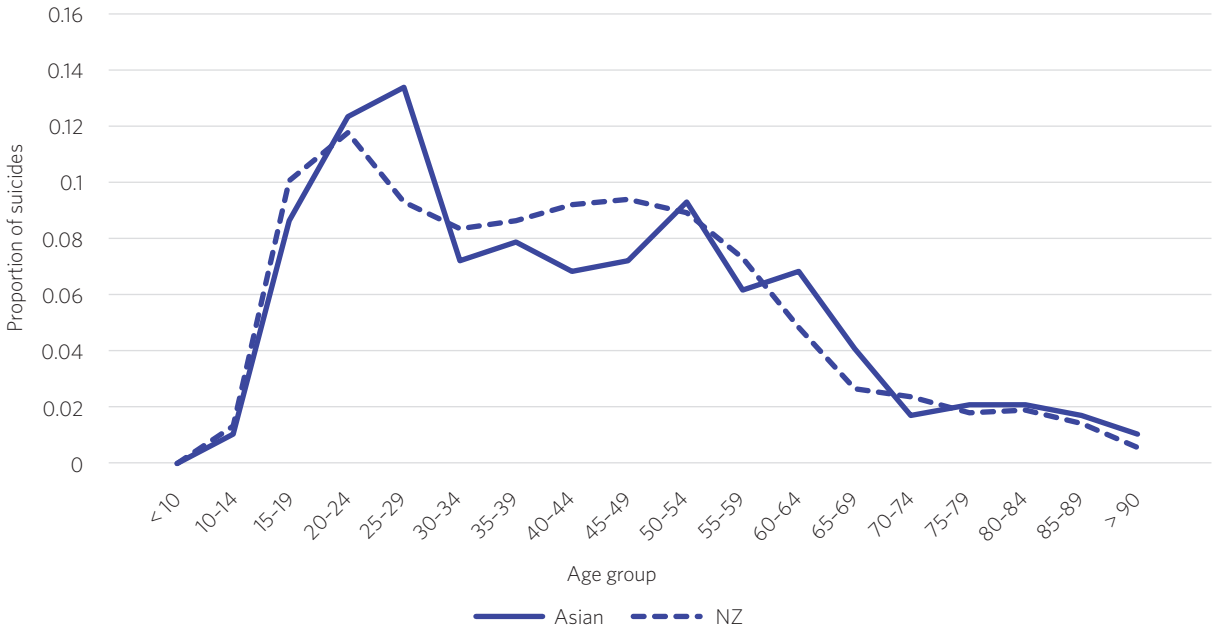
Figure 4: Rate of provisional suicides in the Asian population in Aotearoa New Zealand, 2007/08–2018/19




Source: Data from SuMRC database; best available data from Ministry of Health, may include provisional cases for 2017/18.

Note: The per-100,000 population rate shown in the Chief Coroner's annual report has been calculated using Statistics New Zealand (Stats NZ) annual population information as published following the 2013 Census. Ethnic groups have been classified as: Māori, Pacific peoples, Asian, European and Other. Indian and Chinese made up the majority of Asian suicides between 2006 and 2019; other deceased were from Sri Lanka, Nepal, Bangladesh, Afghanistan, Pakistan, Japan and Korea.

Figure 5: Proportion of confirmed suicides in each age group, by ethnicity (Asian vs non-Asian), 2006–17




Source: Integrated Data Infrastructure.

## Differences between coronial and Ministry of Health suicide data

The following are the main differences between suicide data from the Chief Coroner and that from the Ministry of Health.

- The Ministry reports data for the calendar year whereas coronial data covers the financial year, July to June.
- The Chief Coroner's provisional data includes all deaths initially identified at the coroner's office as self-inflicted. However, only those deaths determined as 'intentionally self-inflicted' after investigation will receive a final verdict of suicide. The Coronial Services Unit publishes the preceding year's provisional data every year, which can be two months after the end of the year, so can include a relatively large number of cases.
- In contrast, the Ministry reports on the data up to three years later so it contains fewer provisional cases: it reports on those deaths determined to be suicide after a completed coronial process and those provisionally coded as intentionally self-inflicted deaths before the final coroner's verdict, but more will have been finalised by the time of reporting.

Both sets of data were analysed by yearly quarter to compare the data more easily. The number of suicides that were reported as provisional by the coroner are higher than the subsequent total number of suicides coded by the Ministry of Health, once the Chief Coroner had determined the death to be a suicide. The provisional numbers were around an average of 10 deaths higher each year.[184]

## Asian ethnicities

Table 3 presents the different ethnic groups that Stats NZ gathers data on within the 'Asian' category.

