Response to the Draft Suicide Prevention Action Plan for 2025-2029

‘The greatest danger for most of us is not that our aim is too high and we miss it, but that it is too low and we reach it’

Michelangelo di Lodovico Buonarroti Simoni (1475-1564)

Introduction

The purpose of this short paper is to provide an organisational response from the Foundation for Equity and Research in New Zealand (FERNZ) to the ‘Draft Suicide Prevention Action Plan 2025-2029’, published for public consultation in September 2024.

FERNZ was founded as a New Zealand charity in 2018 and focuses on addressing inequities that affect diverse communities, ensuring voices are heard and rights upheld. We are driven by a commitment to creating a fair and inclusive society, a society where everyone has the opportunity to thrive.

At the outset of this paper, we believe that it is vital to recognise the context of colonisation, structural racism, unconscious bias, ableism, discrimination, stigma and historical trauma in Aotearoa New Zealand. These have contributed to both historic and current health and social inequities. It is also fundamental to our Kaupapa to clearly state that this paper adopts and reflects an approach which is in accordance with the Crown’s commitment to Te Tiriti o Waitangi.

Herein, we provide some key issues that, we believe, are important to consider when drawing up the final Action Plan. The paper is based both on relevant literature and reports, but also on collecting the lived experiences of people, including those who are suicide survivors or whānau who have been bereaved by suicide. These individuals include people who identify as Māori, Pacific, Disabled People (including people who experience mental distress), people from the Rainbow community and people aged across the life course.

We would like to state up front that we believe that there are many positives within the published draft Action Plan: for example, it is good to see some statistical data

and analysis of a number of the social determinants, and an emphasis on building the capacity of the suicide prevention workforce is welcome.

However, in our view the plan is rather disjointed, it lacks actions and lacks clear pathways for change and transformation. Most concerningly, it misses specific actions required to respond to the needs of some populations who are acutely vulnerable to suicidality.

Background

On 10th September 2019, Manatū Hauora Ministry of Health published Every Life Matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand.

A national Suicide Prevention Office was established to lead, champion and promote collaboration on implementing Every Life Matters strategy 2019-2029 and the 2019-2024 Action Plan. It was always the intention that this office would also lead development of a second Action Plan.

The foreword from the Minister for Mental Health, Hon Matt Doocey recognises this and is looking '…to refresh the focus of our suicide prevention efforts to ensure we meet the current challenges and context.' He specifically mentions '…increasing levels of distress among our young people', (gaps in) 'sustained wellbeing promotion and support for people whose distress escalates into a crisis.' He has also been a past advocate of 'zero suicide'.

Responses to the draft plan are due by 1 November 2024 at 5.00pm.

Content

Firstly, we would like to draw your attention to what we believe to be an error in the Draft Action Plan on page 3 in the Current Data section, which states that '…the average rate of suspected suicide has decreased **by** 10.6% from the historical average for the previous 13 years of data…' This is incorrect as 10.6 is the rate of confirmed and suspected suicides for New Zealand per 100,000 of the population and not a percentage decline. We wonder if the text should say '...has decreased **to** 10.6%'?

In the presentation of this data, mixing ratios and percentages is not helpful to gain the understanding of the general public audience. Perhaps this is something that Senior Data Analysts can consider when preparing and presenting this vitally important information.

We were shocked that '…mental health service users experience around 18.7 times the rate of suicide compared with non-service users'. This made us think how important it will be to get the human rights balance right in the current review of New Zealand mental health legislation. However, it also puzzled us as to why, given this stand-out prevalence, there were no specific actions to address this in the draft Action Plan.

In the section 'Wider contributions to suicide prevention', the first listed is 'Mental health and addiction service and supports' however many people in distress and

whānau who have lost loved ones that we have spoken with feel that some services have contributed to, rather than alleviated, the crisis.

For example, continuing to have the disgraceful practice of seclusion (solitary confinement) in our hospital in-patient environments, despite government policy for over two decades being this outdated practice's elimination, is an illustration of how much progress there is still to be made in our health services. We cannot and should not kick this can further down the road and we need to eliminate seclusion now. It should not be given the legal legitimacy in our new mental health legislation. This is absolutely fundamental if we wish to claim that this new legislation is in accordance with modern human rights requirements. Unfortunately, the advice that the Ministry of Health received during the consideration of this matter in earlier course was flawed and open to the bias of the medical profession.

