Submission on

A Strategy to Prevent Suicide in New Zealand 2017: Draft for public consultation

Thank you for the opportunity to comment on A strategy to Prevent Suicide in New Zealand 2017: Draft for public consultation. This submission is made by Mental Health Foundation of New Zealand.

About us

The Mental Health Foundation of New Zealand (MHF) is a non-government organisation that works towards creating a society where all people can flourish – that is, feel good and function well most of the time. Suicide prevention is a core focus of our work, which includes working with communities and professionals to support safe and effective suicide prevention activities, create support and social inclusion for people experiencing distress, and develop positive mental health and wellbeing.

The MHF has been involved with the government’s national response to suicide prevention for the last two decades, including delivering Suicide Prevention Information NZ (SPINZ) for 15 years initially on behalf of the Ministry of Youth Development, then the Ministry of Health. The MHF currently leads three actions that were identified in the New Zealand Suicide Prevention Action Plan 2013-2016:

- developing information resources for people managing their own suicidal thoughts, those supporting a ōpōtūhia member or someone close to them, and those who have lost a loved one to suicide.
- working with media to encourage safe and effective reporting on suicide and related issues.
- supporting lived experience leaders to develop and run peer support groups through providing information, guidelines, training and networking opportunities.

The MHF’s information service guides members of the public to find the support they need for themselves or a loved one. Its mental health promotion campaigns reach thousands of New Zealanders each week with information to support their wellbeing and help guide them through distress and recovery.

Response to the draft Suicide Prevention Strategy

The draft Suicide Prevention Strategy is not currently adequate as a guiding document for our national response to suicide. We consider that the draft strategy has missed an important opportunity to present a strong, ambitious vision for reducing suicide in New Zealand. Suicide affects us all, and is arguably the most devastating public health issue that New Zealand faces. Everyone has a role to play in preventing suicide, and it is imperative that we work together to do so.
To enable successful collective action to prevent suicide, the Strategy needs to provide national leadership and systems of accountability: outlining a joined-up approach to address common goals. It must be informed by evidence and what we already know about needs and solutions, and be committed to continuously learning through ongoing evaluation and refinement.

**Ambitious, inspiring and accessible**

As the document that guides our national approach to suicide prevention, the Strategy should inspire action across the whole of New Zealand. Suicide affects most people in New Zealand, and there is a high level of public interest in suicide prevention. Many New Zealanders are motivated to get involved. The Strategy should harness that energy and articulate an ambitious vision that everyone can work towards.

To mobilise public response, the Strategy must be written in accessible language that can be understood by the general public, and engages and empowers them to get involved.

**Vision**

The draft Strategy’s current vision: “Ka kitea te pae tawhiti. Kia mau ki te ora. See the broad horizon. Hold on to life.” can be read as an instruction to individuals who are coping with their own suicidal ideation, encouraging them to be stronger and more hopeful. This has the potential to suggest that all the responsibility for recovery and resilience belongs with the person who is struggling.

This vision does not effectively address the role of the whole community in preventing suicide. A suggested way of reframing the Strategy’s vision would be to more explicitly speak to all people living in New Zealand, to help them imagine how they can be a part of reducing the rate of suicide.

We suggest that the vision should be based in the concept of: “communities where everyone has a sense of belonging, purpose and hope, and can manage suicidal thinking safely”.

The concepts of safety, belonging, purpose and hope are drawn from Thomas Joiner’s Interpersonal-Psychological Theory of Suicide and associated academic work.

**Target and goals**

We recommend that the Strategy includes a clear, measurable target for a reduction in the suicide rate. In the WHO Mental Health Action Plan 2013-2020, New Zealand committed to work towards a target of reducing the suicide rate by 10%, a target which is not on track to be achieved. We strongly recommend that the Strategy commits to a reduction of 20% over the next 10 years (the course of the Strategy).

To support the target, we recommend the Strategy includes shared goals that are time-specific and measurable, related to reducing the impact of suicide, suicidal behaviour and distress.

The Strategy’s purpose should be strengthened from “to reduce the suicide rate through reducing suicidal behaviour” to “reduce the suicide rate and reduce suicidal behaviour”.

**Connected up and clearly accountable**

To guide a whole-community response, the Strategy must articulate an approach that all those living in New Zealand can contribute to. It must name and include leadership at all levels—within the Ministry of Health, across Government, within health, education and social service sectors, and in communities.

Suicide prevention is not just a health issue, and the need for a collaborative, coordinated approach is clear. Responsible Government agencies (such as Corrections, Education and Te Puni Kōkiri) and their specific commitments and responsibilities need to be named. The Strategy must clearly represent cross-Government commitment rather than being a Ministry of Health strategy that points to needing to work with “more areas than health alone”.