Table 3: Stats NZ ethnic group profile list within the 'Asian' category

| | | |
|---|---|---|
| 1. Asian, not further defined | 2. Southeast Asian | 3. Filipino |
| 4. Cambodian | 5. Vietnamese | 6. Burmese |
| 7. Indonesian | 8. Laotian | 9. Malay |
| 10. Thai | 11. Chinese | 12. Hong Kong Chinese |
| 13. Cambodian Chinese | 14. Malaysian Chinese | 15. Singaporean Chinese |
| 16. Taiwanese | 17. Indian | 18. Bengali |
| 19. Fijian Indian | 20. Indian Tamil | 21. Punjabi |
| 22. Sikh | 23. Anglo Indian | 24. Sri Lankan |
| 25. Sinhalese | 26. Sri Lankan Tamil | 27. Japanese |
| 28. Korean | 29. Afghani | 30. Bangladeshi |
| 31. Nepalese | 32. Pakistani | 33. Eurasian |

## Prioritised ethnicity

The act of 'prioritising' is a methodology that assigns people to one ethnic group. It gives 'Māori' highest priority, followed by Pacific peoples, Asian, other ethnic groups and then European. In practice, if someone identifies as Māori and Pacific, for example, they will be coded as Māori. If someone identifies as Pacific and European, they will be coded as Pacific. This method simplifies an individual's ethnic identity, but may not represent their preferred ethnic identity, and undercounts all ethnic groups except Māori.

## Integrated Data Infrastructure (IDI)

The IDI is a large research database curated by Stats NZ. It contains matched, de-identified data on people and households in Aotearoa New Zealand that government agencies, Stats NZ surveys and NGOs have collected.[185] The IDI contains longitudinal data on more than nine million individuals, spanning many areas including accident compensation, crime, education, health, medical, social welfare and tax data. Stats NZ receives new data regularly and updates the IDI quarterly.

When integrating new data into the IDI, Stats NZ links each individual's records across multiple data sets before removing all identifiable features such as names, National Health Index (NHI) numbers and Inland Revenue Department (IRD) numbers. This allows researchers to view individuals' records and interactions across services and agencies, with minimal risk that the individual can be identified. This approach is one of the 'five safes', a framework Stats NZ uses to protect data in the IDI. Stats NZ regularly checks matched records as part of its quality assurance. In cases where Stats NZ is unable find an individual's exact match across tables, it uses probabilistic linking. This process estimates the closest possible match using all available information. The IDI can be accessed from secure environments called Data Labs; there are Data Labs at Stats NZ offices.

The SuMRC has used the IDI for analysis of larger population groups. The SuMRC acknowledges that the IDI results in this report are not official statistics. They have been created for research purposes from the IDI managed by Stats NZ. The opinions, findings, recommendations and conclusions expressed in this report are those of the SuMRC, not of Stats NZ or other agencies represented by the data.

Access to the anonymised data used in this study was provided by Stats NZ in accordance with security and confidentiality provisions of the Statistics Act 1975. For more details, see the privacy impact assessment for the IDI, which is available from www.stats.govt.nz.

# Endnotes | Tuhipoka


1 Centers for Disease Control and Prevention. 2011. *Self-directed Violence Surveillance: Uniform definitions and recommended data elements*; and the Clinical Advisory Service Aotearoa.

2 Office of the Chief Coroner of New Zealand. 2019. Provisional suicide statistics 2018/19. URL: https://coronialservices.justice.govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf (accessed 13 September 2019).

3 Ministry of Health. 2006. *Asian Health Chart Book 2006.* Wellington: Ministry of Health.

4 Stats NZ. 2014. 2013 Census QuickStats about culture and identity. Wellington: Stats NZ.

5 For census purposes, an ethnic group is made up of people who have some or all of: a shared culture such as traditions, customs, beliefs or language, a common ancestry, or history of a similar geographic, tribal or clan origin. The appendix lists the 32 ethnicities (along with a 'not further defined' category) that are under the Stats NZ 'Asian' umbrella.

6 Stats NZ. National population projections, characteristics, 2016(base)-2068. URL: http://nzdotstat.stats.govt.nz/wbos/Index.aspx?DataSetCode=TABLECODE7543&_ga=2.32664696.792125511.1557954037-1668522924.1546911850# (accessed 13 August 2019).

7 Stats NZ 2014, *op cit*.

8 Te Ara. Story: Indians. URL: https://teara.govt.nz/en/indians/ (accessed 13 August 2019).

9 Ministry of Health 2006, *op cit*.

10 eCALD. [Website focused on culturally and linguistically diverse groups who are migrants and refugees from Asian, Middle Eastern, Latin American and African backgrounds.] URL: https://www.ecald.com/ (accessed 13 August 2019).

