

SUICIDE IN ASIAN COMMUNITIES

AN EXPLORATORY STUDY IN NZ - 2015

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EXECUTIVE SUMMARY

This is a joint research project between Planning and Funding of the Auckland District Health Board and the Centre for Asian and Ethnic Minority Health Research at the University of Auckland. The overall aim of the project is to study the phenomenon of Asian suicide in New Zealand, Asian countries and other Asian immigrant communities in Western countries to provide better information to guide the development of culturally appropriate suicide intervention strategies in New Zealand. The specific objectives are:

1. To analyse Asian suicide data in New Zealand and to identify high risk groups;
2. To review national and international literature on suicide in Asian communities, including risk and protective factors for suicide, and their implications;
3. To ascertain the impact of immigration on suicide;
4. To interview key service providers to explore and improve understanding of the key issues relating to suicide for Asian families and communities, and to identify effective prevention and postvention strategies; and
5. To make recommendations on the next steps.

Key findings of the project are summarised below. The next section is a brief analysis of Ministry of Health suicide data for Asians between 1996 and 2010. Section three provides a critical review of literature on suicide in Asian countries as well as in Asian immigrant communities in Western countries, focussing on suicide trends, methods, and risk and protective factors. Section four examines the findings of key informant interviews. The interviews have provided insight into warning signs of suicide, vulnerable groups, gaps in current services and suggestions for suicide intervention. The report concludes with some recommendations for future actions and research.

Suicide Data

The data source for this section is Ministry of Health data on suicide deaths for Asians between 1996 and 2010. Preliminary analysis of the dataset shows that:

- the total number of suicide deaths has increased from 80 between 1996 and 2000, to 84 in 2001-2005, with a further rise to 98 in 2006-2010;
- annual Asian suicide rates fluctuated between 3.3 and 11.4 per 100,000 people over this period. These rates are much lower than the estimated rates for the total New Zealand population, which ranged from 12 to 15.7;
- suicide gender ratio in Asians is lower than in the total New Zealand population. In the New Zealand total population, suicide rates for males are about three times higher than those for females. For Asian people, the gender ratio is 1.2:1 in the five years from 2006-2010;
- since the mid-1990s, suicides among middle-aged Asians between the ages of 45 and 64 years, as well as among older people aged 65 years and older, have increased;
- between 1996 and 2010, suicides in the three Auckland DHBs accounted for increasing proportions of the total suicide deaths among Asians, from 52.5 percent in 1996-2000 and 61.9 percent in 2001-2005, to 67.3 percent in the five years between 2006 and 2010.

Literature Review

The documents reviewed in this section covered a wide range of New Zealand and international literature, mostly published between January 2000 and March 2014, to investigate suicide trends, demographic patterns, methods, and risk and protective factors in Asian countries as well as in Asian immigrant communities in Western countries. In total, items in 10 Asian countries or regions were selected for review: China, Hong Kong SAR, India, Japan, South Korea, Pakistan, Singapore, Sri Lanka, Taiwan and Thailand. Due to the limited availability of research on suicide within New Zealand's Asian communities, articles relating to suicidal behaviour in similar Western countries/regions with significant Asian immigrant populations, such as the United States, Canada, Australia and the United Kingdom, were also reviewed.

Suicide trends, demographic patterns and methods

- Global suicide rate is 16 per 100,000 people. Many Asian countries have suicide rates that are higher than the global average: South Korea (31), Japan (24), Sri Lanka (23) and Taiwan (17.6). In comparison, rates in China (13.9), Hong Kong (13.8), India (10.9), Singapore (8) and Thailand (5.7) are lower than the global average. However, it is important to note that there may be substantial under-reporting of suicide in many Asian countries.
- Over the past decade, there have been significant increases in suicide rates for Japan, South Korea and Taiwan while the rates in China, Sri Lanka and Singapore have fallen. Suicide rates in India and Thailand have been relatively stable.
- Global male-to-female suicide ratio is 1.8:1, and in Western countries, the ratios are between 3:1 and 4:1. This suicide gender paradox holds true to a lesser extent in Asia countries, mainly because of higher suicide rates among women. In India, the ratio is near equal, at 1.4:1. In China, the ratio is reversed with the female rate being higher than the male rate, at 0.9:1. Lower male-to-female suicide ratios are also found in Asian immigrant populations in Australia, the United Kingdom and the United States, compared with those of the general population.
- In general, suicide tends to increase with age. There are higher elderly to general population suicide ratios in the East Asian countries of Japan, Hong Kong, South Korea and Taiwan, ranging from 3:1 to 6:1, compared to Western countries where the ratios are between 0.8:1 and 1.7:1. Some Asian immigrant communities in Western countries also have higher elderly Asian rates compared with those of the total older population.
- Young people in South Korea, China, Hong Kong and Japan have high suicide rates. Among middle-aged people, male suicide rates have increased in Hong Kong, South Korea and Thailand as a result of rapid socio-economic changes but the increase has been less dramatic in Singapore and Taiwan.
- The Asian countries of South Korea, Taiwan, India, Sri Lanka and China have higher rural rates of suicide than their urban population. Australia, the United States and Great Britain too have higher rates of suicides in rural rather than urban areas.
- Hanging is the prevailing suicide method worldwide and is also the leading method in the Asian countries. In urban China, Hong Kong and Singapore, jumping from a height is a common suicide method. In Asian countries with large rural populations, pesticide ingestion is a frequent method. Newly emerging techniques include charcoal burning and hydrogen sulphur poisoning.
- Contrary to Western findings, Asian females tend to select more violent methods of suicide such as jumping, drowning, hanging and self-immolation, which partly

explains Asia's lower male-to-female ratios, as these methods are more likely to lead to completed suicides.

Risk factors

- Individual risk factors for suicide among Asians are similar to those found in Western studies, namely the presence of depression or related mental disorders. Additionally, a history of substance or alcohol abuse or misuse, and previous suicide attempt(s) are noted risk factors.
- Acute life events which create stress can be risk factors for suicide. Job or financial losses, family conflict, relational losses, and academic pressure are some common risk factors for suicide in Asian communities.
- Culture (and changes to culture following globalization and migration) plays a key role in influencing suicidal behaviour. Migration, both within Asian countries (from rural to urban areas) and beyond Asia (to Western countries), is accompanied by major cultural transitions such as the disruption of traditional family structures and the changing roles of its members. A wide range of risk factors associated with migration has been recognised: acculturation and settlement stress, family conflict, social isolation, discrimination, loss of social support networks, as well as barriers to accessing mental health services. These factors can contribute to suicidal behaviours directly, but they can also contribute indirectly by influencing individual susceptibility to mental disorders.
- A key player in culturally mediating suicide is the mass media. Portrayals of suicide in Asian media tend to be sensationalized, explicit and simplistic, and can encourage copycat suicides.

Protective factors

- Protective factors guard people against the risk of suicide. Identifying risk and protective factors is important for relevant stakeholders to develop interventions to prevent suicides and to support those bereaved by suicide.
- Asian cultures promote the importance of the family, interdependency and collectivism over individualism. The cultivation and maintenance of societal bonds and healthy family relationships can increase resilience and act as a protective factor against the risk of suicide.
- Religion and spirituality may be a protective factor since they provide a structured belief system and access to a socially cohesive and supportive community with a shared set of values. However, many religious and cultural beliefs may have also contributed towards stigma related to suicide due to their moral stances on suicide. This can discourage help-seeking behaviours.
- Effective positive coping strategies protect against suicide. These strategies include effective problem solving skills, good self-esteem, self-efficacy, and an ability to seek help when needed.
- Creating barriers aids in deterring impulsive suicides. Examples include legal sanctions on pesticide, barriers on balconies and train stations, gun control, and limiting access to charcoal.

Key Informant Interviews

Eighteen key informants were interviewed between July and October 2014. They comprised 11 participants who engaged directly with Asian clients exhibiting suicidal behaviours

(including psychiatrists, practice nurses, general practitioners and counsellors working in the primary and secondary mental health sector, related addiction services as well as in general practice clinics) and 7 participants working in social services, service development and the justice sector, across all three DHBs in the Auckland region. The participants were mostly from Chinese backgrounds, with the exception of two Europeans, two South Asians, and one Korean. Four broad themes emerged from the key informant interviews. They were suicide characteristics; suicide warning signs and risk factors; vulnerable groups; and suggestions for suicide intervention.

Suicide characteristics

- The majority of suicide cases for Asians in the Auckland region noted by the key informants interviewed involved middle-aged people and youth. Drug overdose was cited as a common suicide method for Asian women whereas hanging and jumping from a height were popular choices for Asian men. In addition, a few cases of suicide were linked to culturally specific methods such as charcoal burning, hydrogen-sulphide poisoning, ingestion of herbicide and self-immolation.

Suicide warning signs and risk factors

- Key warning signs of suicide identified by the informants included depression and related mental health conditions, high suicide intention (having a plan), history of self-harming and previous attempts, family history of suicide attempts, and history of problem gambling, substance/alcohol abuse. Additionally, the stresses associated with acculturation, family conflicts and social isolation were considered to heighten the risk of suicide.
- Due to shame associated with suicide and mental illness, Asian people were reluctant to seek help; this could allow their problems to intensify. Hence, attention to warning signs and awareness of possible risk factors were considered to be essential for prevention and intervention. However, informants had noted cases of successful suicide which involved well concealed planning with no overt warning signs. Some informants also noted that some at risk behaviours could be suicidal in origin but were masqueraded as accidents.

Vulnerable groups

- Multiple risk factors were considered to have contributed to suicide in four vulnerable groups: recent immigrants, youth, the middle-aged, and older adults.
- Settlement difficulties were suggested to create feelings of depression, hopelessness, isolation and discrimination among Asian immigrants. Cultural factors surrounding these issues, including stigma of mental illness, shame associated with help-seeking and fear of returning to their country of origin a failure, were stressed as additional factors increasing the risk of suicide in this group.
- Academic pressures, unrealistic parental expectations, parent-child conflicts and possible identity and sexuality crises, were noted as risk factors for Asian youth, with international students being mentioned as a high-risk group.
- Risk factors in the middle ages were suggested to include marital discord, relationship breakdown, and job or financial losses. For middle-aged women, this was also a period that involved other losses such as their primary role as caregiver to their children.

- Relationship issues with adult children and in-laws, increased likelihood of physical illnesses, feelings of being a burden to the family and social isolation were noted as risk factors in older adults.

Suggestions for suicide interventions

- All informants agreed that suicide is preventable. Their views on suicide intervention can be further divided into early intervention strategies; prevention strategies; postvention strategies and intersectoral collaboration.
- With regard to early intervention, informants suggested, in particular, the need to address underlying mental health issues at an early stage. Because of the stigma associated with mental illness in Asian communities, even where specialist mental health services are available, many Asian people with depression and related mental health conditions may choose to visit GPs where they are more likely to report physical complaints rather than psychiatric symptoms. GPs also have the advantage of having good rapport with Asian clients and their families. For these reasons, GPs were believed to have a particularly important role to play in the recognition and treatment of vulnerable persons.
- Other than GPs, suggestions were also made on training teachers, social workers, police, hotline volunteers, family members, community leaders and religious leaders to identify the warning signs and risk factors of suicide, and to be equipped with basic intervention skills to establish rapport with potentially vulnerable individuals, to deal with suicidal crises and to make referrals if necessary.
- Addressing cultural factors was seen as very important in developing strategies to prevent suicide in Asian communities. Other than existing CALD cultural competence training, regular suicide prevention seminars and workshops were recommended in order to improve the capacity and cultural competence of professional groups, families and communities to prevent suicide. The importance of networking and building trust in Asian communities, and continuous promotion work to de-stigmatise mental illness, enhance mental health literacy and promote early help-seeking were also stressed.
- Because of the stigma associated with suicide, family members were noted by informants to be reluctant to identify themselves as having been directly affected by suicide. Hence, there is a clear need to strengthen postvention services to raise awareness about the needs of survivors, and to remove barriers to their seeking support. Above all, informants emphasized that suicide intervention should involve an intersectoral approach, including improving information sharing between mental health services and GP practices, strengthening cultural support for professional groups, community members and survivors, and enhancing the infrastructure for suicide prevention.

Recommendations

The recommendations in this report have been developed from the literature review and qualitative data from the key informant interviews. They are framed within the *New Zealand Suicide Prevention Action Plan (SPAP) 2013-2016*, released by the Government in May 2013 (MOH, 2013). The SPAP acknowledges the multiple risk factors of suicide, and outlines a coordinated approach to prevent suicide across government and non-government organisations, and in partnership with the community.

Support families and communities to prevent suicide

1. Build the capacity of Asian families and communities to prevent suicide

- Strengthen relationships with different Asian ethnic sub-groups and understand specific cultural factors that may influence suicide risk. This will aid in supporting families and communities to develop information and resources related to suicide prevention that are in line with their cultural beliefs.
- Create public 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.
- Identify appropriate mechanisms to deliver suicide prevention messages to diverse Asian communities.
- Encourage the development of support programmes in Asian communities to reduce social isolation of vulnerable persons.

2. Train professional groups and community members to identify and support individuals at risk of suicide in Asian communities

- Upskill general practitioners and related professionals (e.g. counsellors, social workers) on mental health and suicide prevention, including identifying warning signs and possible risk factors of suicide, managing depression and suicide risk, and referral to specialist mental health services where appropriate.
- Train frontline police, hotline volunteers, interpreters, community leaders and religious leaders to identify individuals at risk of suicide, equip them with culturally appropriate intervention skills to deal with suicidal crises, and make referrals if necessary.
- Promote CALD cultural competency training and resources.
- Develop a toolkit on the Asian presentation of suicide for health professionals, particularly for clinicians and GPs.
- Expand Mental Health First Aid training for health professionals with experiences of Asian suicides, who in turn, train community leaders and other volunteers.
- Assist mainstream mental health providers to identify the most at risk clients and families and to implement clinical management plans that are realistic, culturally appropriate and acceptable to Asian clients and families.

Support families and communities after a suicide

3. Develop more responsive, accessible and culturally appropriate support services for Asian families who are bereaved by suicide

- Explore the impact of suicide on each family member affected by suicide.
- Make funding available to ensure there is appropriate bereavement support and follow-up for Asian families affected by suicide.
- Support Asian families to break down resistance and cultural barriers to accessing bereavement support and related services.
- Train Victim Support staff to identify bereaved family members at risk of suicide, provide ongoing support to deal with the impact of suicide, and refer to appropriate mental health and social services if necessary.
- Liaise with GPs in developing an effective plan for providing help to family members at risk of suicide.
- Provide support to clinicians and health professionals after client suicide.

4. Increase the capacity of Asian communities to respond following suicides

- Raise public awareness about postvention services and the potential benefits of postvention services for suicide prevention.
- Increase the knowledge and understanding of community leaders and religious leaders about the needs of survivors.
- Develop appropriate mechanisms and resources to deliver postvention messages to diverse Asian communities.
- Grow community capacity to prevent re-victimisation of bereaved family members.
- Provide support to community members looking after families affected by suicide.
- Improve awareness of the ripple effects of celebrity suicides in Asian communities.

Improve services and support for people at high risk of suicide who are receiving government services

5. Promote better inter-agency referrals and communication

- Improve information sharing and develop service pathways between secondary and tertiary mental health and addiction services and primary health care (GP practices, PHO).
- Improve the care of people presenting to emergency departments with self-harm injuries, and ensure there is appropriate follow-up after discharge.
- Improve the communication and reporting system between GPs, police and mental health and addiction services.
- Increase resources into Asian cultural support and consultation across DHBs.