Similarly, suicide prevention is not just a government issue. The Strategy must include actions and responsibilities outside of government. For example, it needs to be designed so that community-level plans (such as those led by DHBs or iwi) can contribute as a key mechanism for delivering on the Strategy.

**Lived experience voices**

The Strategy must create space for communities and individual champions to contribute to a shared vision, acknowledging their leadership rather than considering them as recipients of “support”. In particular, the Strategy needs to value and include leadership from people with lived experience of suicidal behaviour and suicide bereavement, through their many contributions including service design, research, education, advocacy and facilitation of support groups. We strongly recommend that all actions planned, resourced and funded through the new Strategy should be informed by lived experience leadership.

**Tangata Whenua**

The Strategy must reflect the disproportionate burden of suicide experienced by Tangata Whenua, the Māori-specific responses required to address this, and the Strategy’s role in upholding the Crown’s responsibilities under Te Tiriti o Waitangi. While the draft states that it “reflects the principles of the Treaty of Waitangi”, this intention is not effectively woven through the Strategy. Both the Treaty principles and the vision of pae ora are not apparent in how the action areas are described. As a result it is unclear how the Strategy will prioritise and be responsive to Māori.

**Public health framework**

To be effective, the Strategy needs to be built on a clear public health framework, including a range of responses to a complex issue. As well as supporting people who are currently suicidal, a joined-up response to suicide prevention should include:

- **Addressing the social determinants of health** – creating a more equal and accepting community. New Zealand’s suicide rates are higher in areas which are more socioeconomically deprived and recognised risk factors for suicide include financial problems, childhood adversity, unemployment and loss of financial status. Discrimination against sexual and gender minorities also functions as a social determinant of health: for example, the Youth2000 research series demonstrated a link between school climate and suicidality for same and both-sex attracted boys. In more supportive schools, boys were five times less likely to have attempted suicide in the previous year. The Strategy should articulate the need for a joined-up community response to issues such as discrimination, misuse of alcohol and drugs, poverty, unemployment, child abuse and family violence. These issues are significant barriers to addressing our nation’s suicide risk.

- **Creating safer environments** - reducing access to means, and promote safer and more informed public conversations. Providing strong media guidelines and working with media, entertainment producers and social media influencers to support a positive, safe and non-judgemental public dialogue about suicide and related issues, and safe online environments.

- **Promoting mental wellbeing** - promoting population resilience and mental wellbeing. Investing in evidence-based programmes that improve mental and emotional wellbeing and grow individuals’ capacity to respond well to life’s problems, promoting individual skills and supportive environments within schools, workplaces and communities across New Zealand. We must not continue to accept that individuals experiencing distress will inevitably become so unwell they will become suicidal or need to be hospitalised. Instead, New Zealand must increase its efforts in promoting wellbeing and preventing mental health problems from occurring.

- **Equipping the community** – building social inclusion for people experiencing distress or mental illness and eliminating the prejudice and discrimination they face, equipping people to have safer conversations about suicide and be supportive of their whānau, colleagues or friends. Ensuring
people know how to intervene and help through providing training and clear public messaging. New Zealand’s 20 year Like Minds, Like Mine campaign and the work of people like Sir John Kirwan through the National Depression Initiative have helped to open people up to talking about mental health. However, shame and the fear of what others will say and do still form major barriers to people seeking support, being able to participate in work, and managing or recovering from distress. The support of loved ones can be critical in recovering from mental health problems – our whānau, friends and community are often the real first-responders when someone needs help. The Strategy should build and support a social movement that empowers individuals and communities to have the knowledge, skills and support to have courageous conversations with those who may be experiencing mental or emotional distress and help them on the journey of recovery. Each of us should know what we can do to assist each other and feel that we can safely offer our support.

- **Providing support for crisis and suicidal distress** – ensuring that support is joined-up, timely, person-centred and available whether a person reaches out through a helpline, mental health crisis team, Emergency Department, Police, Alcohol and Other Drug service or to a support person in the community. Crisis and distress support needs to be available based on an individual’s need rather than, for example, their sobriety or alignment with diagnostic criteria. It needs to be culturally-relevant, trauma-informed, and driven by best practice (for example, incorporating safety planning and timely, caring follow-up). Our experience supporting members of the public in crisis suggests that there are major gaps in crisis provision, with individuals or their support people left trying to navigate an over-complicated, under-resourced system at a time when they are extremely vulnerable. Individuals should not be turned away from services because there is no capacity to help them – they must be supported to access adequate and appropriate care when they need it.