11 Yong S. 2018. *An Asian Perspective and the New Zealand Treasury Living Standards Framework.* Wellington: Treasury.

12 Scragg R. 2016. *Asian Health in Aotearoa in 2011–2013.* Auckland: Northern Regional Alliance.

13 Ministry of Health, 2006, *op cit*.

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

15 Wong A. 2015. Challenges for Asian health and Asian health promotion. Auckland: Health Promotion Forum.

16 Fong D. 2016. The first 3 questions I get asked: Where are you from? No, Where are you really from? Do you work in IT? Human Rights Commission. URL: https://www.thatsus.co.nz/david-fong (accessed 13 August 2019).

17 World Health Organization. 2014. *Preventing Suicide: A global imperative.* Geneva: World Health Organization.

18 Lawson-Te Aho K. 2013. Whāia Te Mauriora in pursuit of healing. PhD thesis, Victoria University of Wellington.

19 Mental Health and Addictions Review Panel. 2018. *He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction.* Wellington: Government Inquiry into Mental Health and Addiction. URL: https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/ (accessed 13 August 2019).

20 Commonwealth of Australia. 2017. *The Fifth National Mental Health and Suicide Prevention Plan.* Canberra: Department of Health.

21 World Health Organization, Calouste Gulbenkian Foundation. 2014. *Social Determinants of Mental Health.* Geneva: World Health Organization.

22 Ho E, Au P, Amerasinghe D. 2015. *Suicide in Asian Communities: An exploratory study in NZ.* Auckland District Health Board.

23 Mars B, Heron J, Klonsky E, et al. 2019. Predictors of future suicide attempt among adolescents with suicidal thoughts or non-suicidal self-harm: a population-based birth cohort study. *Lancet Psychiatry* 6: 327–37.

24 Harrison J, Henley G. 2014. *Suicide and Hospitalised Self-harm in Australia.* Injury research and statistics series no 93. Canberra: Australian Institute of Health and Welfare.

25 Cerel J, Maple M, van de Venne J, et al. 2016. Exposure to suicide in the community. *Public Health Reports* 131(1):100–7.

26 Office of the Chief Coroner of New Zealand, 2018, *op cit*. .

27 World Health Organization. 2018. *World Health Statistics.* Geneva: World Health Organization.

28 Naghavi M. 2018. Global, regional, and national burden of suicide mortality 1990 to 2016: systematic analysis for the Global Burden of Disease Study. *BMJ* 364: l94.

29 Dandona R, Anil Kumar G, Dandona L. 2018. Gender differentials and state variations in suicide deaths in India: The Global Burden of Disease Study 1990–2016. *Lancet Public Health* 3: e478–89.

30 Wang C-W, Chan C, Yip P. 2014. Suicide rates in China from 2002 to 2011: an update. *Social Psychiatry and Psychiatric Epidemiology* 49: 929–41.

31 World Health Organization 2018, *op cit*.

32 Pritchard C, Baldwin D. 2008. Elderly suicide rates in Asian and English-speaking countries. *Acta Psychiatrica Scandinavica* 105(4): 271–5.

33 World Health Organization 2014, *op cit*.

34 World Health Organization. 2017. *Depression and Other Common Mental Disorders: Global health estimates.* Geneva: World Health Organization.

35 Ahmed H, Hossain M, Aftab A, et al. 2017. Suicide and depression in the World Health Organization South-East Asia Region. *WHO South-East Asia Journal of Public Health* 6(1) :60–6.

36 Ministry of Health. 2019. Suicide facts: 2016 data (provisional). URL: https://www.health.govt.nz/publication/suicide-facts-2016-data-provisional (accessed 13 August 2019).

37 Office of the Chief Coroner of New Zealand 2018, *op cit*.

38 Ministry of Health. 2018. Suicide facts: Data tables 1996–2015. URL: https://www.health.govt.nz/publication/suicide-facts-data-tables-19962015 (accessed 13 August 2019).

39 Under the Coroners Act 2006, any death in New Zealand 'that appears to have been without known cause, or self-inflicted, unnatural, or violent' must be reported to the coroner (s 14).

40 Office of the Chief Coroner of New Zealand 2018, *op cit*.

41 Organisation for Economic Co-operation and Development. 2018. Suicide rates. URL: https://data.oecd.org/healthstat/suicide-rates.htm (accessed 13 August 2019). Rates are directly age-standardised to the 2010 OECD population to remove variations from differences in age structures across countries and over time; presented as a total and per gender and measured in terms of deaths per 100,000 inhabitants (total).