6. Improve services and support for people experiencing mental health problems, gambling problems, and alcohol and other drug problems

- Raise public awareness about the links between mental health problems, problem gambling, substance/alcohol abuse and suicide.
- Promote the use of mental health services, and problem gambling and addiction services. This may require reframing the message to overcome shame and stigma associated with help-seeking.
- Improve services and support for high risk groups (recent immigrants, international students, youth, international students, the middle-aged, older adults) in Asian communities.
- Ensure that family members are involved in the care plan.

Strengthen the infrastructure for suicide prevention

7. Improve the quality of data on suicide deaths and self-harm incidents

- Disaggregate data collection and reporting to include identifiable Asian ethnic sub-groups (e.g. Chinese, Indian, Korean) to assist with the identification of emerging trends and risk groups.

8. Enhance the role of MOH and DHBs in the area of suicide prevention

- Ensure suicide prevention plans/policies recognise the unique patterns of Asian suicide in New Zealand and vulnerable groups. Attention should also be paid to ensure that relevant authorities understand and appreciate the significant cultural, linguistic and migratory risk factors for suicide within Asian communities.
- Develop policies to build the Asian workforce in mental health and suicide prevention.

- Monitor the progress of prevention, early intervention and postvention services/initiatives to address suicide in Asian communities and evaluate the impact of these services/initiatives on Asian communities.
- Research best practice examples from overseas in the area of suicide prevention and postvention in relation to Asian people.

INTRODUCTION

The number of suicide deaths among Asian New Zealanders has been on the rise in recent years. Ministry of Health (MOH) data show that suicides among Asians have increased from 84 over the five years between 2001 and 2005, to 98 in 2006-2010. There are multiple risk factors involved in increasing a person's vulnerability to suicidal behaviour, spanning across systemic, societal, community, relationship and individual factors (WHO, 2014). The stresses of acculturation, social isolation, lack of social support and discrimination represent some of the significant suicide risk factors for a number of vulnerable groups, including newly arrived immigrants. As over 39 percent of the Asian communities in New Zealand are recent immigrants who have been resident in New Zealand for under 10 years (Statistics New Zealand, 2014a), understanding how these and other risk factors contribute to suicidal behaviours is imperative. Protective factors, such as strong personal relationships, can buffer people against the risk of suicide, so identifying risk and protective factors is important for relevant stakeholders to develop interventions to prevent suicides and to support those bereaved by suicide.

Up until now, Asian suicide in New Zealand, and in particular suicide within Asian migrant communities, is an under-researched phenomenon. The overall aim of this project, therefore, is to study this phenomenon to provide better information to guide the development of culturally appropriate suicide intervention strategies. The specific objectives are:

1. To analyse Asian suicide data in New Zealand and to identify high risk groups;
2. To review national and international literature on suicide in Asian communities, including risk and protective factors for suicide, and their implications;
3. To ascertain the impact of immigration on suicide;
4. To interview key service providers to explore and improve understanding of the key issues relating to suicide for Asian families and communities, and to identify effective prevention and postvention strategies; and
5. To make recommendations on the next steps.

This report is divided into four sections. The next section provides a brief analysis of Ministry of Health suicide data for Asians between 1996 and 2010. Section three is a literature review on suicide in Asian countries as well as in Asian immigrant communities in Western countries, focussing on suicide trends, methods, and risk and protective factors. Section four examines the findings of key informant interviews. The interviews have provided insight into warning signs of suicide, vulnerable groups, gaps in current services and suggestions for suicide intervention. The report concludes with some recommendations for future actions and research.

SUICIDE DATA

The data source for this section is Ministry of Health data on suicide deaths for Asians between 1996 and 2010. Over this period, suicide deaths among Asian people fluctuated between 10 and 28 per year (Table 1). Due to the small numbers per year, the data over the 15 years are aggregated into three five-year periods for further analysis. The results show that the total number of suicide deaths has increased from 80 between 1996 and 2000, to 84 in 2001-2005, with a further rise to 98 in 2006-2010.

Table 1 Suicide deaths for Asians by gender, 1996-2010

	1996	1997	1998	1999	2000	2001	2002	2003	2004	2005	2006	2007	2008	2009	2010
Male	4	6	7	13	16	15	10	16	6	7	5	8	9	14	16
Female	6	5	7	11	5	5	2	12	4	7	9	6	9	9	11
Total	10	11	14	24	21	20	12	28	10	14	14	14	18	25	27

There has been a dramatic growth in the Asian population since the 1990s. Between 1996 and 2013, this ethnic population increased nearly four-fold, from 173,500 to 471,700 (Ho, forthcoming). The estimated suicide rates (per 100,000 population) for Asians and the total New Zealand population between 1996 and 2010 are calculated (Figure 1). Over this period, annual Asian suicide rates fluctuated between 3.3 and 11.4. These rates are much lower than the estimated rates for the total New Zealand population, which ranged from 12 to 15.7 per 100,000 people.

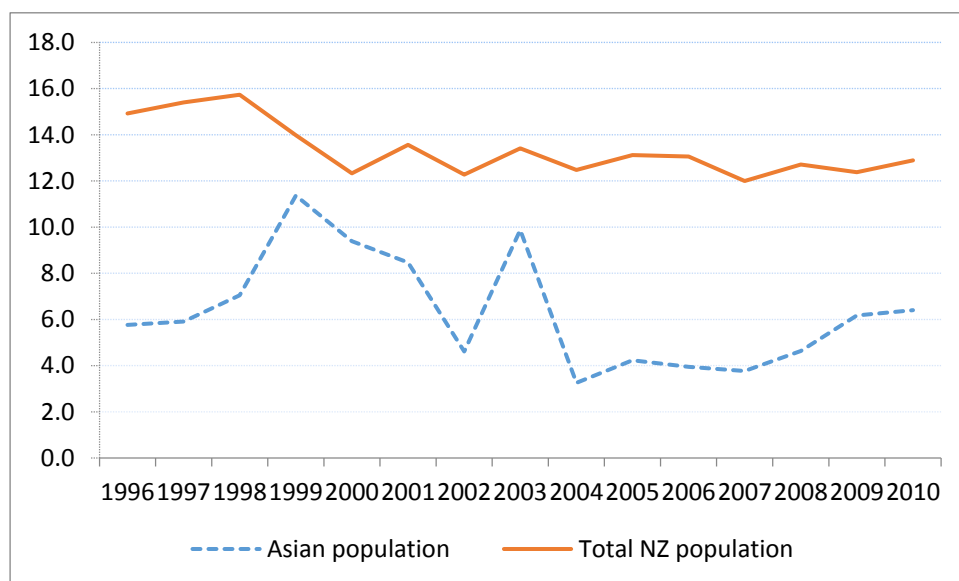


Figure 1 Suicide rates per 100,000 population for Asians and total New Zealand population, 1996-2010

Asian people also have lower male-to-female suicide gender ratio compared with the total population (Figure 2). In the New Zealand total population, suicide rates for males are about three times higher than those for females. For Asian people, the gender ratio is 1.2:1 in the five years from 2006-2010 (Figure 2).

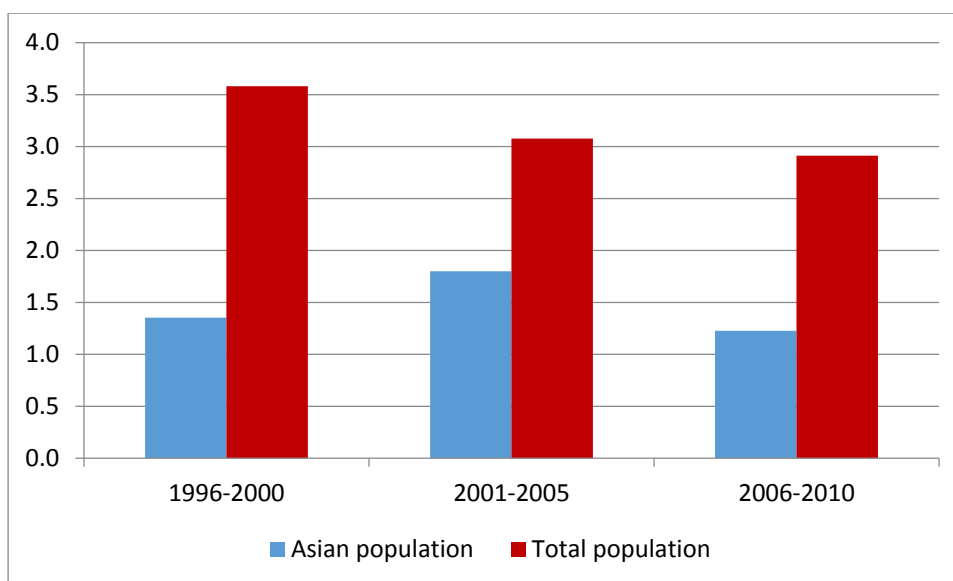


Figure 2 Suicide gender ratio for Asians and total New Zealand population, 1996-2010

The number and proportion of suicides for Asians by age group over the three five-year periods from 1996 to 2010 are shown in Figure 3 and Table 2 respectively. There have been increases in both the number and proportion of suicides among middle-aged people between the ages of 45 and 64 years, as well as among older people aged 65 years and older. Compared with the two earlier time periods (1996-2000 and 2001-2005), suicides in youth (those aged 15 to 24 years) and young adults (aged 25 to 44 years) have decreased in proportion in the five years from 2006 to 2010.

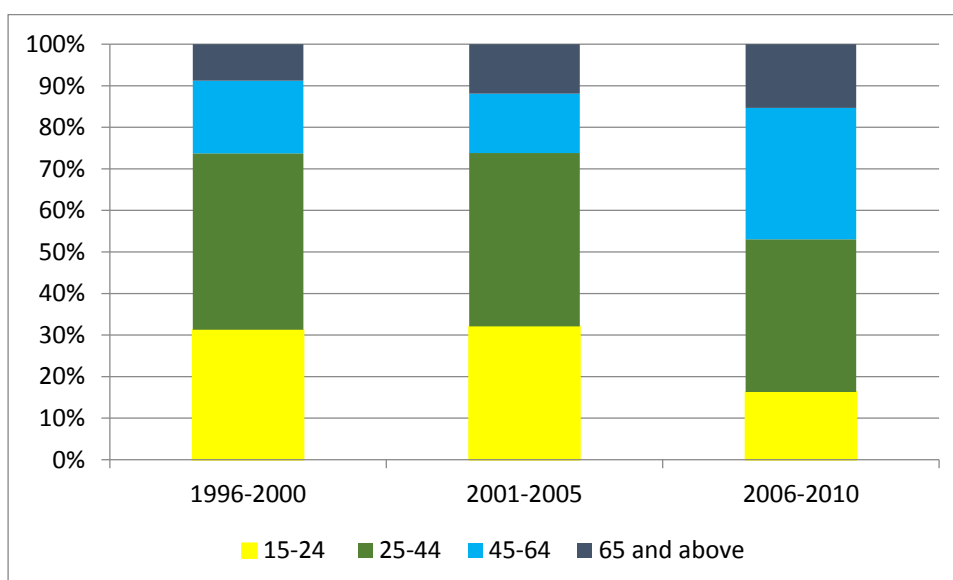


Figure 3 Proportion of suicides for Asians by age group, 1996-2010

Table 2 Suicide deaths for Asians by gender and age group, 1996-2010

Age group	1996-2000			2001-2005			2006-2010		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
15-24	11	14	25	19	8	27	8	8	16
25-44	20	14	34	23	12	35	19	17	36
45-64	10	4	14	7	5	12	18	13	31
65+	5	2	7	5	5	10	9	6	15
All ages	46	34	80	54	30	84	54	44	98

Nearly two-thirds of the Asian population in New Zealand live in the Auckland region. Table 3 presents the number of suicide deaths for Asians by gender and age group for Auckland, Waitemata, and Counties Manukau District Health Boards (DHB) between 1996 and 2010. Suicides in the three Auckland DHBs accounted for increasing proportions of the total suicide deaths among Asians, from 52.5 percent in 1996-2000 and 61.9 percent in 2001-2005, to 67.3 percent in the five years between 2006 and 2010.

Table 3 Suicide deaths for Asians by gender and age group for Auckland, Waitemata and Counties Manukau DHBs, 1996-2010

Age group	1996-2000			2001-2005			2006-2010		
	Male	Female	Total	Male	Female	Total	Male	Female	Total
ADHB									
15-24	2	6	8	3	3	6	2	3	5
25-44	4	4	8	6	4	10	8	1	9
45-64	1	1	2	2	1	3	3	3	6
65+	1	1	2	1	1	2	2	0	2
All ages	8	12	20	12	9	21	15	7	22
WDHB									
15-24	1	0	1	3	1	4	1	1	2
25-44	1	1	2	1	1	2	2	7	9
45-64	0	1	1	2	0	2	3	4	7
65+	1	0	1	0	0	0	2	2	4
All ages	3	2	5	6	2	8	8	14	22
CMDHB									
15-24	2	3	5	6	2	8	1	2	3
25-44	4	3	7	9	2	11	5	3	8
45-64	4	0	4	0	0	0	4	4	8
65+	1	0	1	2	2	4	2	1	3
All ages	11	6	17	17	6	23	12	10	22
Total Auckland Region DHBs (ADHB, WDHB and CMDHB)									
15-24	5	9	14	12	6	18	4	6	10
25-44	9	8	17	16	7	23	15	11	26
45-64	5	2	7	4	1	5	10	11	21
65+	3	1	4	3	3	6	6	3	9
All ages	22	20	42	35	17	52	35	31	66

There are differences in the age and gender distribution of suicides in the three DHBs. However, due to the small numbers, it is not possible to provide the suicide rates for further analysis.

Section summary

Preliminary analysis of Ministry of Health statistics on suicide shows that suicide rates and suicide gender ratio in Asians are lower than in the total New Zealand population. Since the mid-1990s, suicides among middle-aged Asians and older people, as well as suicides among Asians in the Auckland region, have increased. There are many potential reasons for different suicide rates and different suicide gender ratio by age. For example, differences in socially acceptable methods of dealing with stress and conflict for men and women, availability and preference for different methods of suicide, and differences in help-seeking behaviour between men and women can contribute to the difference in these gender ratios. As part of this project a literature review has been undertaken to investigate suicide trends and risk factors in Asian countries as well as in Asian immigrant communities in Western countries. The results are presented in the next section.

LITERATURE REVIEW

The questions addressed in this review were:

1. How have suicide trends changed in Asia and among Asian immigrants in Western countries/regions, over the past two decades?
2. Are there age, gender, method and location-specific patterns of suicide for Asian subgroups?
3. What are the risk and protective factors for suicide?
4. What factors, in the context of migration, influence suicide among Asian immigrants?