The recognition that suicide prevention is everyone's business is welcome, but we have struggled to find evidence that other public services, such as general health, housing, social services, schools and Police have made lasting attitudinal changes and become part of the 'wider contributions' as hoped. As I am sure that you appreciate, participation in a training programme does not necessarily mean concepts are retained and attitudes are changed permanently.

Recent disinvestment in family violence and sexual violence initiatives does not feel like the coalition government recognises the interaction between these initiatives and mental wellbeing and suicide prevention. Such matters are vitally important to consider when striving for reductions in suicidality.

The introduction of more punitive measures, such as bringing back the 'three strikes', implementing highly restrictive actions against gangs and the reintroduction of boot camps for youth offenders, also does not speak of a government that effectively appreciates the link between the response to criminality, mental distress and suicidal ideation/action.

In the 'Approach to suicide prevention' section-we are concerned about the lack of specific approaches needed for some of the groups most at risk? Mental health service users? People with disabilities? People in the criminal justice system? Rainbow community members?

In the 'Leadership of suicide prevention activities' -we believe that of the main criticisms of the Suicide Prevention Office has been its lack of transparency. For the office to regain credibility in its new form, there needs to be agreed and shared outcomes and publicly-reported progress related to achieving those outcomes. Even some targets might be useful to help drive progress.

With regard to 'Restricting access to means'-this is one area where there is strong evidence of an impact on suicide rates (see Mann, Apter, Bertolote et al 2005). However, we are concerned that this coalition government may undo some of the recent progress in firearms legislation, which may have impacted self-inflicted deaths using this means.

One of the simplest and most effective measures that could be taken with regard to restricting means would be to reduce the pack size of Panadol (paracetamol).

If you were to talk to any hospital medical doctor about the devastation caused by paracetamol overdose, you would not hesitate to follow the UK in this simple, but very effective, means restriction, which only results in minor inconvenience to the public.

‘Talking about Suicide’-in this section, how about incorporating into mandatory Health and Safety training for staff, Mental health first aid training, ASIST or Safekeepers, for example? It has also been shown that increasing access to training on depression for clinicians in primary care can impact suicide rates (Mann, Apter, Bertolote et al 2005).

‘Supporting people after a suicide’-there have been major problems with the Coronial process for many years and this has been a major source of distress for those bereaved by suicide. However, it is not clear what has resulted from the recent review of this service by the relevant Ministry, and what impact any changes may have on those involved in Coronial processes regarding suspected suicides?

‘Draft Suicide Prevention Action Plan for 2025-2029-Where we are now’-this starts rather negatively and could instead read: ‘Recent progress has been encouraging, however there are still persistently high rates of suicide in Aotearoa New Zealand with inequitable outcomes for some population groups.’ It is good that concepts of inequity are highlighted here, and in the Data, but we feel that they are too absent elsewhere. We support the strengthening on intervention, however, as one of our participants said:

“We need to build people’s confidence to reach in to me, when I am not strong enough to reach out for help.”

With regard to terminology, we prefer ‘deliberate self-injury’ to the outdated ‘self-harm’. It is also very important to us for the word ‘commit’ to be separated from the act of taking one’s own life in the media. Suicide has not been a crime in New Zealand since 1893 (https://teara.govt.nz/en/suicide/page-6) and should not be spoken about in terms of criminal language, which stigmatises both suicide attempt survivors, the deceased and those bereaved by suicide.

‘Improve Access to suicide prevention supports’-If new funding is going to be proposed in the ‘Health-Led Actions’, we feel that it must be straight-forward to access that funding. Demand on applicants have to be realistic, so that the application and reporting process are not a disincentive for applicants who may have incredibly innovative and valuable ideas.

‘Grow a capable and confident suicide prevention and postvention workforce’-we feel that ‘suicide awareness training’ is a start, but we believe that if people are going to be trained in communities, families and whānau, it is much more impactful for them to be trained not just to be aware, but to know how to intervene and keep an individual safe until someone with greater training and experience can take over.

Therefore, we should be looking to add intervention skills to the training package and not merely raise awareness.