42 National Records of Scotland. URL: http://www.nrscotland.gov.uk (accessed 13 August 2019).

43 govt.uk. http://www.ons.govt.uk (accessed 13 August 2019).

44 Note that numbers reported by the Chief Coroner are provisional and therefore are generally higher than those reported by the Ministry of Health; see the appendix.

45 Suspected self-inflicted death provisional data; coronial services unit data provided to the Suicide Mortality Review Committee.

46 Ministry of Health. 2014. *Suicide Facts: Deaths and intentional self-harm hospitalisations 2011*. Wellington: Ministry of Health.

47 Ministry of Health 2006, *op cit*.

48 Ministry of Health 2019, *op cit*..

49 Ministry of Health 2006, *op cit*.

50 Wang J, Ho E, Au P, Cheung G. 2018. Late-life suicide in Asian people living in New Zealand: a qualitative study of coronial records. *Psychogeriatrics* 18: 259–67.

51 Stats NZ. 2013. New Zealand Census 2013. Wellington: Stats NZ.

52 OECD 2018, *op cit*.

53 Asian Family Services, personal communication, 2019.

54 Wyatt L, Ung T, Park R, et al. 2015. Risk factors of suicide and depression among Asian American, Native Hawaiian, and Pacific Islander youth: a systematic literature review. *Journal of Health Care for the Poor and Underserved* 26(20): 191–237.

55 Fitzpatrick SJ. 2018. Reshaping the ethics of suicide prevention: responsibility, inequality and action on the social determinants of suicide. *Public Health Ethics* 11(2): 179–90.

56 World Health Organization 2014, *op cit*.

57 Mackin J, Perkins T, Furrer C. 2012. The power of protection: a population-based comparison of native and non-native youth suicide attempters. *American Indian and Alaska Native Mental Health Research* 19(2): 20–54. DOI: 10.5820/aian.1902.2012.20 (accessed 14 August 2019).

58 Jones C. 2000. Levels of racism: a theoretical framework and a gardener's tale. *American Journal of Public Health* 90(8): 1212–5.

59 Robson B, Harris R (eds). 2007. *Hauora: Maori Standards of Health IV. A study of the years 2000–2005*. Wellington: Te Ropu Rangahau Hauora a Eru Pomare.

60 Harris R, Cormack D, Tobias M, et al. 2012. The pervasive effects of racism: experiences of racial discrimination in New Zealand over time and associations with multiple health domains. *Social Science and Medicine* 74: 408–15. DOI: 10.1016/j.socscimed.2011.11.004 (accessed 14 August 2019).

61 Paradies Y, Ben J, Denson N, et al. 2015. Racism as a determinant of health: a systematic review and meta-analysis. *PLoS ONE* 10(9): e0138511.

62 Painting R. 2019. Colourism: Skin deep. URL: https://www.hqsc.govt.nz/blog/colourism-skin-deep/ (accessed 14 August 2019).

63 Veenstra G. 2011. Mismatched racial identifies, colourism, and health in Toronto and Vancouver. *Social Science & Medicine* 73(8): 1152–62.

64 Reid P, Cormack D, Paine SJ. 2018. Colonial histories, racism and inequity – the experience of Māori in Aotearoa New Zealand. *European Journal of Public Health* 28(Supplement 1). DOI: 10.1093/eurpub/cky044.003 (accessed 14 August 2019).

65 Smith LT. 2012. *Decolonizing Methodologies: Research and indigenous peoples* (2nd ed). Dunedin: Otago University Press.

66 Durie MH. 2001. *Mauri Ora: The dynamics of Māori health.* Auckland: Oxford University Press.

67 Harris R, Tobias M, Jeffreys M, et al. 2006. Racism and health: the relationship between experience of racial discrimination and health in New Zealand. *Social Science & Medicine* 63(6): 1428–41.

68 Te Ara, Story: Indians, *op cit*.

69 Te Ara. Story: Chinese. URL: https://teara.govt.nz/en/chinese (accessed 14 August 2019).

70 Harris R, Stanley J, Cormack D. 2018. Racism and health in New Zealand: prevalence over time and associations between recent experience of racism and health and wellbeing measures using national survey data. *PLoS ONE* 13(5): e0196476.

71 Crengle S, Robinson E, Ameratunga S, et al. 2012. Ethnic discrimination prevalence and associations with health outcomes: data from a nationally representation cross-sectional survey of secondary school students in New Zealand. *BioMed Central Public Health* 12(45).

72 Huang J, Dotterweich E, Bowers A. 2012. Intercultural miscommunication: impact on ESOL students and implications for ESOL teachers. *Journal of Instructional Psychology* 39(1): 36–40.