Review Method

The scope of the literature search was limited to articles from January 2000 to March 2014. The key words used were "suicide" and "Asia" in combination with "risk factor", "protective factor", "method", "intervention" and "migration". Databases searched for international literature were PubMed, Google Scholar and Scopus, the World Health Organization [WHO] website and Official government and/or state health departments of relevant countries. Databases searched for national literature were the Ministry of Health [MOH], District Health Boards and relevant external links on these websites to organizations such as Suicide Prevention Information New Zealand [SPINZ] and the Centre for Asian and Ethnic Minority Health Research. Due to the limited availability of research on suicide within New Zealand's Asian communities, articles relating to suicidal behaviour in similar Western countries/regions with significant Asian immigrant populations, such as the United States, Canada, Australia and the United Kingdom, were also reviewed. In addition, secondary searching was performed by inspecting reference lists of relevant articles such as the comprehensive international review on suicide in Asia, conducted by Chen, Wu, Yousuf and Yip (2011). Additional articles obtained from this review included Ajdacic-Gross, Weiss, Ring, Hepp, Bopp, Gutzwiller and Rössler (2008), Chen, Park and Lu (2009), Yip and Liu (2006), as well as Wei and Chua (2008), which were sourced from Google Scholar using keywords from their titles and primary authors' names.

Suicide is defined as the act of taking one's life intentionally. This definition does not include suicide attacks or bombings, i.e., any cases of suicide associated with terrorism. Suicidal behaviours include attempted suicide (a suicidal act that does not result in death) and suicidal ideation (thoughts about engaging in suicide, with or without a specific suicide plan).

The definition of "Asian" varied across articles. Most international research used broad definitions, encompassing countries in the Middle East and Central Asia. However, increasingly in New Zealand (health) research, the definition of Asian is exclusively limited to people originating from South Asia, Southeast Asia and East Asia. According to the MOH (2006a, p.xii), only "people with origins in the Asian continent from Afghanistan in the west to Japan in the east and from China in the north to Indonesia in the south" fall under the Asian ethnic group category. Therefore, to keep in line with national usage, this review adopted the same definition. In total, 10 Asian countries or regions were selected: China, Hong Kong SAR, India, Japan, South Korea, Pakistan, Singapore, Sri Lanka, Taiwan and Thailand.

Some countries were excluded because data quality was poor (i.e., not representative of the population, not relevant to the topic) or did not exist. These countries include Nepal, Maldives, Philippines, Indonesia, Vietnam, Bangladesh and Cambodia. Other countries (such as China and India) did not have population-wide surveillance systems and suicide data were only available from some locations. Hence, both whole population and local sample data for these countries were reviewed.

The search yielded 97 documents in total that met the inclusion criteria. Of these, 42 items were related to suicide in Asian countries, 30 were on Asian immigrants in Western countries and 25 on Asians in New Zealand. Key findings from these studies were reviewed, including prevalence rates, trends, demographic patterns, common methods and socio-cultural influences on suicide. Risk and protective factors are also identified and discussed below.

Suicide trends, demographic patterns and methods

Trends

Globally, it is estimated that there are 1 million suicides a year, with a global rate of 16 per 100,000 people (Chen et al., 2011). More than 60 percent of the world's suicides occur in Asia, with China and India accounting for more than half of the Asian portion (Wei & Chua, 2008). Many Asian countries have suicide rates that are higher than the global average: for example, South Korea (31), Japan (24), Sri Lanka (23) and Taiwan (17.6). In comparison, rates in China (13.9), Hong Kong (13.8), India (10.9), Singapore (8) and Thailand (5.7) are lower than the global average (Chen et al., 2011; MOH, 2014; Värnik, 2012). New Zealand has a rate of 10.6 per 100,000 people, which is also below the global average (MOH, 2014).

Over the past decade, there have been significant increases in suicide rates for Japan, South Korea and Taiwan while the rates in China, Sri Lanka and Singapore have fallen (Chen et al., 2011; De Silva, Senanayake, Dias & Hanwell, 2012). Suicide rates in India and Thailand, on the other hand, have been relatively stable. With regard to New Zealand, rates were at their highest in 1998 (15.1), and have gradually declined to 10.6 in 2011 (MOH, 2014).

However, it is important to note that suicide data in many Asian countries is considered to be of poor quality and there may be substantial under-reporting of deaths. For example, China does not have a complete country count of suicide. Random sampling from surveillance sites are used to provide an estimate of the country's suicide rate (Chen et al., 2011).

Gender ratio

Globally, more men than women commit suicide, resulting in a global male-to-female suicide ratio of 1.8:1, based on 2008 WHO estimates (Värnik, 2012). This suicide gender paradox holds true to a lesser extent in Asia compared to Western countries, mainly because of higher suicide rates among women (Chen et al., 2011). Compared to Western countries which have ratios between 3:1 and 4:1 (Beautrais, 2006), in India, the ratio is near equal, at 1.4:1 (Mayer & Tahereh, 2002; Vijaykumar, 2007). In China, the ratio is reversed with the female rate being higher than the male rate, at 0.9:1 (Värnik, 2012; Yip

& Liu, 2006). China and India's lower ratios have mainly been attributed to high rates of suicide among rural women (Yip & Liu, 2006). Lower male-to-female suicide ratios are also found in Chinese communities in other Asian countries such as Taiwan, Hong Kong, and Singapore, at 1.2:1 (Chen et al., 2011; Leong & Leach, 2010; Yip & Tan, 1998).

In Western countries, the risk of suicide appears noticeably higher for Asian women compared to Asian men (Ratkowska & De Leo, 2013). As a result, lower suicide gender ratios for Asian immigrant populations in Australia, the United Kingdom and the United States have also been observed, compared with those of the general population (CDC, 2014a). For example, the ratio for Australian Asians was 1.9:1 in 2010 whereas that of the total population was 3.5:1 (Australian Bureau of Statistics, 2012a).

Age

In general, suicide tends to increase with age. There are higher elderly to general population suicide ratios in the East Asian countries of Japan, Hong Kong, South Korea and Taiwan, ranging from 3:1 to 6:1, compared to Western countries where the ratios are between 0.8:1 and 1.7:1 (Chen et al., 2011; Chiu, Takahashi & Suh, 2003; Pritchard & Baldwin, 2002). Some Asian immigrant communities in Western countries also have higher elderly Asian rates compared with those of the total older population (CDC, 2014a; Leong, Leach, Yeh & Chou, 2007; Simon, Chang, Zeng & Dong, 2013).

Within Asia, young people in China, Hong Kong and Japan have high suicide rates (Hendin, et al., 2008; Lotrakul, 2006). However, the highest rate of suicide in young people is found among young women in South Korea, at 22.1 per 100,000 people (Värnik, 2012). Among middle-aged people, suicide rates have worsened as a result of rapid socio-economic changes. During the Asian Financial Crisis, for example, suicide rates for middle age groups were higher than the elderly in Japan (Chen et al., 2011). Male middle-aged rates have also increased in Hong Kong, South Korea and Thailand but this increase has been less dramatic in Singapore and Taiwan, whose economies were not as badly impacted. Suicide rates were closely correlated with unemployment rates over this time (Chang, Gunnell, Sterne, Lu & Cheng, 2009; Lotrakul, 2006). Following the economic recovery, rates improved in Hong Kong and Thailand (Chen et al., 2011). Likewise, in India, the higher rates of suicide among young adults were associated with liberal economic reforms which created job insecurity and exacerbated wealth gaps (Vijayakumar, 2007).

Rural vs. Urban

Rapid globalization in Asia has been accompanied by a movement from rural to urban areas and subsequent lifestyle changes. This progression has largely affected young, rural Asians. Over the past decade suicide rates in China have halved, mainly because urbanization has helped Chinese women avoid three major risk factors for suicide: low status, family conflict and access to pesticides (Chen et al., 2011).

Similar trends in declining rural female suicides are seen in Taiwan and South Korea (Wu, Chen & Yip, 2012). Rural deprivation comprises poverty, social isolation, stigma, a lack of knowledge about mental illness and access to services, as well as easy access to lethal means (mainly pesticides) (Hendin et al., 2008). Countries with a large rural population having higher rural rates of suicide than their urban population include South Korea, Taiwan, India, Sri Lanka and China (Hendin et al., 2008). The latter three countries have rural rates that are at least twice as high as their urban or overall population rates (Chen

et al., 2011). Australia, the United States and Great Britain too have higher rates of suicides in rural rather than urban areas (Browne-Miller, 2012; Hendin et al., 2008).

Urbanization, however, brings its own risk factors for suicide. Young people who have migrated to cities but have had problems finding employment, and older people left behind in rural areas, form particularly vulnerable groups (Hendin et al., 2008; Ji, Kleinman & Becker, 2001; Wu et al., 2012).

Suicide methods

Preferred methods of suicide vary between countries. Hanging is the prevailing method worldwide and is also the leading method in the Asian countries of Japan, South Korea, Taiwan, Thailand, Pakistan and India (Chen et al, 2011; Värnik, 2012). Firearms suicide prevails in the Americas and some European countries (mainly among males) but this is a less popular choice in Asian countries (Värnik et al., 2008). On the other hand, pesticide ingestion, charcoal burning and self-immolation are more culturally specific to Asia and rarely appear in Western statistics (Värnik et al., 2008).

Accessibility is a key determinant of the choice of suicide method. As ligatures and ligature points are widely available, it is not surprising that hanging is the most common suicide method globally and is also the leading method when no other major alternative is available (Varnik, 2012). Jumping from a height is the most frequent suicide method in urban China, Hong Kong and Singapore (Wu et al., 2012). More than 80 percent of citizens live in high-rises in the latter two countries; thus jumping provides a simple and easy route for the elderly, as well as impulsive youth who wish to take their lives (Wei & Chua, 2008). Solid or liquid poisoning (usually by pesticide ingestion) is a frequent method in Asian countries with large rural populations such as China, India, South Korea, Pakistan and Sri Lanka and affects mainly young women (Wu et al., 2012). In parts of the Indian subcontinent where there is easy access to kerosene in the household, a large proportion of women choose to burn themselves (Kumar, 2003; Wu et al., 2012).

Newly emerging techniques include charcoal burning (carbon monoxide poisoning) in urban Hong Kong, Taiwan and Japan (Chen et al., 2011). This is now the second leading suicide method and the dominant one adopted by middle-aged men in the first two countries (Chen et al., 2011). Charcoal burning suicide was a major driver of the escalation of rates in Japan from the 1990s to 2009, especially in males (Chan, Yip, Au & Lee, 2005; Yip, Law, Fu, Law, Wong & Xu, 2010). Hydrogen sulphur poisoning and internet suicide "pacts" are also a recent trend in Japan (Morii, Miyagatani, Nakamae, Murao & Taniyama, 2010; Naito, 2007).

Culturally-specific suicide methods for Asians may change as migrants acculturate. An increasing number of South Asian women in England were observed to be adopting methods of the general female population, by replacing self-immolation with drug overdose (Ineichen, 2008). On the other hand, traditional methods can also prevail. A review by Leong et al. (2007) found that suicide rates of Japanese Americans were higher than other Asian immigrant groups and that cutting was a preferred method for less acculturated immigrants, built on cultural acceptance of the traditional samurai practice. In the United States, the dominant methods were hanging for Asian women and poisoning for Asian men. Asian Americans used firearms to a lesser degree than any other ethnic group and had a higher proportion of poisoning, falls and other methods (CDC, 2014b).

Risk factors

Individual risk factors

Individual risk factors for suicide among Asians are similar to those found in Western studies, namely the presence of depression or related mental disorders (Vijayakumar, 2005). The few Asian studies that have carried out psychological autopsies of suicide victims found less prevalence of pre-existing psychiatric disorders compared to Western studies (Hendin et al., 2008). However, this could be due to differences in diagnostic tools used in Asian countries which could lead to under-diagnosis of the issue (Leong & Lau, 2001). Additionally, a history of substance or alcohol abuse or misuse, and previous suicide attempt(s) are noted risk factors (WHO, 2012).

Situational risk factors

Acute life events which create stress can be risk factors for suicide. In regards to Asian men, this was more likely to be job or financial losses (unemployment, gambling and work-related stress) whereas for women it was noted to be more relational or social losses (family conflict) (Beautrais, 2006). Other situational factors include easy access to lethal means, for instance, pesticide poisoning in rural Asia, building jumping in Hong Kong and Singapore, and ingestion of household chemicals in Japan, South Korea, and Taiwan (WHO, 2012; Wu et al., 2012). Likewise, self-immolation is correlated with easy access to kerosene in South Asian households (Wu et al., 2012).

Several studies on young Asian Americans noted academic pressure and family conflict as risk factors for suicidal ideation and attempts (Leong et al., 2007; Yong-Beom & Haslam, 2010). In Great Britain, family conflict was a major determinant for suicidal behaviours among South Asian women (Hicks & Bhugra, 2003). In New Zealand, anecdotal evidence from a newspaper article and stakeholder interviews highlighted financial complications (problem gambling, debt, etc.) to be a factor influencing suicidality in the Asian communities (Sobrun-Maharaj, Rossen & Wong, 2012; New Zealand Herald, 2013).

Socio-cultural influences

Over and above these individual and situational risk factors, wider societal influences in Asia also contribute to opportunities and restrictions for suicide.

Suicide is criminalised, usually by religious laws, in India, Pakistan and Singapore. In these countries, families may fear being shunned by their communities, and are more inclined to conceal a suicide which may result in its misclassification and under-reporting (Hendin et al., 2008; Khan, 2002; Vijayakumar, 2007). On the other hand, suicide can be culturally accepted in certain circumstances, such as when it is thought to be carried out for altruistic purposes. An example is self-immolation as a form of social protest (Vijayakumar, 2004). There are also traditional cultural practices such as *hara-kiri* or belly-cutting in Japan to restore honour, and *suttee* in the Indian subcontinent where a Hindu widow jumps into her husband's funeral pyre (Kumar, 2003; Naito, 2007). In Ancient China, suicide could be taken as an honour, either for the family or for the country (Lee & Kleinman, 2000). Although these are not common contemporary practices, they have a historical influence on the permissiveness of suicide in these societies and choice of method used in the present day.

The traditional extended family system in Asia, which advances the importance of family before the individual, can also play prominent role in influencing suicide risk. Domestic violence in arranged marriages following dowry disputes are common in India, Pakistan and Sri Lanka, where women can be forced to stay in these abusive relationships by their family members (Kumar, 2003). Suicide by self-immolation is a frequent method used by such South Asian women but their deaths at home may be concealed as kitchen accidents by in-laws in order to avoid blame or stigma (Ineichen, 2008; Kumar, 2003). In China, family pressure to have a son under the One Child policy can drive women to commit suicide (Chen et al., 2011). Marital problems and social pressures are believed to be the major causes for the excessive number of female suicides in China (Zhang, Jia, Wiecek & Jiang, 2002). Traditional gender roles allow for placing primary blame on women for family conflict and can lead to fatalistic suicide as these women feel trapped in unhappy marriages. Contrary to Western findings, Asian females tended to select more violent methods of suicide such as jumping, drowning, hanging and self-immolation, which partly explains Asia's lower male-to-female ratios, as these methods are more likely to lead to completed suicides (Chen et al., 2009; Wu et al., 2012).

On the other hand, the breakdown of traditional extended family systems can also drive suicide rates up. With economic development and urbanization, the size of the family and role of its members change. Suicide rates are found to be higher in Asian countries that have achieved rapid economic growth (China, Hong Kong, Japan and Korea) than in those that experienced more gradual development, such as Singapore (Hendin et al., 2011). Also, social isolation, faced by individuals who have never married, and childless couples have been suggested as a major reason for the increase in rates for elderly Japanese (Hendin et al., 2011). Their deaths can be perceived as a form of altruistic suicide, done for the benefit of their family as they believe they have become a physical and economic burden (Lau & Pritchard, 2001). Suicide notes many older people leave behind indicate this choice (Yip, 2008). Social isolation has also been noted as a major risk factor for the rise in elderly suicides and the higher elderly suicide rates in Asian communities than in Western countries. Lau and Pritchard (2001) suggest that the fundamental cause is the comparison between the accelerated social and economic change in Asia that has left a large number of older people unsupported by their children and poverty-stricken, and the slower, more stable changes in Western countries.