The Strategy should continue to strength the role of primary health care providers in response to suicidal distress. When an individual is unwell, their GP may be the first person they reach out to. GPs need ongoing training to ensure they can effectively respond to people experiencing distress. GPs should be enabled to spend more time with patients who need extra support and should be able to make urgent referrals to counsellors and other mental health supports.

- **Supporting recovery** – providing options for support that are recovery-focused, engaged with whānau and support networks, peer-led or informed, and culturally responsive. Suicide-specific therapies need to be available – in particular, talk therapies. Self-care should be enabled and respected as central to recovery. People who have lost loved ones to suicide should be offered support to work through their grief process.

Mental health services must be adequately resourced and oriented towards recovery. While service data shows the majority of people who receive support from New Zealand mental health services are satisfied with their care, one in five are dissatisfied and a significant number of people don’t receive appropriate support. Demand for mental health services has increased by 70% in the last decade and resourcing has not kept pace. Under these pressures many services report high staff turnover. In light of rising demand for services over the last decade, DHBs need to prioritise an adequate and stable mental health workforce in hospital and community settings. This will ensure that people are receiving the support and care they need to recover and can have access to an appropriate mix of home, community or hospital-based services. Improving staffing levels would reduce the pressure on mental health workers and ensure they have safe and supportive working conditions. The MHF is also deeply concerned about the inadequate provision of mental health services in prison.

Models of care also need review to ensure that services are responsive to suicide risk. Commenting
on suicide deaths of mental health service users between 2007 and 2011, the Suicide Mortality Review Committee (2016) noted a common pattern that before some individuals’ deaths “there was a pattern of increasing (the amount of) contact with mental health services, without necessarily identifying whether it was the most appropriate care for that person; in other words, more of the same care was given, without consideration of its efficacy.” New Zealand continues to use outdated, non-therapeutic practices such as seclusion and restraint in its mental health services, and Māori are 3.6 times more likely to face compulsory treatment than non-Māori.

Those in distress or recovering from emotional crisis across New Zealand need increased access to free or heavily subsidised counselling and other early-intervention therapies and supports (including peer support) so they are accessible and affordable for all. These supports must be available in a variety of forms including face-to-face, online and via telephone, as well as through schools, GPs and community organisations so individuals and whānau can get mental health support quickly and affordably. There must be increased promotion of and continued investment into effective locally-developed e-therapies such as The Journal and SPARX.

Services for people recovering from suicidal distress need to be joined up and recovery-focused. Many clinical mental health services remain too focused on diagnosis and the subsequent treatment of symptoms without prioritising a need to understand the full picture of each individual’s life circumstances and experiences. It is essential that services are oriented to expect recovery, and that individuals are given the holistic social and clinical support they need to function well and control their own lives. Mental health services should connect with other medical services to provide joined-up care for people with more than one diagnosis (for example a mental illness and a drug or alcohol addiction). Services should connect and work alongside social services such as housing, Whānau Ora, employment and education to support individuals to lead lives where they have choices and dignity.

Services also need to include and value family, whānau and culture. Services are more effective when they understand and respect individuals’ support circles and identities. A person’s connection with their family, culture and identity can be a source of strength and recovery. Staff training, flexible systems and inclusive practices are needed. This is true for all people and is especially relevant for Māori, Pacific, Asian, Deaf and LGBTI communities.

Specialist support should be made available for people who lose loved ones to suicide, including low- or no-cost specialist counselling and wrap-around support for family, whānau and friends to equip them to support each other well. A separate submission from our Suicide Bereavement Advisory Group provides more detail about the support needs of people bereaved by suicide.

Some of these areas appear missing or weak in the draft Strategy, in particular addressing community safety, supporting positive mental health, addressing the social determinants of health, and strengthening recovery-focused models of care within mental health services.

In particular, the action area to “promote positive wellbeing throughout people’s lives” as currently written emphasises the need to equip individual people with wellbeing and resilience skills. While this is important, this action area also needs to take a broader public health approach to promoting wellbeing by addressing policies, working with communities and service settings, and reducing systemic barriers to wellbeing. A range of actions and activities are needed that address social determinants of health and create a more accepting and equal community, promote resilience and positive mental health for communities and people, and increase safety and reduce access to suicide means.
The Strategy should provide mechanisms to enable agencies, services, individuals and whānau working at each of these levels to connect and communicate.

**Evidence-based and continuously learning**
The Strategy needs to be grounded on a real commitment to build on what works and to keep learning. The draft states an aim to focus on “evaluation and improvement”. Despite this, the action areas demonstrate little focus on learning and no explicit connection with previous work or the last Strategy.