73 Chick K. 1996. Intercultural communication. In S McKay, N Hornberger (eds) *Sociolinguistics and Language Teaching*. Cambridge: Cambridge University Press.

74 Health Quality & Safety Commission. 2019. *A window on the quality of Aotearoa New Zealand's health care 2019 – a view on Māori Health Equity*. Wellington: Health Quality & Safety Commission. URL: https://www.hqsc.govt.nz/assets/Health-Quality-Evaluation/PR/Window_2019_web_final.pdf (accessed 14 August 2019).

75 PMMRC. 2018. *Twelfth Annual Report of the Perinatal and Maternal Mortality Review Committee: Reporting mortality 2016*. Wellington: health quality & Safety Commission. (accessed 14 August 2019).https://www.hqsc.govt.nz/assets/PMMRC/Publications/12th-PMMRC-report-final.pdf

76 Stanley J, Harris R, Cormack D, et al. 2019. The impact of racism on the future health of adults: protocol for a prospective cohort study. *BMC Public Health* 19: 346–56.

77 Love C, Lawson-Te Aho K, Love N, et al. 2016. *'Towards Mauri Ora': Entrepreneurship Education and Community Development for 'hard to reach' Rangatahi and their Whānau: Pathways and models for sustainable development.* Whakatāne: Te Whare Wānanga o Awanuiārangi.

78 Nazroo J. 1998. The racialisation of ethnic inequalities in health. In D Dorling, S Simpson (eds) *Statistics in Society*. London: Arnold.

79 Ministry of Health 2006, *op cit*.

80 Scragg 2016, *op cit*.

81 Tiatia-Seath J. 2014. Pacific peoples, mental health service engagement and suicide prevention in Aotearoa New Zealand. *Ethnicity and Inequalities in Health and Social Care* 7(3): 111–21.

82 Collins F. 2006. Making Asians students, making students Asian: the racialisation of export education in Auckland, New Zealand. *Asia Pacific Viewpoint* 47(2). 217–34.

83 Jones C. 2000. Levels of racism: a theoretical framework and a gardener's tale. *American Journal of Public Health* 90(8): 1212–5.

84 eCALD, *op cit*.

85 Harris R, Cormack D, Tobias M, et al. 2012. Self-reported experience of racial discrimination and health care use in New Zealand: results from the 2006/07 New Zealand Health Survey. *American Journal of Public Health* 102: 1012–9.

86 Sheriden N, Kenealy T, Connolly M, et al. 2011. Health equity in the New Zealand health care system: a national survey. *International Journal for Equity in Health* 10: 45.

87 Came H, McCreanor T, Haenga-Collins M, et al. 2019. Māori and Pasifika leaders' experiences of government health advisory groups in New Zealand. *Kōtuitui: New Zealand Journal of Social Sciences Online* 14(1): 126–35.

88 Harris et al 2018, *op cit*.

89 ActionStation. 2018. Online Racial Abuse Workshop, August.

90 Sharpe M. 2019, Taxi driver suspended after telling a man who's been a Kiwi for nearly 20 years to 'go home. *Stuff*. URL: https://www.stuff.co.nz/national/112430469/taxi-driver-suspended-after-telling-a-man-whos-been-a-kiwi-for-nearly-20-years-to-go-home (accessed 19 August 2019).

91 Small Z. 2018. 'Go home': Filipino family told New Zealand 'is for white people'. *Newshub*. URL: https://www.newshub.co.nz/home/new-zealand/2018/10/go-home-filipino-family-told-new-zealand-is-for-white-people.html (accessed 19 August 2019).

92 Whyte A. 2019. Racism 'something we're going to have to confront as a nation'. *Newsnow*. URL: https://www.tvnz.co.nz/one-news/new-zealand/racism-something-were-going-have-confront-nation (accessed 19 August 2019).

93 Harris D. 2019. Academic accused of 'racism' for saying 'Pākehā' after championing ethnic communities. *Stuff*. URL: https://www.stuff.co.nz/the-press/news/112474316/academic-accused-of-racism-for-saying-pkeha-after-championing-ethnic-communities (accessed 19 August 2019).

94 The Human Rights Act 1993 makes it unlawful to incite racial disharmony through publication or speech. The Crimes Act 1961 provides for potentially severe punishments for those who seek to harm others through their words.

95 International Covenant on Civil and Political Rights. URL: https://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx (accessed 14 August 2019).