A key player in culturally mediating suicide is the mass media. Portrayals of suicide in Asian media tend to be sensationalized, explicit and simplistic (i.e., caused by immediate stressors such as problems with work, study or relationships), and can encourage copycat suicides (Hendin et al., 2008). Tabloid stories of charcoal-burning suicide as an uncomplicated and peaceful method in Taiwan and Hong Kong is one such example (Chen & Yip, 2011). Another is the Werther effect observed in the aftermath of celebrity suicides in South Korea (Ju, Lee, Noh & Yip, 2014; Tam, Tang & Fernando, 2007). Furthermore, unlike many Western countries, only a few Asian countries have national guidelines on media reporting of suicide (Hendin et al., 2008).

Migration-related risk factors

A wide range of risk factors associated with migration has been recognised: acculturation and settlement stress, family conflict, social isolation and loss of social support networks, as well as barriers to accessing mental health services. These factors can contribute to

suicidal behaviours directly, but they can also contribute indirectly by influencing individual susceptibility to mental disorders (WHO, 2014).

Non-recognition of overseas qualifications, as well as a lack of local working experience and English language proficiency, are factors associated with unemployment or under-employment for Asian immigrants (Henderson, 2004; Ho, Au, Bedford & Cooper, 2002). In New Zealand, although Asian immigrants are more likely to have higher educational qualifications compared to other ethnic groups, they have unemployment levels that are much higher than that of the European population and significantly lower income differentials (Ho, forthcoming; Statistics New Zealand, 2013; 2014b). Additionally, English language barriers pose a significant problem for migrants from Cambodia and Vietnam and to a lesser extent, Koreans and Chinese (Ho et al., 2002). These circumstances can generate feelings of depression, isolation and discrimination, and increase the risk of suicide.

Another major challenge encountered by Asian immigrants in Western countries is culture change. Assimilation, separation and marginalization are acculturation strategies adopted by migrants that involve rejecting contact with either, or both, the host society culture and their own heritage culture (Berry, 2006). Research in New Zealand and internationally associated all three strategies with poorer mental health outcomes as they reduce the chance of having social support networks and increase the risk of suicidal behaviour, whereas integration is associated with better mental health outcomes (Berry, 2006; Eyou, Adair & Dixon, 2000; Yeo, 2012).

Different rates of acculturation between family members can result in intergenerational tension or conflict within a family (Costigen & Dokis, 2006; Rosenthal & Feldman, 1990). For example, the clash of cultural values can create conflict between couples. As Asian women become more acculturated, they may no longer be willing to conform to traditional gender roles. Consequently, males may step-up their efforts to dominate women, including using violence (Raj & Silverman, 2002). Research on South Asian women in England found rates of completed suicide were more than double that of the White population (Hicks & Bhugra, 2003). Moreover, these women were 2.5 times more likely to attempt suicide than South Asian men (Hicks & Bhugra, 2003). Focus group discussions identified the primary causes of suicide attempts to be associated with traditional arranged marriages (domestic violence, infidelity, torture for dowry by in-laws) and a lack of family and societal support (Hicks & Bhugra, 2003). Clashing ideologies between traditional and modern values may increase the risk of suicide for this group (van Bergen, Smit, Kerkhof, Colucci & Montesinos, 2013).

Conflict between Asian immigrant parents and their children may arise when children, who have greater exposure to the host culture at school, adopt the values and lifestyles of the new country while their parents expect their children to uphold traditional cultural values (Au & Ho, 2015). In some families, role reversal may arise when parents rely on their children as interpreters in their dealings with everyday activities. Furthermore, migration may result in family separation and the disruption of family and social support networks, which can lead to social isolation, depression and feelings of loneliness and despair. All of these are factors associated with increased risk of suicide (Ratkowska & De Leo, 2013).

A host society's policies and attitudes towards immigrants and immigration can provide additional sources of stress, with higher rates of suicide and poorer mental health

associated with racial discrimination, marginalisation and a lack of acceptance from the host population (Abbott, Wong, Williams, Au & Young, 2000; Cheng et al., 2010; Harris et al., 2012). Faye (2005) highlights the dangers associated with the host society's stereotype of Asian immigrants as the model minority, such as having a strong work ethic, being academically and financially prosperous, and well-adjusted. These presumptions can create false images about their mental health needs, and place doubts about the need for improving the accessibility and responsiveness of mental health services for Asian immigrants.

Timely and effective access to health care is essential to reducing the risk of suicide. However, navigating the health systems is a challenge for many new Asian immigrants (Anikeeva, Bi, Hiller, Ryan, Roder & Han, 2010; Ho, 2013). Stigma against mental disorders and substance abuse can further compound the difficulty. Many studies on Asian immigrants highlight a behaviour of "hiding up" mental illness, which involves not actively seeking treatment and keeping an individual's problems hidden from the community. Treatment is seen as a last resort, only to be used when the individual's problems have deteriorated to the point where they can no longer be handled within the family (Cheng et al., 2010; Morrison & Downey, 2000; Wynaden, Chapman, Orb, McGowan, Zeeman & Yeak, 2005).

Research on American Asian students found that they were more likely to be "hidden ideators" compared to their European peers; i.e., they did not readily self-disclose their suicidal ideation, which only became apparent when a counsellor performed a suicide risk assessment (Cheng et al., 2010; Morrison & Downey, 2000). Furthermore, the Youth '07 survey in New Zealand, which assessed changes in suicidal ideation and attempts from 2001 to 2007, found a reduction among Chinese students and no significant change among Indian students (Parackal, Ameratunga, Tin Tin, Wong & Denny, 2011; Yeo, 2012). However, 20 percent of Asian male students and 31 percent of female students reported 'poor' mental and emotional health, particularly Indian students who reported higher than average symptoms of mental illness (Yeo, 2012). Therefore, it is possible that Asian New Zealand youth, like their American counterparts, are hidden ideators.

Some Asian immigrants may seek alternative treatment, including the use of traditional medicines, prayer and visiting temples and churches (Ho et al., 2002). A study in Australia by Wynaden and colleagues (2005) also noted that some Australian Asians preferred seeking help from GPs who were of the same country of origin, based on the belief that these GPs had better cultural understanding of their mental health problems. On the other hand, some Asians sought non-Asian GPs to maintain confidentiality and reduce the likelihood of information being divulged to their community (Wynaden et al., 2005).

Asians are more likely to somaticize, i.e., report physical rather than psychological symptoms, including the self-pity, sadness and anger of mental illness (Ho et al., 2002; Wynaden et al., 2005). Males are more likely to deny suicidal ideation and depression because it is seen as a sign of weakness (Au & Ho, 2015). The different ways of expressing symptoms by Asian people can lead to misdiagnosis or under-diagnosis of mental health problems by Western services (Ineichen, 2008; Leong & Lau, 2001). Hence, Leong and Leach (2010) stress the need to understand Asian beliefs and attitudes towards mental health, as their delay in help-seeking behaviours can mean that the first time mental health services are accessed by this group, Asian clients may already have elevated levels

of distress and hopelessness, and clinicians may have to attend to the first meeting as an emergency situation.

Protective factors

Social support

In contrast to risk factors, protective factors guard people against the risk of suicide. Asian cultures promote the importance of the family, interdependency and collectivism over individualism. Hence, the cultivation and maintenance of societal bonds and healthy family relationships can increase resilience and act as a protective factor against the risk of suicide (Chen et al., 2011; Cheng et al., 2010; Wong, Uhm & Li, 2012; Yee, 2003). Relationships are especially protective for adolescents and the elderly, who have a higher level of dependency (Leong et al., 2007; WHO, 2014).

Religious or spiritual beliefs

Religion and spirituality may be a protective factor since they provide a structured belief system and access to a socially cohesive and supportive community with a shared set of values (Sullivan, 2009). Studies in the United Kingdom have found that, compared to other immigrant groups from the Indian subcontinent, Muslim immigrants have lower rates of suicide, particularly for the overseas-born (Ineichen, 2008). However, as discussed earlier, many religious and cultural beliefs may have also contributed towards stigma related to suicide due to their moral stances on suicide. This can discourage help-seeking behaviours.

Positive coping strategies

Effective positive coping strategies protect against suicide (WHO, 2012). At the individual level, these strategies include effective problem solving skills, good self-esteem, self-efficacy, and an ability to seek help when needed. English language proficiency, high income and employment are additional factors contributing to positive mental well-being for Asian migrants in New Zealand (Ho et al., 2002; Ministry of Social Development, 2008). Improving English communication skills provide greater opportunities for positive social interactions and to build stronger support networks (Leong et al., 2007).

Restricted access to means of suicide

Creating barriers aids in deterring impulsive suicides. Examples include legal sanctions on pesticide, barriers on balconies and train stations, gun control, and limiting access to charcoal (Wu et al., 2012). Reducing access to lethal means necessitates working with various departments, for example, agriculture for pesticide control and infrastructure for subways and bridges. It is important to note though, that most deaths occur at home in Asia, for example, hanging (Hendin et al., 2008).

Prevention strategies for Asian immigrants

The New Zealand Suicide Prevention Strategy 2006-2016 acknowledges the need for suicide prevention efforts to consider the cultural differences and varying degrees of acculturation within the Asian population (MOH, 2006). The strategy has placed emphasis on the Chinese group as they account for the largest proportion of the Asian population, and as it has also been found that strong stigma attached to suicide exists within this community. Chinese immigrants have reported preferences for consulting with Chinese

therapists due to mutual sympathy, common language, and flexible appointment schedules (Ho et al., 2002). One goal of Auckland DHB's Annual Plan 2013-14 is reduce adult suicides through staff training and health promotion as part of its responsibilities to the national plan.

As a result of these strategies, developments to promote better mental health among Asians (and therefore reduce risk factors for suicide) have been initiated in recent years. They include improvements to anti-stigma campaigns, information sources, referrals between agencies and workforce developments (Te Pou, 2008). Asian-specific services (mainly related to interpreting and translation) have been established in mainstream DHB services in the Auckland region (Yee, 2003; Te Pou, 2008). Moreover, Cultural Competency Training (CCT) as well as recruiting more Asian professionals into mental health services has been undertaken (Te Pou, 2008; Waitemata DHB, n.d). Examples of service adaptation include providing translations and educating communities about mental health using ethnic press, radio and television media, as well as church and other religious groups (Te Pou, 2008). A specific example is Kai Xin Xing Dong, the Chinese adaptation of the Like Minds, Like Mine campaign. Its goals are to reduce stigma and discrimination and to educate the Chinese community in Auckland about mental illness. The SPINZ (n.d) website also contains Chinese-translated suicide prevention videos and a pamphlet for suicide survivors. Moreover, Henare and Ehrhardt (2004) noted that Asian liaison officers are present in the the Auckland, Hamilton and Christchurch police force and may be requested to assist the police in dealing with families with a member who has committed suicide. They may make use of networks within the Asian communities in their areas to seek help from community leaders of the same cultural group as the bereaved (Henare & Ehrhardt, 2004).

Section summary

The dominant theme that has emerged from the literature is that culture (and changes to culture following globalization and migration) plays a key role in influencing suicidal behaviour. Migration, both within Asian countries (from rural to urban areas) and beyond Asia (to Western countries), is accompanied by major cultural transitions such as the disruption of traditional family structures and the changing roles of its members. It has been observed that Asian ethnic groups carry cultural patterns of suicide with them on migration: immigrant suicide patterns in the Western countries analysed in this study are closer to those of their homeland than those of their host country, namely, lower male-to-female suicide ratios and higher elderly suicide rates. More acculturated migrants can adopt suicide methods that match those of their host population while less acculturated migrants may follow more culturally specific methods in their countries of origin.

Although overall suicide rates for Asians appear low in New Zealand and other Western countries, compared to the general population, it is important to address the risk factors for suicide within Asian communities because suicide may be the final outcome of a variety of acculturation stresses that have been overlooked. Suicide is more likely to occur during calamities associated with disruptions in relationships, unemployment, alcohol and drug abuse, depression and other forms of mental illness, as well as barriers to accessing mental health services. In the next section, to highlight current issues and understandings of suicide within New Zealand's Asian communities and to identify culturally responsive suicide interventions, the findings of a qualitative study involving key informant interviews are presented.

KEY INFORMANT INTERVIEWS

The qualitative part of this research project involved exploring the perceptions of key service providers who come into contact with Asian suicides, in order to gain a better understanding of the major issues relating to the topic under study. Consultation for the qualitative study began in April 2014. The research team made a presentation on suicide intervention within Asian communities to the Cross-cultural Interest Group (supported by ADHB) on April 29. Over 70 attendees, including psychiatrists, clinical psychologists, mental health nurses, counsellors, GPs, occupational therapists, cultural support workers, service managers and interpreters, participated. A list of potential participants for the key informant interviews were identified by the attendees. Further consultation was made at the Centre for Asian and Ethnic Minority Health Research (CAHRE) symposium on July 5, following a presentation by the research team on the literature review findings. These presentations also helped to inform relevant stakeholders about the research team, the project and its aims.

An interview guide (Appendix 1) was developed to collect information on the following research questions:

1. What are the recent suicide trends among Asian New Zealanders? How do these trends compare with the general population in New Zealand?
2. Are there age, gender, method and location-specific patterns of suicide among Asian sub-groups?
3. What factors influence suicide among Asian New Zealanders in Auckland? What are the impacts of suicide on family? In the community?
4. What are the warning signs of suicide (for different age groups and gender)?
5. How well are our current services doing in terms of prevention of, early intervention for and postvention of suicide within Asian communities?

Ethics approval was obtained from the University of Auckland Human Participants Ethics Committee on July 2, 2014 (Reference 012193) and all participants provided written informed consent. Overall, 17 face-to-face interviews were conducted between July and October 2014, involving a total of 18 key informants. They were broadly divided into two groups for analysis: the first group comprised 11 participants who engaged directly with Asian clients exhibiting suicidal behaviours. These participants included psychiatrists, practice nurses, general practitioners and counsellors working in the primary and secondary mental health sector, related addiction services as well as in general practice clinics. The second group involved 7 participants working in social services, service development and the justice sector, across all three DHBs in the Auckland region. The participants were mostly from Chinese backgrounds, with the exception of two Europeans, two South Asians, and one Korean.

The interviews were audio recorded, transcribed and subsequently analysed using inductive thematic analysis strategies (Thomas, 2006). Four broad themes emerged from the interviews: suicide characteristics; suicide warning signs and risk factors; vulnerable groups; and suggestions for suicide intervention. Participants' views on suicide intervention can be further divided into early intervention strategies; prevention strategies; postvention strategies and intersectoral collaboration. These themes and sub-themes are described and discussed below.