‘Strengthen the focus on prevention and early intervention’-if we are to create safer environments in inpatient mental health and addiction facilities, it is not just about a focus on ligature points! While this practical step is important and easy to conceptualise, there is a much more fundamental change that is required.

We need to start with the ABCs, that is the Attitudes, Behaviour and Culture of the staff in these environments. Unless these change, people who have used services say that in-patient suicide attempts and deaths are highly unlikely to reduce.

We need to have much less coercive environments of care, many more open doors and absolutely no seclusion (solitary confinement), with as minimal a level of restraint as possible. This is especially important considering the incredibly high rates of mental health service users who attempt suicide or die by suicide, as the Plan acknowledges. Yes, the consequence of these changes may require higher staffing levels, so the mental health workplace issues should be an absolute priority.

We are very concerned that disabled people seem to be invisible in this Plan, despite decades of underinvestment in their needs and the cost pressures that they have been facing. One exception is in one data point which shows suicide prevalence in young disabled people. Given the recent upheaval in this area, this coalition government has been said to be ‘failing disabled people’ (DPO Coalition Statement-Changes to Whaikaha Sep 2024), by not meeting its obligations to engage with them prior to making substantial decisions about the future role of Whaikaha and the provision of Disability Support Services (DSS).

We therefore wonder to what extent disabled people have had any opportunity to input into the development of the Action Plan. Also, why does that not seem to have been translated into their voice being obvious in the Plan throughout? If we know that 50% of young disabled people are having thoughts of suicide, as the Action Plan states, what actions are going to be taken to ensure that this is reduced and young disabled people are prioritised in thoughts about and investment in creating ‘…safer and more supportive environments, particularly for children and young people’?

(Holly Walker, 2020) describes in her report the post-Covid-19 levels of loneliness, with disabled people having the highest self-reported feelings of loneliness most or all of the time. With the unemployment rate of disabled people, at the time of her report, being almost double that of the general population, this compounds feelings of disconnection, worthlessness and may contribute to vulnerability to mental distress and suicidality. She states ‘While not surprising, high rates of loneliness among disabled people are stark and alarming.’

International research in a large study (Meltzer et al, 2011) states that ‘Those with some form of disability were four times more likely to have attempted suicide after adjusting for significant sociodemographic and socioeconomic correlates…’ with managing money and dealing with complex paperwork the cognitive tasks which showed an ‘independent association with suicide attempts’.

We note the commissioning of the review (PWC, 2023) looking specifically at suicide prevention in the Māori community, where rates (2021/22 data) continue to show almost double the rate of suspected self-inflicted deaths of Māori males and females in comparison to the comparable non-Māori, non-Pacific rates. We feel that consideration in the Action Plan of the six recommendations in this review will be vital if we wish to address this significant inequity in outcomes for Māori.

We are also concerned that a survey, in the aforementioned review, shows a lack of awareness in professionals of Pacific suicide prevention and postvention services, with over half stating that they were not aware of the services. Although (Coroner's Court/Health New Zealand Suicide Data Web Tool, 2024) shows a statistically significant decrease from the average in the rate of suspected self-inflicted deaths per 100,000 Pacific population in the 2022/23 financial year, we cannot become complacent.

Chief Executive of Le Va, Denise Kingi-'Ulu'ave said in October 2023 "While it is encouraging to note that the suicide rate for Pacific populations has seen a statistically significant reduction, we are mindful that our numbers of deaths by suicide are low and open to fluctuation,"

(Moira Clunie, 2021) reflects concerns from the New Zealand Rainbow Community: 'A range of research shows that the rainbow population is at much higher risk of suicide than many other demographic groups. Despite this, rainbow people are most often not recognised as a priority population in suicide prevention strategies…' Whilst there was involvement of Moira and other Rainbow advocates in the creation of the Strategy, it is concerning to us that they have stated they feel their needs will only be really well met by the creation of a separate Action Plan.

According to (WHO National Suicide Prevention Strategies 2018) Ireland includes in its priority groups; '…persons with alcohol and drug problems, the bereaved, prisoners, sex workers and people with chronic illness or disability'.

Although there may be some mention of these groups in the original Strategy, the Action Plan is either very silent or completely mute regarding action which will specifically target their particular vulnerabilities and needs. Of course, people who identify in more than one of these vulnerable groups are particularly at risk.