96 Mok, Tze Ming . 2019. Violent racist guilty of violent racist attack: the law says: nah, no hate crime. *Spinoff*. URL: https://thespinoff.co.nz/politics/23-07-2019/violent-racist-guilty-of-violent-racist-attack-the-law-says-nah-no-hate-crime/ (accessed 14 August 2019).

97 eCALD, *op cit*.

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

99 Simon-Kumar R. 2018. Ethnic perspectives on family violence in Aotearoa New Zealand. Issues Paper 14, April. Auckland: New Zealand Family Violence Clearinghouse.

100 Pillai S. 2001. Domestic violence in New Zealand: an Asian immigrant perspective. *Economic and Political Weekly* 36(11): 965–74.

101 Bryant-Davis T, Chung H, Tillman S. 2009. From the margins to the center: ethnic minority women and the mental health effects of sexual assault. *Trauma, Violence, & Abuse* 10(4): 330–57.

102 Yingling J, Morash M, Song J. 2014. Outcomes associated with common and immigrant-group-specific responses to intimate terrorism. *Violence Against Women* 21(2): 206–28.

103 Scragg 2016, *op cit*.

104 East L, Dorozenko K, Martin R. 2019. The construction of people in suicide prevention documents. *Death Studies*. DOI: 10.1080/07481187.2019.1626938 (accessed 14 August 2019).

105 Asian Family Services, personal communication, March 2019.

106 UK: problem gamblers more likely to attempt suicide, research shows. 2019. *Yogonet Gaming News.* URL: https://www.yogonet.com/international/noticias/2019/07/22/50411-uk-problem-gamblers-more-likely-to-attempt-suicide-research-shows (accessed 14 August 2019).

107 Ministry of Health. 2019. *Progress on Gambling Harm Reduction 2010 to 2017: Outcomes report – New Zealand Strategy to Prevent and Minimise Gambling Harm.* Wellington: Ministry of Health.

108 Penfold A, Hatcher S, Sullivan S, et al. 2006. Gambling problems and attempted suicide: part II — alcohol abuse increases suicide risk. *International Journal of Mental Health and Addiction* 4: 273–9.

109 Ning B. 2018. *Wellington Chinese Psychological Health Survey 2018: An analytical report.* Asian Family Services.

110 Karlsson A, Hakansson A. 2018. Gambling disorder, increased mortality, suicidality, and associated comorbidity: a longitudinal nationwide register study. *Journal of Behavioral Addictions* 7(4): 1091–9.

111 Knox K, Conwell Y, Caine E. 2004. If suicide is a public health problem, what are we doing to prevent it? *American Journal of Public Health* 94(1)::37–46.

112 Shaw M, Dorling D, Davey Smith G. 2006. Poverty, social exclusion, and minorities. In R Wilkinson, M Marmot (eds) *Social Determinants of Health.* Oxford: Oxford University Press.

113 Kopasker D, Montagna C, Bender K. 2018. Economic insecurity: a socioeconomic determinant of mental health. *SSM – Population Health* 6: 184–94.

114 Collings S, Blakely T, Atkinson J, et al. 2005. *Suicide Trends and Social Factors New Zealand 1981–1999*. Report 5: Social Explanations for Suicide in New Zealand. Wellington: Ministry of Health.

115 Ministry of Health 2006, *op cit*.

116 Daniel S, Goldston D. 2009. Interventions for suicidal youth: a review of the literature and developmental considerations. *Suicide and Life-Threatening Behavior* 39(3): 252–68.

117 Chuang, B. 2016. Coming to New Zealand and making it home. Human Rights Commission.URL: https://www.thatsus.co.nz/coming_to_new_zealand_and_making_it_home (accessed 15 August 2019).

118 O'Connor R. 2014. *'Then Came Reality': Lived experiences of refugee youth in their first 12 months in New Zealand.* Hamilton: New Zealand Red Cross Refugee Services.

119 Rasanathan K, Ameratunga S, Chen J, et al. 2006. *A Health Profile of Young Asian New Zealanders Who Attend Secondary School: Findings from Youth2000.* Auckland: University of Auckland.

120 Metzger N, Ihaka T, Cameron E, et al. 2018. *New Migrant Parents: Understanding the experiences and attitudes of new migrant parents.* Auckland: Point Research and Whānau Mārama Parenting.

121 Ahmed et al 2017, *op cit*.

122 Lee KCK, Williams MW. 2017. The effectiveness and cultural compatibility of a guided self-help cognitive-behaviour programme for Asian students in New Zealand. *New Zealand Journal of Psychology* 46(2): 23–34.

123 O'Connor 2014, *op cit*.

124 Rasanathan K, Ameratunga S, Tse S. 2006. Asian health in New Zealand – progress and challenges. *New Zealand Medical Journal* 119(1244).