Suicide characteristics

Only seven informants reported that they had encountered between two and five Asian suicides each, in the 12 months prior to the interview. Of these informants, only three had directly engaged with the Asian clients who subsequently committed suicide. The remaining four recalled cases that either their colleagues had encountered (i.e. not directly under their care) or had provided support services for family members of suicidal individuals. Due to this small number, informants were unable to identify suicide trends. However, two participants considered that the increasing rate of referrals for people exhibiting suicidal behaviours was possibly due to the growth in the Asian population in their area of service. Most informants agreed that Chinese, followed by Koreans, were the most common ethnic subgroups for suicide. Suicide within the South Asian community was seldom discussed overall; only the two informants from South Asian backgrounds raised suicide as a concern within their own communities. Both informants pointed to studies from the United Kingdom on risk factors for suicide in South Asian/Indian immigrant communities, as there was a dearth of research on this topic in New Zealand.

Two informants acknowledged the existence of the suicide gender paradox, which was thought to cut across all ethnic groups. The majority of cases discussed focused on middle-aged and youth populations. Some participants stated that an increasing number of young Asians were engaging with mental health services. However, one informant questioned the existence of a middle-age trend, asserting instead that there was a significantly higher number of youth and elderly suicides in his area of service.

Methods of suicide quoted by all informants were overdose, hanging and jumping from a height. Drug overdose on prescription medicines was reported by all participants as a common method of both completed and attempted suicide for Asian women. On the other hand, eight informants cited hanging and jumping from a height as a frequent method chosen by Asian men. Three clinicians discussed the importance of accessibility in determining the choice of method. For example, two informants asserted that the presence of structural barriers on high rises in Auckland was a guard against death by jumping in Asian clients who had ideated this method. Moreover, eight informants recalled four specific instances of attempted and completed suicide that involved jumping from a height, with three of these incidents using locations (a house, cliff and building respectively) with no barriers present.

With regard to culturally specific methods, a handful of suicides linked to charcoal burning in New Zealand (3 completed, 2 attempted) were recollected by three informants. It was reasoned that sensationalized tabloid stories of celebrity suicides in international, especially Asian, media could influence suicidal behaviours amongst less-aculturated immigrants as well as Asian youth, particularly with regard to the choice of charcoal burning. Six informants mentioned a few rare cases of other culturally specific methods, including hydrogen-sulphide poisoning, the ingestion of herbicide and Dettol as well as self-immolation. Furthermore, three informants stressed that the total suicide count for Asians in New Zealand may be underreported. They highlighted that cultural factors, such as the anticipated "shame" brought on family members in the aftermath of a suicide, may lead to more concealed methods of self-inflicted death. They proposed that some deaths by road traffic accidents for the Asian population may actually be misclassified, and are hidden suicides.

Suicide warning signs and risk factors

No overt warning signs

All informants were able to point out forms of verbal or behavioural cues, for suicide attempts and for the majority of completed suicides they had encountered, either directly or indirectly. However, those who directly engaged with suicidal clients noted three cases where the completed suicide occurred “unpredictably” with either “vague” or no warning signs — that is, when the suicidal client’s problems were believed to have been managed adequately at the time.

No warning signs. And he was ... you know, already come to see me to get antidepressants. And everything seems all calm. No warning. And one day I got a notice - notification from – can't remember - from the police or from the family. ... Yeah! It was a shock. ... there's no warning ... no, nothing we can really prevent it because ... they thought he had quite good support from family and friends, that we offered and I think it's one of odd case.

These informants deliberated whether such instances could be due to missed opportunities at a primary care level to recognise the culturally specific signs and symptoms of Asian suicide. Many informants indicated that some cases of successful suicide involved well concealed and calculated planning. Hence, catching the early warning signs before an individual’s risk factors escalated to the stage of having a high intensity for suicide, with a well-hidden plan, were believed to be essential for prevention.

The majority of informants acknowledged that underutilization of mental health services by the Asian population was a major barrier in this regard. The shame and “loss of face” associated with discussing mental health issues outside the immediate family was proposed by most informants as significant reasons behind late presentation. Three informants added that such cultural beliefs were perceived to impact on the family’s future prospects (social standing, children’s marriage, etc.) if it was revealed that a member had a mental illness or had attempted suicide. Five informants explained that denial of suicidal behaviours or suppression of relevant information by Asian clients, such as trivializing or minimizing stressors, until trust was established with the health professional, was a common occurrence. Moreover, one clinician noted that for the Asian clients who did engage with mental health services, early termination of treatment was an additional problem.

The factors discussed in the remainder of this sub-section were identified as warning signs for suicide within Asian individuals and their families. Beyond the influence of individual and situational circumstances or behaviours, the wider influence of Asian cultures, such as the shame associated with having a mental illness and fear of failing familial expectations, played a significant role in increasing the likelihood of suicidal behaviours. A common theme that emerged in each conversation was that Asians faced multiple risk factors, as opposed to a single, dominant influence on their suicidal behaviours.

I think with Asians especially it's never, maybe it's with everybody, it's never because of one thing. It's interrelated and sometimes it blows up.

Depression or a change in mood

The majority of informants, including all mental health service providers consulted, discussed the tendency of Asian clients to present late, with undiagnosed mental disorders. The most common disorder identified by all informants was depression, and its deviations, described as “chronic unhappiness” or “low mood”. In fact, one clinician proposed that there was a large group of people in the Asian community with undiagnosed depression, partly due to the failure by some clinicians to recognize somatic presentation of mental illnesses. Four more clinicians also reported that they were more likely to come across such culturally specific symptom presentation in middle-aged and elderly clients, rather than in youth. The delay in treatment due to under-recognition was, therefore, suggested to expose these individuals to a greater risk of suicide and other complications, as their mental health problems were allowed to intensify over an extended period of time.

While long periods of low mood or depression was recognized as an important warning sign for suicide, a sudden change in mood in the opposite direction (from a negative to positive state of mind) was also identified by four informants as a cause for concern. For example, one of these informants, upon self-reflection, deliberated whether change in mood was a missed warning signal in a particular incident involving a completed suicide:

... she gave me a bunch of flowers and just said to me 'Oh thank you very much for coming to see me' ... I didn't feel she had any warning signals but obviously [name of organization withheld] missed, they saw and said that she was safe. Unfortunately never quite, not sure why she decided to do that [method of suicide withheld].

A clinician added that a client's change in mood from one of persistent distress to comfort, following a long process of suicidal ideation that involved the formation of a concrete suicide plan, eventually led to a completed death:

He admitted that [details of suicide plan withheld]. And for him that was his safety net, he actually described kind of feeling reassured that if and when he wanted to, he could end his life and that was actually a protective thing for him because it actually made him feel less anxious, and if he was less anxious, he felt okay to go on for another day or two. So that was the way he managed, you know, the internal conflict that he was experiencing.

Intent

In the context of recognising warning signs, informants also discussed the motivations or intentions behind attempted and completed suicide for both genders. Some informants proposed that self-harming could be a way Asian women externalise stress that they were unable to cope. A few informants questioned whether attempted suicides among this group were carried out as a way of getting attention from partners and other family members, rather than with a strong intention to die. They suggested that if previous attempts achieved no secondary gains, and their relationship problems continued to disintegrate, the subsequent feelings of hopelessness and despair, a need for revenge and/or to escape, may ultimately lead to completed suicide for some Asian women.

One informant illustrated this situation by giving an account of her own attempted suicide — the emotional state and thoughts that led to that decision:

So for myself ... because I think I overdosed with my own medication – this is, I have access. I didn't really want to kill myself basically. It's more my relationship turn really sour, so I threaten him, it's more like that. ... And I think it's because then we won't die - so overdose, you still can get help or someone rescue you.

All participants acknowledged overdosing on prescription medicines was a common method for both attempted and completed suicide for this group. Some informants further explained that Asian women were more likely to opt for a passive, peaceful route to death, compared to Asian men. Two informants, however, revealed that suicidal ideation among Asian women could be more violent than their actual attempts. Thoughts of stabbing and throat cutting were mentioned in a few Asian clients encountered by one clinician, with another informant adding that these were “threats” more than deliberate plans.

On the other hand, some informants noted that both attempted and completed suicide methods for Asian men tended to be more violent, and with higher probability of fatality. Eight participants suggested that hanging and jumping were common for Asian men. Two informants thought that these patterns matched those of the general population. A few informants proposed that the majority of suicide attempts among Asian women were distress calls of low intent, involving the use of less lethal methods such as overdosing, due to the belief that there was a possibility of being saved, as highlighted in the case above. In contrast, Asian men were thought to choose more violent methods to ensure the success of their suicide; that is, they did not want to be saved.

I think males, if they're gonna do it, want to know that they will be successful which is why in particular they pick hanging and jumping from height 'cause they know they'll be more likely to be successful.... I think when men particularly are pushed to the point of suicide - whether it's tied in with this whole 'success' thing - so we mention middle-aged men and their fear of being a failure because their business has failed or they've made poor investments, it could be tied in with the same thing, you know ... equally 'I don't wanna be a failure in suicide'.

Informants also examined the differences between impulsive and planned suicides in the context of recognising warning signs. In cases of impulsive and unplanned suicides, it was suggested by all three GPs interviewed that individuals wanted permission or a reason to kill themselves and may test their suicidal ideation out on others, including primary care practitioners as well as family members. In contrast, many informants believed that the plans of those who had successfully completed suicide were more premeditated and undisclosed, involving the selection of a time and/or place where they were unlikely to be disturbed or found. Seven clinicians who directly engaged with Asian clients repeatedly used similar questioning tactics (*Do you have a plan?*) to distinguish between impulsive and planned suicides.

I think it depends on the motive of the psycho-behaviour. If the motive is to kill themselves I don't think we can stop this person, because this person would have already planned and he would have hidden all his ideas about this plan would have been carried out very smoothly. It would be hard for people to identify, to know that this person wanted to kill himself.... but if this person has a secondary agenda ... then I think the rescue factor would be very high, where he would make sure that someone is in the house ... or the column of the house is

loose enough and not able to withstand his weight [related to a case of hanging]. So I think he would do a lot to rescue. But compared to women, men's determination to kill themselves is I think stronger.

History of suicidal behaviours

Seven informants, particularly those who engaged directly with suicidal clients, emphasized knowledge of an individual's family and psychiatric history as important factors in determining the likelihood of suicide. One clinician pointed out that while there may be many false positives that arise in the process of recognising warning signs, a history of self-harming and previous attempts were the strongest predictors of completed suicide. Due to shame associated with disclosure, many informants noted that Asian families and clients would admit to a history of self-harming and suicide attempts only after trust had been established, or in the aftermath of a suicide.

Most Asians, especially Chinese ... they don't admit to killing themselves. 'Oh, it was an accident' or they might say 'I don't remember'.

Until she committed suicide the second time around, and then after having a conversation with the family members, they told us that you know, she tried once. So we had no idea ...

The informants revealed that many of these suicidal individuals had not come into contact with mental health services during their past episodes. Therefore, contacting the family and GPs to obtain information was important in assessing whether the client's current behaviours could be considered as warning signs for suicide.

Past psychiatric history, it's very hard to gather sometimes ... we often contact as many people as possible to get collateral information. So if for example, we've had a referral for a middle-aged Asian male, then we'll try speak with the wife, possible the children if the children are old enough to do that; we'll speak with the GP if they're registered with a GP as well, and we've got ability to access some software called Concerto ... there'll be discharge summaries there and clinic follow-up letters so it kind of helps us to piece together as much of a map as we can about that person's previous health issues, along with getting the information from the family, just in terms of if there's been any previous episodes, any other stressors, what the premorbid personality structure's like and that kind of information.

Moreover, it was not only the client's own history of suicidal behaviours but that of the family's which was considered a warning sign by some informants; as it could create a ripple effect. The suicide of a family member was proposed to have triggered thoughts or attempts amongst other close family members in four cases recollected by some clinicians. Furthermore, three informants described two cases that involved the forming of suicide pacts between Asian family members, for example:

... him and Mum made a suicide pact and that's how they came to our attention, so we were actually initially involved with Mum. ... And we made a referral to [name of service withheld] for him. So he was involved with [name of service withheld] for a couple of years. ... what we didn't know at that time was that he'd started to talk to Mum about issues around his gender and sexuality which Mum

couldn't accept - she didn't want to hear about it. Which kind of isolated and ostracized him even more. And that was partly why this suicide pact came about because it was all too much, so Mum wanted to kill herself, so he was saying 'Well if you kill yourself I'll kill myself'.... then he came to our attention again, probably a few months before he suicided.

Acculturation difficulties

The stresses associated with acculturation were consistently advanced as root problems behind suicidal behaviours by fourteen informants. Settlement issues, including English language difficulties and a lack of recognition of overseas qualifications, were suggested to lead to unemployment or under-employment and consequently, exacerbate financial difficulties. Job and financial losses were repeatedly asserted as a major driver of suicide in Asian men.

Some informants proposed that settlement difficulties created feelings of depression, isolation and discrimination for Asian immigrants, along with unfamiliarity with and mistrust of social and health-care services, especially mainstream services that did not cater to their cultural needs. A lack of knowledge about the availability of Asian-specific services was also suggested by some informants as a reason for under-utilization. Additionally, one clinician considered that fears of being denied citizenship and employment opportunities as being the central reason behind an Asian client hiding past suicide attempts.

Problem gambling, substance/alcohol abuse

The problems with adjusting to New Zealand society, highlighted above, were thought to manifest in the development of risky behaviours for some Asian migrants. Alcohol and substance abuse or misuse were considered by some informants to be less prevalent in the Asian population compared to other ethnic groups. Discussions with professionals who worked in addiction and social services, however, revealed that within the group of Asian clients who engaged with their services, a considerable number were noted to be diagnosed with co-occurring issues. These included alcohol or drug addiction along with mental health disorders or problem gambling behaviour, the combination of which was considered to inflate the risk of suicide.

They mentioned they go out drinking with their friends and ... sometimes they feel like just want to drunken to sleep and then don't want to wake up ...

These informants asserted that the stigma associated with being diagnosed with an addiction and subsequent denial about problems, were important factors that contributed to low prevalence rates. Furthermore, there were discussions regarding the cultural interpretation of "risky" and "suicidal" behaviours. Two clinicians deliberated whether heavy drinking and smoking in Asian cultures could be understood as a slow but intentional means to death, in individuals who felt a sense of hopelessness and inevitability about their circumstances. Rather than taking an active and clear-cut method to end their lives, they revealed that Asians, particularly Chinese men, could opt for a more gradual, unsuspecting route, to spare any shame placed on family members upon their death. Besides alcohol issues, problem gambling was identified by seven informants as a way of escaping distress. They suggested that the casino was perceived as a place to meet other Asians, form new social networks and enhance self-worth for recent immigrants who were struggling with

adapting to New Zealand society. Moreover, three informants suggested that falling into financial debt as a consequence of problem gambling, and the inability to re-pay loan sharks, were prominent reasons behind completed suicides in some Asian men.

He owed a lot of money, for gambling ... I think it's more like stress related and probably he couldn't repay the money ... and that's why he chose the most violent method to kill himself, so definitely he will be dead.

Notably, these stressors and their manifestations were described as not only affecting the individual engaging in risky behaviours but also having an impact on the suicidality of other family members.

I do have some clients ... they do have suicidal thoughts. It's because in their psyche, in their family ... their parents got alcohol or drug and gambling addiction issues. So they feel like they have no hope. So ... high risk for suicide but ... they didn't really commit.

Social isolation

Nine informants identified the disruption of family and social support networks as a possible warning sign for suicide, with four of these informants adding that social isolation was associated with psychological consequences, such as depression. One clinician illustrated a case which explained how this correlation deteriorated support networks even further, heightening the risk of suicide:

Mum and two daughters suicided together as a result, in the context of financial difficulty ... I suspect there's probably more to it then, I suspect that there might have been some depression as well ... Dad came over to New Zealand to bury or to the funeral and then he himself suicide within a week, er in staying in New Zealand. So I think there's definitely a factor of the family disconnection, social disconnection is a big issue.