**Acknowledging what we know about the local context**
The draft Strategy does not name or connect with the previous Strategy, and does not acknowledge work that has been done, or what has been learned. The Strategy needs to provide this link, telling the story of progress made and what has been learned from previous and current action. For example, the draft Strategy states that it takes a “broader view than previous strategies and considers how different sectors and the whole community can contribute.” It is not clear why it makes this claim – the idea of a cross-Government and multi-sector approach was a core part of the last Strategy.

We recommend that the Strategy refer to local research on needs and solutions at every relevant point, to ensure it is grounded in the issues that we face in New Zealand. For example, where “secure cultural identity” is generically listed as a protective factor, specifically reference the protective effects of te reo, whakapapa, connection with marae and whānau (noted for example in the work of Dr Nicole Coupe). Where the strategy refers to “further work” being required to understand LGBTI needs, specifically acknowledge the work that was undertaken under the last strategy as part of the New Zealand Suicide Prevention Research Fund to produce a needs assessment for this population. When referencing the need to “build Māori leadership in suicide prevention”, acknowledge the value of community-driven Māori responses that are grounded in whakapapa relationships and acknowledge the effects intergenerational historical trauma, as explored in the work of Dr Keri Lawson-Te Aho.

Relevant findings from the trial Suicide Mortality Review Committee, the Waka Hourua research programme, the New Zealand Suicide Prevention Research Fund and major health and wellbeing studies including the New Zealand Health Survey, Youth2000 series, Christchurch Health & Development Study, and Dunedin Multidisciplinary Health and Development Study, should be referenced where relevant, as well as significant work undertaken by local suicide prevention researchers over the last three decades including Dr Keri Lawson-Te Aho, Dr Annette Beautrais, Dr Sunny Collings, Dr Jemaima Tiatia-Seath and others. In addition, the Strategy must learn from international evidence and best practice, and ensure we are learning from what works in other countries.

**Continuous learning**
The Strategy must include mechanisms to continually learn, through commitment to evaluation of all funded programmes, structured ways of learning from experiences of suicide (including Coroner’s findings, serious incident investigations in healthcare, deaths in custody and Police attendance to suicide attempts), and structured mechanisms to ensure that lived experience of suicide informs all activity.

The Coroner’s process needs to be resourced adequately so that it happens in a timely way, investigates every death satisfactorily, and provides a positive opportunity to learn from relevant data and stories. The experience of family, friends and those close to someone who has died are invaluable in understanding what went wrong and what our communities and services can learn to prevent further tragedy. For example, for every suicide death of a child, the parents should be offered an in-depth interview for the purpose of data collection. There is enormous value in hearing and learning from the psychosocial stories surrounding each death, if families and support networks are willing to share.
All suicide prevention activities undertaken as part of this Strategy need to be informed by lived experience of suicide – both the experience of bereavement and the experience of being suicidal. Our Suicide Bereavement Advisory Group is a good example of a mechanism that has been providing lived experience advice to the Mental Health Foundation for the last three years. As part of the new Strategy, a national lived experience network should be established to allow those with lived experience to not only have a voice, but also an opportunity to influence policy and services.

**Action-oriented**

Alongside this Strategy, an Action Plan is needed that is tightly linked to the Strategy and well resourced. We recommend that both documents are released at the same time, to support immediate joined-up action, and that further targeted consultation with communities, agencies and services to identify ambition and realistic actions that will support a reduction in the suicide rate.

Actions and resourcing need to be based where the needs are greatest:
- prioritising Māori whānau and communities
- continuing to focus on Pacific communities
- increasing focus on mandating and requiring best practice in healthcare settings
- continuing to focus on the justice, social services and education sectors
- resourcing approaches that are responsive to the needs of young people and men, and
- resourcing community leadership among LGBTI populations and those bereaved by suicide

The draft Strategy does not adequately reflect the needs of young people (for example, does not recognise young people or include relevant actions in each of the proposed action areas), and does not adequately recognise men**, LGBTI** populations or people bereaved by suicide** as priority groups. It does not clearly identify healthcare settings as a priority area for action, and does not clearly mandate or require best practice in care for people experiencing suicidal distress.

**Contact**

Thank you for the opportunity to comment. We welcome further discussion with the Ministry of Health on any of these points.

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**References**


Suicide Mortality Review Committee, 2016. (as above).


Men are at significantly higher risk of dying by suicide in New Zealand, noted for example in Ministry of Health. (2016a) as above.

Detailed in a separate submission that MHF has co-signed, as well as in a range of research for example: Adams, J., Dickinson, P. and Asiasiga, L. (2012) *Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report*. Auckland: Te Pou.