125 Ministry of Health 2006, *op cit*.

126 Lim S, Mortensen A. 2013. *Best Practice Principles: CALD Cultural Competency Standards and Framework*. URL: Waitematā District Health Board. URL: http://www.comprehensivecare.co.nz/wp-content/uploads/2013/03/Best-Practice-CALD-Cultural-Competency-Standards-Framework-Jun13.pdf (accessed 19 August 2019).

127 Te Pou. 2010. *Talking Therapies for Asian People: Best and promising practice guide for mental health and addiction services.* Auckland: Te Pou o te Whakaaro Nui.

128 'Western' here refers to primarily approaches used in the United Kingdom, the United States of America, continental Europe, Australia, Canada and New Zealand.

129 Ho E, Johnson M. 2013. Behaviours and beliefs about pain and treatment among Chinese immigrants and New Zealand Europeans. *New Zealand Medical Journal* 126(1370): 10–22.

130 Chisholm D, Layard R, Patel V, et al. 2013. *Mental Illness and Unhappiness*. CEP Discussion Papers dp1239.

131 Ning 2018, *op cit*.

132 Henare K, Ehrhardt P. 2004. *Support for Māori, Pacific and Asian Family, Whānau and Significant Others Who Have Been Bereaved by Suicide: Findings of a literature search.* Wellington: Ministry of Youth Development.

133 Takeuchi D, Mokuau N, Chun C. 1992. Mental health services for Asian Americans and Pacific Islanders. *Journal of Behavioral Health Services and Research* 19(3): 237–45.

134 East et al 2019, *op cit*.

135 Te Pou 2010, *op cit*.

136 Gibb S, Cunningham R. 2018. *Mental Health and Addiction in Aotearoa New Zealand. Recent trends in service us, unmet need, and information gaps.* Report commissioned by the Mental Health and Addictions Inquiry Panel.

137 Suicide Mortality Review Committee. 2016. *Ngā Rāhui Hau Kura: Suicide Mortality Review Committee Feasibility Study 2014–15*. Wellington: Health Quality & Safety Commission. URL: https://www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/2471/ (accessed 15 August 2019).

138 Integrated Data Infrastructure obtained January 2019.

139 Ministry of Health 2006, *op cit*.

140 Mehta S. 2012. Health needs assessment of Asian people living in the Auckland region. Auckland: Northern District Health Board Support Agency.

141 Scragg 2016, *op cit*.

142 China Youth and Children Research Center, Institute of Psychology under Chinese Academy of Sciences. 2019. China Youth Daily.

143 Hong Kong Playground Association. 2018. *Study on Life Situation and Mental Well-being of Youth in Hong Kong*. URL: http://hq.hkpa.hk/newscontent1.php?lang=en&news_id=40 (accessed 15 August 2019).

144 Ngai MMY, Latimer S, Cheung VYM. 2001. *Final Report on the Healthcare Needs of Asian People: Surveys of Asian people and health professionals in the North and West Auckland.* Auckland: Waitematā District Health Board. URL: https://www.ecald.com/assets/Resources/Healthcare-Needs-of-Asian-People.pdf (accessed 15 August 2019).

145 Lim S, Mortensen A, Feng K, et al. 2015. *Late Presentations by Asian People to WDHB Mental Health Inpatient Services Project Report*. Auckland: Waitematā DHB.

146 Ameratunga S, Tin Tin S, Rasanathan K, et al. 2008. Use of health care by young Asian New Zealanders: findings from a national youth health survey. *Journal of Paediatrics and Child Health* 44: 636–41.

147 The Werry Workforce – Whāraurau. 2017. *2016 Stocktake of Infant, Child and Adolescent Mental Health and Alcohol and Other Drug Services in New Zealand*. Auckland: University of Auckland.

148 Ministry of Health. 2013. *New Zealand Framework for Dementia Care*. Wellington: Ministry of Health.

149 Te Pou o te Whakaaro Nui. 2018. DHB mental health and addiction employees: 2018 profile. Auckland: Te Pou o te Whakaaro Nui.

150 Ministry of Health. 2016. *Preventing Suicide: Guidance for emergency departments*. Wellington: Ministry of Health.

151 Ministry of Health. 2006. *Te Kōkiri: Mental Health and Addiction Action Plan 2006–2015*. Wellington: Ministry of Health.

152 New Zealand Health and Disability Sector Standards 2008.

153 New Zealand Public Health and Disability Act 2000.

154 Te Pou. Service responsiveness to Asian, refugee and migrant populations: Factsheet series. URL: https://www.tepou.co.nz/resources/service-responsiveness-to-asian-refugee-and-migrant-populations-factsheet-series/141#downloads (accessed 15 August 2019).