Some informants raised concerns about immigrant families forming intense social bonds between immediate family members and partners as a result of losing support links with extended family and friends overseas. They further explained that these bonds could result in unhealthy relationships, heightening the risk of suicide, as one informant illustrated in the case of the suicide pact between mother and child, described above. Many informants stressed that social isolation was most common among the elderly, international students, as well as members in astronaut families, as they were more likely to have reduced social support. Another example of problems associated with intense social bonds was pointed out by a clinician. This was a rare completed case of murder-suicide in New Zealand involving an Asian family. In addition, three mental health service providers mentioned clients who had either attempted or expressed the desire to kill their family member(s) before taking their own lives, as they believed there was no one to take care of their family members after they died.

Family conflict and cultural expectations

Relationship conflicts (such as marital discord) and/or losses (the death of a partner) were identified by all informants as potential warning signs for suicide. It was further explained that this was due to the inability to cope with grief and distress during these events. As

described previously, informants also discussed conflict in unhealthy family relationships (intense social bonds) as a risk factor for suicide. Many participants believed that Asian cultural values, which advance the importance of family before the individual, played an influential role in suicide in such circumstances.

While most informants agreed that more Asian men than women committed suicide, the majority of cases recollected were women. Four informants presumed this to be because Asian women sought help more actively than men, and they were more verbal about their problems. Hence, warning signs for suicide among women could be detected more easily. The majority of informants frequently stated reasons behind suicide attempts for Asian women to stem from relationship breakdowns with their partner, with three informants citing cases of attempted and completed suicides involving the partner having an extra-marital affair.

Some informants suggested the cultural aspects which could exacerbate the risk of suicide in these circumstances included traditional gender roles placed on Asian women, their low status in the family, and a lack of social support, especially if the extended family were still in their country of origin. Additionally, one clinician proposed that the shame associated with having no relationship, that is, being a single mother or unmarried in the middle ages, was an added stressor for some clients. Furthermore, personality disorders were discussed as a risk factor for suicide in Asian women by four informants who directly engaged with Asian clients; the symptoms associated with these disorders included affective instability and poor interpersonal skills. The informants further explained that the combination of cultural and psychological factors resulted in inadequate coping skills — not knowing how to address relationship problems and wanting to stay in the relationship, possibly due to the fear of being shamed by their community and family if they left. The subsequent feelings of stress and hopelessness were suggested to have led to suicidal attempts, as these women felt powerless to address their relationship issues.

For Asian men, the majority of informants explained that a “fear of failure” to act as a successful provider for their families, influenced the decision to take their lives. Common factors for men pointed out by these informants included failed businesses or investments and consequently, falling into financial debt. The cultural factors surrounding these issues included a fear of failing both their immediate family in New Zealand and their extended family in their country of origin. Some informants reasoned that a major incentive for migrating to New Zealand was to secure a future for their families. Therefore, the loss of ambition and hope of making a better life post-migration, and the shame of returning home unsuccessful as a provider, were noted as underlying influences behind suicidal behaviours in Asian men. Additionally, a few informants pointed out that there could be repercussions on the wider family abroad, such as their social standing, for returning home a failure.

Family violence was raised by two informants working in social services as a concerning issue influencing the risk of suicidal behaviours in the South Asian community. One of these informants recollected a case of completed suicide involving such issues. It was explained that undiagnosed mental health problems could mediate both the use of violence by one partner and resulting thoughts of depression and suicidal ideation for the victim of violence. These issues were known to be kept hidden from the community due to the shame attached to disclosure outside the family. Therefore, the combination of social

isolation, hopelessness, stigma of mental illness, and ongoing violence was thought to increase the likelihood of suicidality in such victims.

In the interviews, every informant mentioned family discord as an underlying issue behind Asian suicide. The influence of family conflict or loss on the risk of suicide is discussed in further detail for different age groups under the “Vulnerable groups” section below.

Vulnerable groups

Recent migrants

One clinician identified the first three to four years as the toughest period for new migrants. Thirteen informants further suggested that acculturation difficulties and the pressure to succeed, described previously, created a period of high stress which could, if unresolved, escalate the risk of suicide during this time. Thoughts of being stranded, having no solution to their settlement problems and not being able to turn back and return to their countries of origin a “failure”, were common reasons given for depression among this group.

They were new migrants to this country. But the husband has got a really, really good job, a very high profile job back in his country. And the wife is also holding quite a good job but when they came here, there was no job of such calibre for him. The wife managed to find, similar although lower ... than her previous job ... and he went quite deep into depression that the wife actually came and talked to me that he's thinking of suicide. And of course it's not just about the job, it's about 'How do I support my family?' It's about what will the other family members back home think of him, as a failure, as a loser, so those cultural, face factors, becomes important. And then this person then indulges in drinking, so went into a bit of alcohol but luckily because there was very quick identified by the wife ... and came to see me and we talked and we got help.

Young people

Academic pressures from family, which generated an intense fear of failure, were mentioned repeatedly by twelve informants, as a dominant factor influencing suicidal behaviours for Asian youth. Half of these informants selected international students as a high-risk group, suggesting that reduced social support and English language difficulties, in addition to academic pressures could increase their risk of suicide. Concerns were voiced particularly for Chinese international students by one clinician, who proposed that they were likely to come from one-child families and therefore be the sole point of focus of parental pressures. Two informants raised the issue of increasing referrals for this group during exam times, which was recognized as high-risk period for suicidal behaviours, as the outcomes of exams could determine their further stay in the country.

Unrealistic parental expectations were emphasized by the majority of informants as a major source of distress and low self-esteem for Asian youth in general. Examples of parent-child conflicts specified by two clinicians included both emotional and physical abuse such as negative, invalidating comments, hitting and throwing objects when expected grades had not been achieved, as well as acting in an authoritative manner over their children's career path. They proposed that Asian youth with such family backgrounds were more likely to have emotional dis-regulation problems and engage in self-harming

behaviours, but they were not necessarily considered suicidal at this early stage. A GP added that self-harming and suicidal behaviours for Asian youth tended to be unpredictable and impulsive, and that they were more likely to present at the Emergency Department (ED) than at the clinic. An informant working in social services also added that young South Asian women had particularly high rates of presenting at ED for self-harming.

Ten informants discussed the effects of Asian culture in shaping the parent-child relationship. Half of these informants suggested that cultural expectations placed on Asian parents, such as having a "duty to work", meant less time bonding with children and a greater expectation placed on children to succeed academically in return for their sacrifice. Notions of filial piety and a lack of respect were mentioned by some informants as further explanations for intergenerational clashes. Five informants also proposed that bi-cultural youth may face an identity crisis, trying to "straddle two worlds": presenting a more traditional culture at home but a more Westernized one at university or school.

... with the different cultures who are coming here to succeed, I think happiness is not as important, it's more hard work. So when you achieve something, then after that, you should be happy.

Gender differences in suicidal behaviours for youth stemmed from similar reasons to those of the middle-aged groups. Some informants made comparisons between fear of academic failure in young males to that of financial failure in middle-aged men, as a factor influencing their decision to suicide. For young Asian women, relationship problems as well as family conflict, in addition to academic pressures, were suggested by four informants to be significant influences on their suicidality. Particularly for female international students, one GP suggested that relationship breakdowns could intensify suicidal thoughts as their partners may be the only support network they have. Another informant distinguished two types of motives behind self-harming and suicide attempts for this group:

And they do a lot of attention-seeking behaviour, lot of Asian younger people attempt self-harming. Cutting and taking tablets just for attention. So we're seeing two sorts; one that do it for attention-seeking behaviour, two that actually have, are finding it hard to adapt with families and their cultures and going out onto the community and mixing with their peer groups ...

Additionally, five informants suggested other, more hidden issues which were thought to elevate the risk of suicide for Asian youth. Gender and sexuality crises as well as sexual abuse from family members or family friends were only discussed amongst a minority of cases recollected. Four mental health service providers indicated the stigma around these issues and the reluctance of clients to disclose their thoughts out of fear of shaming and/or repercussions from their families. Even amongst Asian clients they had engaged with for over a year, two clinicians revealed their clients had an unwillingness to disclose these issues:

His parents had given up a lot to come here, for them to have better opportunities. Both parents were working two jobs. I think there was a lot of pressure on him academically ... Not only that, I think he started to decline academically, he was going through very severe identity crisis, he was disillusioned with what the church said - quite religious parents - and what the science said. I think he was struggling and in all that stuff there was his sexuality

and body dysmorphia and he just, ... [method of suicide withheld] ... And again we think that this was pre-meditated. His family weren't letting him out of their sight. And he described this kind of chronic, you know, thoughts of 'I'd rather be dead than deal with this.'... we knew there was more going on but he just wouldn't tell us. Interestingly, because I saw him twice at home and on both locations I asked his mum, 'Could we speak with him alone?' She refused to leave his room.

Five informants discussed the effects of the internet in the forming of suicide pacts and peer-influenced suicidal behaviours on young Asian New Zealanders. The influences of emerging methods in Asian countries, such as hydrogen sulphur poisoning, on Asian youth suicides in New Zealand were mentioned by two informants. The copycat effect was stressed to be considerably influential on youth suicidal behaviours by two informants.

Middle-aged

Many informants considered the 20 to 50 year age range as being a time of high stress for Asian migrants. The interplay between mental health issues, cultural expectations and situational risk factors for this group were suggested to act as important triggers for suicidal behaviours. For example, one informant proposed the presence of undiagnosed mental health issues in the Asian population, which worsened as they aged, in conjunction with stress factors in the middle-ages (such as marital discord and job losses) elevated the risk of suicide during this time. As previously mentioned, the culture of having a "duty to work" was suggested to play a role in their delay in help-seeking behaviours. Particularly for middle-aged women, one clinician suggested that it was a period that involved other losses such as their primary role as caregiver to their children. This loss of identity, combined with the aforementioned cultural clashes with children, were thought to create a sense of loneliness and despondency, leading to suicidal thoughts as a way of expressing distress. Paradoxically, children were also identified by some informants as reasons for middle-aged and elderly women deciding not to follow through on suicidal ideation, as the expected shame placed on the family would scar their children's lives.

Older people

Some informants explained that many older Asians came to New Zealand to be re-united with their children who migrated earlier, and that the resources and savings invested in their children meant they had little to save for themselves. The informants further explained that there was a cultural expectation that upon migration, their children would look after them in return. They discussed the motivations behind suicide in elderly Asians when this transition was thought to not happen as smoothly as anticipated. Seven informants identified the feelings of being an economic burden to their families as being a common reason for suicide among elderly Asians. They collectively described the stressors that influenced suicide among this group as stemming mainly from changes in the traditional family structures and roles post-migration. These changes were thought to result in intergenerational clashes between the elderly and their children as well as in-laws, and lead to thoughts of hopelessness and depression, increasing the risk of suicide. Other factors that influenced suicide in elderly Asians, suggested by five informants, included the presence of a physical illnesses and not wanting to live in pain. Furthermore, English language and mobility barriers were thought to contribute to social isolation and subsequently, suicidal behaviours.

... some older people here to ... help the family with grandchildren. And ... when grandchildren grow older they are not wanted anymore. And they can't go back to China, by that time nobody in China is going to take care of them. Go to rest homes is a very shameful thing. So where do they go? ... So that's another way older people kill themselves or because of chronic illness.

One clinician discussed findings from studies conducted on mental illness within elderly populations in New Zealand, revealing that older people, including Asians, have significantly higher depressive symptoms. Six informants further discussed the need to look for signs of somaticization within older Asians, and argued that the warning signs for suicide among this group as more subtle, compared to the young or middle-aged.

From my experience, for older people that were considering suicide, they will be more subtle. 'Cause they will say 'Oh well, I'm feeling old' ... well that's a fact - you are old. 'Oh, you know, I'm feeling old, I'm feeling tired, I don't feel the energy anymore.' And what they really mean is 'What's the point?'

... haven't been out for few days. Just stay at home. And cannot sleep well and so normally assess these kinds of physical things ... they don't eat, that might be ... slow dying. ... They normally say 'I don't have the hope to live,' 'I don't have the point' ... they think 'If I die, problem free.'

Following from this, six informants suggested that older Asians were more likely to commit suicide in a way that could be perceived as an accident or slow death.

For older people, they either get vanished or they try to put on an accident, where they will try ... rush in front of a car or bus. Or one patient jumps - pretends as if he's watching fishing on the rocks and he fell into the sea.

Early intervention strategies

All informants agreed that suicide is preventable, and many stressed in particular the need to address the underlying mental health issues at an early stage. A range of suggestions were made on training both professional groups and community members to identify warning signs of suicide more effectively. In addition, it was also suggested that general practitioners could play an important role in the recognition and treatment of vulnerable persons.

Role of GPs

A significant finding from the interviews was the dual role of GPs in acting as both counsellor (catching early warning signs) and physician to Asian patients. The three GPs interviewed revealed that they would often go beyond the standard consultation time of fifteen minutes, to spend one to one-and-a-half hours counselling patients they believed to be at risk for suicide. This need to go beyond their call of duty was found at some popular, individual Asian GP practices. One GP pointed out that larger practices with non-Asian staff may miss such opportunities due to time constraints and a lack of cultural awareness and trust between them and their clients. The three GPs interviewed stressed the need to take a more holistic approach when addressing the issues of their Asian patients, as their patients' psychiatric problems and propensity for suicide were only one part of many

issues/illnesses they faced. Due to the lack of Asian-specific suicide prevention training, the GPs interviewed had, through trial and error, developed their own style or system of identifying and treating patients who exhibited suicidal behaviours. One such example was the use of the PHQ-9 form as a conversation piece or guide. It was explained that this tactic was developed as a result of Asians patients having difficulties completing the form themselves due to language barriers, but this had resulted in a method of questioning that worked well for the GP in picking up warning signs of suicide and in giving an indication of the patient's mental health status. Another GP asserted the importance of being constantly on the lookout for warning signs, as an individual's suicidal tendency is not a one-off event:

I think suicide prevention is ... a misnomer in that, it sounds like somebody's gonna have a heart attack and then you have to catch them and then you stop the suicide, [like] you stop the heart attack. Whereas suicide is something that can be going on, an ongoing process. Just because they don't kill themselves today doesn't mean they're not gonna do it tomorrow ... that propensity is always there.

The three Asian GPs interviewed regarded themselves as having a unique advantage in suicide prevention compared with other service providers, if the client and their family were all enrolled in the same practice. The GPs reasoned that they had both the patient's individual and family history and could offer better continuity of care over the lifetime of the patient, unlike referrals to mental health services, which could be one-offs or only periodic engagements. Four clinicians also advanced the need to look into the history of the patient via the GP. The three GPs interviewed further suggested that they had better insights into the circumstances surrounding the risk factors for suicide in their Asian patients, could notice a difference in their patient's behaviour, and were therefore in a better position to pick up warning signs:

I would ask, from little hints, what you can feel something ... Because with family background, with family you probably get a little bit of information because a long period of contact, can probably sense something. And also can ask if you've got suicidal thought, pain ... you can feel that ... gut feeling.