(CDC 2022) states that '…a select group of strategies based on the best available evidence to help communities…with the greatest potential to prevent suicide' includes as the first priority, to strengthen economic supports, including improving financial security and stabilising housing.

We do not see any mention of these important factors in the Plan and given New Zealand's current levels of rising child poverty, financial instability, rising unemployment and increasing difficulty getting into the housing market, we wonder what influence the new Mental Health Minister can have on his Ministerial colleagues to ensure that these wider priorities can be considered? Particularly concerning is the impact on population well-being and mental distress, coming on top of the already rising levels of distress that we are seeing post Covid-19.

Finally, a quick look at the available data related to suicide prevention in New Zealand highlights the absence of publicly available specific data and evidence, particularly as related to some of the specific groups as previously mentioned in this response. The (Coroners Court/Health New Zealand Suicide Data Web Tool, 2024) at the moment, does not include the ability to look at data across the whole life course, we are unable to see suspected/completed suicides among disabled people, unable to look at the professions of the deceased and unable to look at data for the 1 in 20 that we now know, due to the latest Census, are part of the Rainbow community in Aotearoa New Zealand.

Suicide prevention planning needs to be based on the ability to have much more accurate and diverse data sets, to inform high quality research and evidence, which can in-turn influence future policy and planned action. Some progress is being made, but there is still quite a way to go.

We look forward to any further involvement opportunities and to contributing towards future progress in the direction of an Aotearoa New Zealand with zero suicides.

References:

CDC. (2022). Suicide Prevention Resource for Action: A Compilation of the Best Available Evidence. Atlanta, GA: National Center for Injury Prevention and Control, Centers for Disease Control and Prevention.

Clunie, M; We hold the kaupapa: Community-led rainbow suicide prevention in Aotearoa; A thesis submitted in partial fulfilment of the requirements for the degree of Master of Social and Community Leadership; The University of Auckland, 2021

Coroners Court/Health New Zealand-Suicide Data Web Tool 2024, https://tewhatuora.shinyapps.io/suicide-web-tool/ accessed 09/10/24

https://www.infoexchange.nz/dpo-coalition-statement-changes-to-whaikaha/ **accessed 07/10/24**

https://www.leva.co.nz/news/provisional-pacific-suicide-rates-reduce-significantly/ accessed 08/10/24

Mann, J John; Apter A; Bertolote J et al. 'Suicide Prevention Strategies: A Systematic Review' JAMA. 2005;294(16):2064-2074 (doi:10.1001/jama.294.16.2064)

Meltzer, H; Brugha, T; Dennis, M.S; Hassiotis, A; Jenkins, R; McManus, S; Rai, D; Bebbington, P 'The influence of disability on suicidal behaviour' ALTER-European Journal of Disability Research 6 (2012) 1-12

Ministry of Health. 2019. Every Life Matters – He Tapu te Oranga o ia tangata: Suicide Prevention Strategy 2019–2029 and Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand. Wellington: Ministry of Health.

Ministry of Health. 2024. *Draft Suicide Prevention Action Plan for 2025–2029: Public consultation document*. Wellington: Ministry of Health.

PricewaterhouseCoopers New Zealand: Te Aka Whai Ora suicide prevention and postvention review, November 2023

https://teara.govt.nz/en/suicide/page-6 accessed 07/10/24

https://www.tewhatuora.govt.nz/for-health-professionals/data-and-statistics/suicide/data-web-tool#:~:text=By%20ethnicity&text=The%20rate%20of%20suspected%20self%2Dinflicted%20deaths%20per%20100%2C000%20Pacific,CI%3A%202.8%2C%207.4). Accessed 08/10/24

Walker, H; Alone Together: The Risks of Loneliness in Aotearoa New Zealand Following COVID-19 and How Public Policy Can Help, Post-Pandemic Futures Series (Auckland: The Helen Clark Foundation and WSP, June 24, 2020), https://helenclark.foundation/wp-content/uploads/2020/06/alone-together-report-min.pdf.

World Health Organisation, National suicide prevention strategies: progress, examples and indicators. Geneva:2018. Licence: CC BY-NC-SA 3.0 IGO.