155 Coupe N. 2005. Whakamomori: Māori suicide prevention. PhD thesis, Massey University.

156 Iwamoto, D, Liu W. 2010. The impacts of racial identity, ethnic identity, Asian values and race-related stress on Asian Americans and Asian international college students' psychological well-being. *Journal of Counselling Psychology* 1(57): 79–91.

157 S Nada-Raja, personal communication, 2019.

158 Ho E, Bedford C, Cooper J. 2002. *Mental Health Issues for Asians in New Zealand: A literature review prepared for the Mental Health Commission*. Hamilton: University of Waikato.

159 Durie M. 1997. Māori cultural identity and its implications for mental health services. *International Journal of Mental Health* 26(3): 23–5.

160 Puna E, Tiatia-Seath J. 2017. Defining positive mental wellbeing for New Zealand-born Cook Islands youth. *Journal of Indigenous Wellbeing* 2(1).

161 Ihi Research. 2019. *Perceptions of Asian and Asian Peoples from a Te Ao* Māori Perspective – 2018 Survey. Asia New Zealand Foundation – Te Whītau Tūhono.

162 National DHB General Manager Māori Strategic Reference Group. 2018. Tumu Whakarae. Submission to the Government Inquiry into Mental Health and Addiction.

163 Simmonds S. 2019. *Evidence Review of Effective Reduction Interventions for Māori Whānau and Communities*. Wellington: Fire and Emergency New Zealand.

164 Walker S, Eketone A, Gibbs A. 2006. An exploration of kaupapa Māori research, its principles, processes, and applications. *International Journal of Social Research Methodology* 9(4). 331–44.

165 Wong A. 2015. Challenges for Asian health and Asian health promotion in New Zealand. Auckland: Health Promotion Forum of New Zealand.

166 Dube S, Anda R, Felitti V, et al. 2001. Childhood abuse, household dysfunction, and the risk of attempted suicide throughout the life span. *Journal of the American Medical Association* 286(24): 3089–96.

167 Mortensen A, Latimer S, Yusuf I. 2014. Cultural case workers in child disability services: an evidence-based model of cultural responsiveness for refugee families. *Kotuitui: New Zealand Journal of Social Sciences* 9(2): 50–9.

168 Lim et al 2015, *op cit*.

169 Phuang J. 2016. People who tell us to go home need to know: we are home. Human Rights Commission. URL: https://www.thatsus.co.nz/jessica-phuang (accessed 15 August 2019).

170 Mental Health and Addictions Inquiry Panel 2018, *op cit*.

171 Lim et al 2015, *op cit*.

172 Kim H. 2013. Parenting patterns of '1.5 generation Kowis' in New Zealand: take best of both worlds to raise the next generation. *New Zealand Journal of Asian Studies* 15(2).

173 ActionStation, Ara Taiohi. 2018. Ngā Kōrero Hauora o Ngā Taiohi. Wellington: ActionStation, Ara Taiohi.

174 Ministry of Health 2006, *op cit*.

175 Lee KCK, Williams MWM. 2017. The effectiveness and cultural compatibility of a guided self-help cognitive-behaviour programme for Asian students in New Zealand. *New Zealand Journal of Psychology* 46(2): 23–34.

176 Te Pou. 2019. *Developing Sustainable Interprofessional Practice in Mental Health and Addiction Services: A literature review*. Auckland: Te Pou o te Whakaaro Nui.

177 Waitematā DHB – CALD training and resources, www.ecald.com.

178 Te Pou 2010, *op cit*.

179 World Health Organization. 2018. World Health Statistics. Geneva.

180 The Coroners Act 2006 states that any deaths in New Zealand 'that appears to have been without known cause, or self-inflicted, unnatural, or violent' must be reported to the coroner (s 14).

181 Office of the Chief Coroner of New Zealand 2018, *op cit*.

182 Ministry of Health 2018, *op cit*.

183 Office of the Chief Coroner of New Zealand 2018, *op cit*.

184 Ministry of Health. Understanding suicide in New Zealand. URL: https://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide/understanding-suicide-new-zealand (accessed 16 August 2019).

185 Social Investment Agency 2017. *Social Investment Agency's Beginners' Guide to the Integrated Data Infrastructure.* Wellington: Social Investment Agency. https://sia.govt.nz/assets/Documents/Beginners-Guide-To-The-IDI-December-2017.pdf (accessed 19 August 2019).

newzealand.govt.nz

Health Quality & Safety Commission New Zealand
*Kupu Taurangi Hauora o Aotearoa*