All three GPs underlined the importance of building good rapport with Asian clients. Perceptions of the GP as a friend and a person who had the family's best interests at heart were understood by the GPs interviewed as factors that encouraged disclosure of sensitive information, such as family conflict, symptoms of depression or suicidal thoughts. One GP emphasized the usefulness of the following questioning tactic, as Asian patients tended to not be forthcoming about their problems:

Because of the relationships I have with patients I can ask them straight ... 'Tell me what really is happening' ... if I realise something behind it, I just ask them straight about depression, anxiety symptoms, suicidal, 'Do you have any plan?' ... Normally when they come to present me with physical symptoms, say palpitations or headaches and then I ask them if they sleep, then I just say after all that 'Is there anything else going on? How's the home? How's the umm school?' you see ... 'How is everything else?'... It's something I cannot explain if I can feel, it's like you say 'gut feeling' ... can discover lots of other things, behind it when they start telling other issues ... so if I ask 'Is there anything else?' there normally is, and they will say 'Oh, something did happen ...'

Another GP mentioned that Asian families would visit both individually and as a family for consultations, allowing for the opportunity to disclose problems in the former visit. This GP then used the latter appointment to discuss issues in a frank manner through informal family therapy conducted in a culturally acceptable way.

... important to have common sense I think, as a GP. 'Cause sometimes you can say 'Well I'm not allowed to talk about this case to anybody.' But if somebody's going to kill themselves or they might be distressed, you say 'Oh, can I have permission to talk to so-and-so? [Referring to another family member].

The importance of GPs in taking a proactive role in suicide prevention was also advocated for by one clinician, who surmised that the Asian population may find it more culturally acceptable to receive support for early-stage mental health issues from the GP practice, rather than from mental health services.

Training to identify warning signs

1. General practitioners

While one of the GPs interviewed mentioned receiving basic psychiatry training, there was consensus among the GPs interviewed that they had developed their own style of detecting warning signs and managing suicidal Asian patients. Collating the different questioning tactics these GPs used to elicit information from patients who were not forthcoming about suicidal behaviours could help other GPs, particularly those in non-Asian practices, at recognising culturally specific warning signs. Moreover, the suggested use of family counselling strategies to address such issues may also help other GPs manage such circumstances.

2. Interpreters

Three clinicians deliberated on the ability of interpreters to satisfy language needs as well as the meanings behind the language. Concerns were raised about some interpreters they had worked with in the past, who only provided summaries of their conversations with patients:

Sometimes my feeling is that the interpreters are not proper trained interpreters. So they make a summary, you know of the whole conversation, and they say 'yes' and I say 'It's impossible, this kind of question to be yes or no when you were talking four minutes'.

One clinician pointed out that some interpreters who had years of experience working in the field of mental health interpreting, had also developed their own skills in detecting warning signs:

... you notice the difference with them because not only do they give you a literal translation, they'll talk about whether something's been used out of context, or they'll talk about whether there was hesitation in the answer. So they've provide those extra little nuances that are quite important to us ... 'cause again there's that whole thing that we would interpret body language and nonverbal cues in a certain way which might actually be quite different to that culture, so it's useful to have that understanding provided to us by the interpreters.

Training interpreters to be aware of such cues may be useful in assisting clinicians and GPs with identifying warning signs.

3. Police

In the interviews with three informants working in the justice sector, one mentioned undertaking a suicide prevention course and another had conducted workshops with SPINZ on Asian suicide. All three informants explained that they were mostly involved in suicide prevention through their work in the communities, including delivering courses on stress management, depression and settlement difficulties. However, two informants discussed encountering Asian individuals showing signs of depression and/or suicidal ideation and how they helped these individuals/their families improve their circumstances. It was further explained that the role of the police, particularly those who work in Asian communities was not limited to postvention but also included early identification and prevention. Therefore, more training for frontline police officers on suicide awareness was required in this regard.

4. Community leaders

Some informants drew attention to the need to educate the public about best practice measures to help Asian individuals in the community exhibiting suicidal behaviours:

... people will ask 'Do we call mental health? Or call police?' So people not sure what to call. And all of them said 'Call ambulance first!' because depends what happened. If the person is violent, like holding a knife, call police. Don't call mental health, we won't deal with this violence. So people not quite sure where to ring or what to do as well, so lots of education to the public, to the community what to do as well.

In addition, three informants proposed more training such as Mental Health First Aid (MHFA) workshops and suicide awareness seminars be conducted to address this issue. They stressed the need to target community leaders, particularly religious leaders, to enable better referrals to mental health services. These informants argued that such leaders could be the first point of contact for a suicidal individual, given their status in the community and the lack of trust Asian individuals may have with health services.

5. Hotline staff

Three informants suggested improving training for hotline staff, as most telephone hotline staff were volunteers. They pointed out that training, in particular, was required to increase hotline staff's sensitivity to warning signs of suicide in Asian cultures and how to respond to suicide crises.

Prevention strategies

Strategies suggested by informants to prevent suicide in Asian communities focussed on addressing cultural factors influencing patterns and responses to suicide in these communities. These included training to increase awareness of Asian cultural issues; cultural support to increase care-seeking and engagement; building trust and the need for a face; and ongoing promotion efforts with greater outreach.

Training to increase awareness of Asian cultural issues

Three clinicians voiced the need for more in-house clinical training on suicide prevention, particularly on understanding the cultural risk factors and promoting protective factors for the Asian population. A one-size fits all approach was regarded as ineffective due to differences in the presentation of suicide in Asian cultures. Existing CALD cultural competence training was found to be useful to support the health workforce, but not all health practitioners received the training. Other than CALD training, a workshop on suicide in Asian communities organised by the Cross-cultural Interest Group was noted as being informative. A few informants stressed that this type of training or workshop should be ongoing and not just one-offs. Some informants also suggested that such training and education should be expanded to a variety of groups that come into contact with Asian suicides (e.g. teachers, social workers, hotline volunteers, police, community leaders, religious leaders), and not just health professionals.

Cultural support to increase care-seeking and engagement

Many participants shared knowledge on successful engagement tactics with Asian clients and their families. Collectively, their suggestions included addressing the root causes of the problem (such as gambling debt or acculturation difficulties), re-framing the problem in a positive light, and at times minimizing the issue to normalize the treatment process. Furthermore, three clinicians perceived themselves to be facilitators or mediators who provided a supportive environment for solving the underlying issues of family discord in suicidal patients. One clinician added that providing longer-term follow up and family support were beneficial for easing the shame associated with mental illness and helping clients discuss family issues they had previously hidden, out of fear. As one clinician asserted:

I do not see an individual as the cause of a problem. I see that the whole family, the whole system could have some degree of contribution to the person's suicidal thought or even, ideation. So when you ask how I should ... prevent this from happening, my answer would be doing a good thorough assessment and involving as many people in the family as possible. To get as much collateral information as I can, before I can look at what is happening with this person ... Even if I have treated this mental state, if the circumstantial factors do not change, like if he is still experiencing pressure from his gambling debt, or if he is still experiencing argument with his family members, I am not able to deal with the root of the problem.

A group of informants endorsed the effectiveness of the Asian Psychological Service developed in WDHB in 2013. The pilot project provided language-appropriate psychological therapies to Asian clients, and was thought to be particularly successful in building rapport and engagement with suicidal clients. Providing cultural support and psycho-education to Asian patients and their families were recommended by many informants interviewed. However, some informants stated that some of the existing Asian cultural support services were limited by the geographical boundaries of the DHB they serve, and that costs were additional barriers to service engagement with the Asian population. One GP mentioned that he could not send patients for free first referral to mental health services if the patients were not living in a high needs area.

Building trust and the need for a familiar face

The importance of networking for health promotion in Asian communities was stressed by many informants interviewed. Some informants proposed that it was more effective to visit community groups directly to discuss suicide prevention, rather than inviting such groups to their organizations because many community groups were initially reluctant to engage in discussing taboo topics such as mental illness and suicide. Informants also noted that many Asian people were reluctant to seek help from mental health services directly. Instead, they would go to specific, trusted individuals such as community leaders, religious leaders or GPs to seek advice. Often these clients would at first pretend to be concerned about a friend's problems, and then later begin to disclose their own problems in a more open manner. Their reluctance to engage with mental health services may be due to fears of gossip being spread, particularly if they came from small communities and the Asian staff in those services were also from the same communities. Two informants working in the justice sector also suggested that the distrust of services by Asian immigrants could be due to previous negative experiences in their country of origin, such as corruption in public services. Other explanations for a lack of engagement included fears of deportation if diagnosed with a mental illness, and worries about their diagnosis affecting employment prospects.

Informants, therefore, asserted the need to educate the public with clearer information on what their services provide and what circumstances would meet a breach in confidentiality.

... we explain our professional role, what we can help. And then once the client comes into our services, like face-to-face for the very first session ... and the very first topic covered, that's confidentiality. We explain that there's only two situations where we disclose your information - that when you suicided yourself or harm others. And then if any other situation need the client's consent to release ... which part of the information and that all rely to the client. Even we say 'When we see outside in the supermarket, you don't have to say hello.'

Informants also discussed the need for a face to develop trust:

I always put my photograph and my landline, my mobile and my email. Because I want people to know who you're talking to when you call. Because with us Asians, the more I see your face, the more I say 'Okay. I can trust or not.'

One informant further argued that the use of mastery of crisis stories in suicide prevention was an appropriate promotion tool for the Asian population:

Storytelling is very powerful among our communities ... share without sharing names, of helping so and so, or even tweak the story lines, so let people know that this is how they've helped somebody.

On-going promotion efforts with greater outreach

Communities play a critical role in suicide prevention. A majority of the informants interviewed recommended continuous promotion work in the Asian communities to de-stigmatise mental illness, enhance mental health literacy and promote early help-seeking, using a multi-faceted approach involving the media (e.g. newspapers, TV, magazines, internet), at-risk populations (e.g. young people, elderly depressed patients) and events

(e.g. festivals). As a starting point to engage with the community, three informants proposed that re-framing the problem with regard to promotion was useful:

For Asians especially ... I think breaking that cultural barriers become very important as a first step so that the public can understand. I give an example, like family violence. In the past, Asians don't want to report. But since the 'It's OK' campaign, people are beginning to trust. With Asian the trust factor is so huge.

Greater outreach via suicide education in schools to target the youth population was recommended by several informants; this strategy was noted to have been underway in some districts. One informant added that there were articles being published on self-harming and youth mental health for the South Asian community. These materials helped to increase awareness of early warning signs.

Middle-aged men were described by some informants as a difficult group to engage, due to cultural beliefs about not wanting to appear weak. One participant working in social services pointed out that attempts had been made to target this group but that more awareness workshops were required:

Another step for the Ministry [is] to provide a lot of awareness to get people to engage with their GPs more freely. ... We're trying to get out there through the John Kirwan ads ... We're getting senior people to do it so men don't think 'Oh. It's just for wimps' you know. 'See, big heroes also suffer from depression' ...

Specifically for the Chinese population, one clinician suggested using a programme on Chinese TV conducted by the Auckland Chinese Medical Association, which invited professionals to discuss a variety of health issues. It was noted that many middle aged and elderly Chinese people tuned in to this programme.

Postvention strategies

The aftermath of suicide on Asian families and communities were not well known by the majority of informants and many survivors of suicide were noted to have been lost to follow-up. In the interviews, informants discussed some common barriers to the provision of services for survivors, and made suggestions regarding strengthening services to support families bereaved by suicide.

Barriers to the provision of services for survivors

A few cases recollected by four informants revealed that some suicide victims had either left the country quietly, or had lied to their extended families and communities about the cause of death being a road accident or medical condition. These informants pointed out that the stigma associated with suicide played a prominent role in this “hiding up” behaviour — they were used to avoid shame, disgrace and gossip being spread about family members. One clinician also described a case where an Asian family had covered up a suicide in order to allow religious funeral rights that would have otherwise been declined. In this particular case, concerns were also voiced about re-victimization of family members by the (religious) community if the suicide was made known. Moreover, the stigma associated with suicide was also discussed by many informants to result in a tendency for bereaved family members to minimize grief, not wanting to appear weak.

I think people can easily be lost to follow-up. And I think that also as Asians in general ... very courteous ... 'Oh thank you very much for that. It's wonderful but no thank you, we don't need it.' ... 'We're gonna be okay.' ... [We] might be falsely reassured that things are actually okay. I'd rather see people actually really follow-up up for a period of time so that we can really establish that the person is well, rather than saying 'Oh, they said they don't need our help.' I think this is a bit generalising but they're less likely to seek help, even if the family are concerned, they are less likely to express it.

However, one clinician stated that some Asians may actually grieve in an exaggerated manner, to fulfil cultural expectations following the death of a family member:

Grief is a common thing. And everybody doesn't really know that in the Chinese, we grieve for three years. That is by Western standards pathological grief. Now a lot of these are put on, you know just to fulfil the cultural requirements and they're not really that grieved. And if they are really grieved ... if there's prolonged grief, it's under-recognised because it's part of culture what I mean is these things actually sort of clouded the presentation.

Services to support families

Three clinicians revealed that grief counselling for bereaved family members was offered as part of routine mental health service protocol but declining such support was common among Asian families. The presence of depression in family members who were lost to follow-up was a serious concern voiced by two of these informants, who suggested that there is a need to improve postvention services by conducting more assertive follow-ups. Two other clinicians were unsure whether postvention services were adequate for Asian families as they only experienced a small number of Asian suicides in their time working in their current roles. One informant mentioned a case involving re-referrals; where a survivor had declined support after initially seeking help and then been referred to mental health services again, highlighting that early termination of treatment may be a problem for Asians. The longevity of support provided appeared to not only depend on the willingness of the family members to seek help but also on the organizational rules of each service. For example, some informants mentioned that there was a specific time-frame allowed for follow-up care in their organization, due to the funding contract. However, some informants pointed out that for Asian people, the longer the time of support, the better the rapport and the more open the clients in disclosing their suicidal intentions. One clinician mentioned a rare case of working with a self-funded, bereaved family member for some years and another revealed that their service had no limitation to the number of psychological support sessions provided, which were free of charge and could therefore support clients for as long as required.

Acculturation difficulties may persist or worsen in the aftermath of a family member taking their own life, heightening the risk of subsequent suicidal behaviour in other family members. Hence, two participants discussed the necessity to provide support services other than grief counselling, using an intersectoral approach, which will be discussed in the next section.

... she doesn't want to talk about it ... because in grief situation ... and in that stage, for us, we can try to do as much support. Like food parcel, Housing New Zealand ... because for my client as a widow and ... she need to look after the son as well ... So it's very important ... with the follow-up and see what support, emotionally, mentally and then physically.

Discussions with three informants working in the justice sector acknowledged the police were commonly the first responders at the site of a completed suicide. All three informants interviewed asserted that the role of Asian Liaison police officers in postvention was to listen and put Asian suicide victims in contact with other services including ACC, funeral planning, and Victim Support. Some informants noted that they had also provided cultural support in cases where there were language difficulties. One informant working in service development explained that there was no Asian-specific suicide prevention coordinator and that postvention for suicide in Asian communities was linked to Victim Support, who provided immediate assistance in terms of grief counselling to families, if the families agreed. However, the cultural appropriateness of Victim Support was questioned by a few informants, who suggested more cultural training was required due to the nature of Asian families in declining support out of shame. A few informants also recommended improving information sharing between Victim Support and clinicians.

Strengthening community support

Community support/survivor support groups were contemplated by some participants. One clinician strongly advocated the need for long-term community support to survivors of suicide, as mental health services dealt with more at-risk clients. Due to the shame attached to suicide, language barriers and the small number of Asian suicides, however, the effectiveness of running such groups in Asian communities was questioned. In terms of promoting postvention services in Asian communities, it was suggested again, that the problem should be re-framed in a positive light:

Still very big stigma. I think, you know, community groups, they need to talk about it. Instead of saying suicide, ... focus on how to keep healthy, how to just give a positive spin to it.

So public education is most important. Then the other one is overcome shame and how do you talk about grief and you have to reframe it like the harmony thing.

The role of religious leaders in providing grief counselling for family members and in destigmatizing suicide was also discussed by five informants. Providing training to these leaders was vital, in an effort to increase their capacity not only to provide early intervention to suicidal individuals (discussed above) but also to help bereaved family members to deal with the impact of suicide. It was acknowledged, however, that the effects of intervention may be mediated by the degree to which a given religion sanctions suicide.

Another informant working in service development compared postvention services in other ethnic minority communities to highlight a lack of knowledge on how to address such issues in Asian communities:

I can go to the Pacific and say 'We can work through our churches to work on our mental health issues' and I can go to Māori people and say 'Can you do something through your maraes?' and stuff like that. We can't do postvention without involving the maraes because they will invite all the family onto the marae. Again that's a cultural thing. ... [But] we haven't mapped that out with the Asian community. So big gap there.

This informant also clarified that culturally-appropriate postvention training was being undertaken in schools (targeting school counsellors and nurses) as well as in universities. It was explained that if an Asian youth committed suicide in any school, the Traumatic Incident Team was sent by the Ministry of Education (MOE) to support staff members. The informant also stressed that while efforts had been made to manage affected youth populations, the needs of middle-aged suicide victims were left largely unaddressed.

Intersectoral collaboration

Finally, informants emphasized the need for intersectoral collaboration in suicide intervention. In the interviews, they highlighted some issues they currently encountered and also made suggestions for improvement.

Several informants called for closer liaison between mental health services and GP practices. A clinician serving in a DHB pointed out that there were problems sending discharge summaries/assessment reports of clients to GPs. These problems related to the use of different software between the two practices and access level issues. Another GP added that communication with mental health services was difficult initially (concerning waiting lists for referrals) but that once contact was made, communication had improved. Two clinicians from a different area of service, however, supported limiting access to GPs due to privacy concerns and reported sending summaries of clinical assessments instead.

Within mental health services itself, some clinicians noted information on clients' past histories, such as previous engagements with psychiatric services and reports of attempted suicides from EDs, were easily accessible and considered useful for building a mental health history of the patient. However, they raised concerns about the passing of clients onto other agencies (when they re-located and were under a different DHB) where appropriate cultural support was not available.

... lack of similar services in other DHBs. We transfer someone to [name of organization withheld] and try to find out what services they have. We feel very unsafe to change it but we have to. But when someone transfer to us, we got all the additional services here ... I would say it's extremely important for the Asian people ... for the other DHB would build up similar service ... But they don't have a CSC [Cultural Support Coordinator] to be assigned. We like handing over properly.

For Asians outside the Auckland region, it was suggested that improving communication methods such as telephone services and video conferencing with staff in Auckland-based cultural support services were beneficial. Suggestions for improved communication were also made with regards to the police. Two informants highlighted a lack of information sharing between the police and hospitals for cases of self-harming and attempted suicide.

However, another informant argued that privacy issues outweighed the need for police to have access to such information.

Calls for improvements to the suicide reporting system were also recommended by some informants. Two participants raised concerns about missing information, stating that no hospital records were kept for self-harming and attempted suicide records from EDs, when the patient was discharged before 24 or 48 hours. Additionally, three informants suggested there should be greater accountability for referrals:

There should be a record of when it was reported, when this person was seen and the follow up ... There should be an audit. ... We also want to see since the report was referred, when was this person seen? So there should be some kind of collating ... something to say that 'I have sent it to you on this date, so that you are held accountable for not taking actions quick enough.'

Four clinicians acknowledged the benefits of receiving cultural support, either from specific Asian services or collegial feedback. However, they considered that closer collaboration, such as conducting joint assessments when required, would also be beneficial:

I think ... the general training ... would be good for us. For clinicians maybe to have a little more access in speaking with people about cultural aspects. It would be good if I could phone someone in mental health and say 'Look, I would like to discuss this case with you.' We don't necessarily want them to get involved or make a referral, but we want to check out some of the potential cultural stuff. So it would be good if we could have a few points of contact.

Hence, one informant suggested that there is the need for an integrated service that helps clients with a variety of problems. A few informants asserted the need for a leader to champion suicide awareness and prevention in Asian communities and be responsible for undertaking the suggestions made above relating to improving integration:

We do have that interagency information sharing, we do have that, but somehow nobody take the lead.

Section summary

Four broad themes emerged from the key informant interviews. They were suicide characteristics; suicide warning signs and risk factors; vulnerable groups; and suggestions for suicide intervention. The majority of suicide cases for Asians in the Auckland region noted by the key informants interviewed involved middle-aged people and youth. Drug overdose was cited as a common suicide method for Asian women whereas hanging and jumping from a height were popular choices for Asian men. In addition, a few cases of suicide were linked to culturally specific methods such as charcoal burning, hydrogen-sulphide poisoning, ingestion of herbicide and self-immolation.

Key warning signs of suicide identified by the informants included depression and related mental health conditions, high suicide intention (having a plan), history of self-harming and previous attempts, family history of suicide attempts, and history of problem gambling, substance/alcohol abuse. Additionally, the stresses associated with acculturation, family

conflicts and social isolation were considered to heighten the risk of suicide. However, due to shame associated with suicide and mental illness, Asian people were reluctant to seek help; this could allow their problems to intensify. Hence, attention to warning signs and awareness of possible risk factors were considered to be essential for prevention and intervention. However, informants had noted cases of successful suicide which involved well concealed planning with no overt warning signs. Some informants also noted that some at risk behaviours could be suicidal in origin but were masqueraded as accidents.

Multiple risk factors were considered to have contributed to suicide in four vulnerable groups: recent immigrants, youth, the middle-aged, and older adults. Settlement difficulties were suggested to create feelings of depression, hopelessness, isolation and discrimination among Asian immigrants. Cultural factors surrounding these issues, including stigma of mental illness, shame associated with help-seeking and fear of returning to their country of origin a failure, were stressed as additional factors increasing the risk of suicide in this group. Academic pressures, unrealistic parental expectations, parent-child conflicts and possible identity and sexuality crises, were noted as risk factors for Asian youth, with international students being mentioned as a high-risk group. Risk factors in the middle ages were suggested to include marital discord, relationship breakdown, and job or financial losses. For middle-aged women, this was also a period that involved other losses such as their primary role as caregiver to their children. Relationship issues with adult children and in-laws, increased likelihood of physical illnesses, feelings of being a burden to the family and social isolation were noted as risk factors in older adults.

All informants agreed that suicide is preventable. Their views on suicide intervention can be further divided into early intervention strategies; prevention strategies; postvention strategies and intersectoral collaboration. With regard to early intervention, informants suggested, in particular, the need to address underlying mental health issues at an early stage. Because of the stigma associated with mental illness in Asian communities, even where specialist mental health services are available, many Asian people with depression and related mental health conditions may choose to visit GPs where they are more likely to report physical complaints rather than psychiatric symptoms. GPs also have the advantage of having good rapport with Asian clients and their families. For these reasons, GPs were believed to have a particularly important role to play in the recognition and treatment of vulnerable persons. Other than GPs, suggestions were also made on training teachers, social workers, police, hotline volunteers, family members, community leaders and religious leaders to identify the warning signs and risk factors of suicide, and to be equipped with basic intervention skills to establish rapport with potentially vulnerable individuals, to deal with suicidal crises and to make referrals if necessary.

Addressing cultural factors was seen as very important in developing strategies to prevent suicide in Asian communities. Other than existing CALD cultural competence training, regular suicide prevention seminars and workshops were recommended in order to improve the capacity and cultural competence of professional groups, families and communities to prevent suicide. The importance of networking and building trust in Asian communities, and continuous promotion work to de-stigmatise mental illness, enhance mental health literacy and promote early help-seeking were also stressed.

Because of the stigma associated with suicide, family members were noted by informants to be reluctant to identify themselves as having been directly affected by suicide. Hence, there is a clear need to strengthen postvention services to raise awareness about the

needs of survivors, and to remove barriers to their seeking support. Above all, informants emphasized that suicide intervention should involve an intersectoral approach, including improving information sharing between mental health services and GP practices, strengthening cultural support for professional groups, community members and survivors, and enhancing the infrastructure for suicide prevention.

RECOMMENDATIONS

The recommendations in this report have been developed from the literature review and qualitative data from the key informant interviews. They are framed within the *New Zealand Suicide Prevention Action Plan (SPAP) 2013-2016*, released by the Government in May 2013 (MOH, 2013). The SPAP acknowledges the multiple risk factors of suicide, and outlines a coordinated approach to prevent suicide across government and non-government organisations, and in partnership with the community.

Support families and communities to prevent suicide

1. Build the capacity of Asian families and communities to prevent suicide

- Strengthen relationships with different Asian ethnic sub-groups and understand specific cultural factors that may influence suicide risk. This will aid in supporting families and communities to develop information and resources related to suicide prevention that are in line with their cultural beliefs.
- Create public 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.
- Identify appropriate mechanisms to deliver suicide prevention messages to diverse Asian communities.
- Encourage the development of support programmes in Asian communities to reduce social isolation of vulnerable persons.

2. Train professional groups and community members to identify and support individuals at risk of suicide in Asian communities

- Upskill general practitioners and related professionals (e.g. counsellors, social workers) on mental health and suicide prevention, including identifying warning signs and possible risk factors of suicide, managing depression and suicide risk, and referral to specialist mental health services where appropriate.
- Train frontline police, hotline volunteers, interpreters, community leaders and religious leaders to identify individuals at risk of suicide, equip them with culturally appropriate intervention skills to deal with suicidal crises, and make referrals if necessary.
- Promote CALD cultural competency training and resources.
- Develop a toolkit on the Asian presentation of suicide for health professionals, particularly for clinicians and GPs.
- Expand Mental Health First Aid training for health professionals with experiences of Asian suicides, who in turn, train community leaders and other volunteers.
- Assist mainstream mental health providers to identify the most at risk clients and families and to implement clinical management plans that are realistic, culturally appropriate and acceptable to Asian clients and families.

Support families and communities after a suicide

3. Develop more responsive, accessible and culturally appropriate support services for Asian families who are bereaved by suicide

- Explore the impact of suicide on each family member affected by suicide.

- Make funding available to ensure there is appropriate bereavement support and follow-up for Asian families affected by suicide.
- Support Asian families to break down resistance and cultural barriers to accessing bereavement support and related services.
- Train Victim Support staff to identify bereaved family members at risk of suicide, provide ongoing support to deal with the impact of suicide, and refer to appropriate mental health and social services if necessary.
- Liaise with GPs in developing an effective plan for providing help to family members at risk of suicide.
- Provide support to clinicians and health professionals after client suicide.

4. Increase the capacity of Asian communities to respond following suicides

- Raise public awareness about postvention services and the potential benefits of postvention services for suicide prevention.
- Increase the knowledge and understanding of community leaders and religious leaders about the needs of survivors.
- Develop appropriate mechanisms and resources to deliver postvention messages to diverse Asian communities.
- Grow community capacity to prevent re-victimisation of bereaved family members.
- Provide support to community members looking after families affected by suicide.
- Improve awareness of the ripple effects of celebrity suicides in Asian communities.

Improve services and support for people at high risk of suicide

5. Promote better inter-agency referrals and communication

- Improve information sharing and develop service pathways between secondary and tertiary mental health and addiction services and primary health care (GP practices, PHO).
- Improve the care of people presenting to emergency departments with self-harm injuries, and ensure there is appropriate follow-up after discharge.
- Improve the communication and reporting system between GPs, police and mental health and addiction services.
- Increase resources into Asian cultural support and consultation across DHBs.

6. Improve services and support for people experiencing mental health problems, gambling problems, and alcohol and other drug problems

- Raise public awareness about the links between mental health problems, problem gambling, substance/alcohol abuse and suicide.
- Promote the use of mental health services, and problem gambling and addiction services. This may require reframing the message to overcome shame and stigma associated with help-seeking.
- Improve services and support for high risk groups (recent immigrants, international students, youth, international students, the middle-aged, older adults) in Asian communities.
- Ensure that family members are involved in the care plan.

Strengthen the infrastructure for suicide prevention

7. Improve the quality of data on suicide deaths and self-harm incidents

- Disaggregate data collection and reporting to include identifiable Asian ethnic sub-groups (e.g. Chinese, Indian, Korean) to assist with the identification of emerging trends and risk groups.

8. Enhance the role of MOH and DHBs in the area of suicide prevention

- Ensure suicide prevention plans/policies recognise the unique patterns of Asian suicide in New Zealand and vulnerable groups. Attention should also be paid to ensure that relevant authorities understand and appreciate the significant cultural, linguistic and migratory risk factors for suicide within Asian communities.
- Develop policies to build the Asian workforce in mental health and suicide prevention.
- Monitor the progress of prevention, early intervention and postvention services/initiatives to address suicide in Asian communities and evaluate the impact of these services/initiatives on Asian communities.
- Research best practice examples from overseas in the area of suicide prevention and postvention in relation to Asian people.

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APPENDIX 1 INTERVIEW GUIDE

A. Background information

- What is your role in your organization? How long have you been working in this role?
- What is your role in suicide intervention/ prevention?
- Are Asian people the key target group of your service?
- What is the proportion of your time involved in working with Asian people?

B. Asian suicide trends and patterns

- How many deaths or attempted suicides involving Asian people have you encountered in your work over the past 12 months?
- Have incidents of suicide involving Asian people increased, decreased, or been more or less the same over the past few years?
- Can you describe the patterns/characteristic of Asian suicide in New Zealand – e.g. gender, age group, ethnic sub-groups, suicide methods, lethality.
- Are these patterns/ characteristics different from the general population? In what ways?

C. Suicide factors and impacts

- What are the main factors influencing suicidal behaviours among Asian people in New Zealand? Explore:
 - Migration factors
 - Cultural beliefs and attitudes
 - Family issues
 - Gender and age issues
 - Mental health/ Clinical issues
 - Other factors (e.g. effects of media (in New Zealand and home countries))
- Are these factors different from those in the general population?
- What are the impacts of suicide on family? In the community?

D. Services, resources, pre/post-vention strategies

- Referring to your area of service (e.g. primary health, mental health, problem gambling, domestic violence, police, settlement service), how well is the service addressing suicide among Asian people? What is working well and what isn't?
- Beyond your current area of service, what kind of work is required in other services to address suicide among Asian people? What is working well and what isn't?
- What are the warning signs of suicide (for different age groups and gender)? Are we responding to the warning signs adequately?
- How well are our current services doing in terms of preventing suicide within Asian communities? What is working well and what isn't?
- There is a huge stigma attached to suicide within Asian communities. What efforts have been made to address this stigma? What efforts have been made to help the bereaved? How well are we doing in these areas?
- How well are our current services doing in terms of post-vention of suicide within Asian communities? What is working well and what isn't?
- Are there any examples of Asian-specific prevention and post-vention strategies from other countries that you would recommend to implement in New Zealand?