Submission on the Ministry of Health Draft Strategy to Prevent Suicide in New Zealand

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Introduction

1. Nelson Marlborough Health (Nelson Marlborough District Health Board) (NMH) is a key organisation involved in the health and wellbeing of the people within Te Tau Ihu. NMH appreciates the opportunity to comment from a public health perspective on the Ministry of Health's Strategy to Prevent Suicide in New Zealand.

2. NMH makes this submission in recognition of its responsibilities to improve, promote and protect the health of people and communities under the New Zealand Public Health and Disability Act 2000 and the Health Act 1956.

3. This submission sets out particular matters of interest and concern to NMH, particularly in relation to targeted action areas, implementation and monitoring. It discusses areas that NMH supports and also provides recommendations where NMH believes changes to the draft Strategy will better meet the Strategy's objective of reducing suicidal behaviour in New Zealand.

General Comments

Targeted action areas

4. NMH strongly supports the multi-sectoral approach promoted in the Strategy in order to reduce suicide rates and improve wellbeing and mental health. Mental health is influenced by a wide range of environmental, social and behavioural factors beyond the health sector. Initiatives to improve mental health outcomes and overall quality of life must also involve organisations and groups outside of the health sector.

5. NMH is pleased to see that the Strategy has a strong emphasis on integrating Treaty principles and targeting actions that may lead to better health outcomes for Māori.

6. However, NMH is concerned that targeted actions are focused heavily on addressing suicidal behaviour itself but more effort is required to address the causes of such behaviour.

7. Social economic disadvantage is a key risk factor for suicidal behaviour.[1] This is recognised in the introduction of the Strategy whereby the broad determinants of health which influence suicidal behaviour such as education, housing and employment are set out. The Strategy also recognises the impact of these influences on more vulnerable population groups by stating *"living in an area of high socioeconomic deprivation is also strongly linked to higher suicide rates among Māori and Pacific peoples"*. The World Health Organization places emphasis on the importance of addressing this area stating that "*the greater the inequality, the higher the inequality in risk. In order to reduce these inequalities and reduce the*

[1] Samaritans. (2017) *Dying from inequality: Socioeconomic disadvantage and suicidal behaviour. Summary report 2017.* Samaritans, Surrey

incidence of mental disorders overall, it is vital that action is taken to improve the conditions in everyday life".[2]

8. Given the above, NMH considers that the Strategy needs to include targeted actions focused on reducing social economic disadvantages such as low income, debt, poor housing, lack of education and unemployment. This would require commitment from a range of both government and non-government organisations to deliver a series of actions to reduce social inequalities resulting in greater wellbeing, better mental health and a reduction in suicide rates.

9. Furthermore, many suicides occur as a result of situational distress, such as relationship difficulties, social isolation or job loss as opposed to mental illness. Often suicide prevention strategies lead through to mental health specialists for diagnosis and treatment. While this approach may help people who have a mental illness, it is of limited use to people at risk of situational suicide.[3] NMH believes that the Strategy needs to contain actions such as providing support services for those experiencing situational distress such as relationship breakups and suffering from alcohol or drug harm. Currently many secondary providers need to provide support services out of hours because the community and primary services are under resourced to respond especially during after hours.

10. While the Strategy recognises the importance of building positive wellbeing[4] throughout people's lives, NMH considers this needs to be underpinned by targeted actions to reduce economic disadvantages and situational distress.

Recommendation

11. That the Strategy includes targeted actions which aim to reduce social economic disadvantages (e.g. low income, debt, poor housing, and unemployment) and address situational distress (e.g. relationship breakups, suffering from alcohol or drug harm).

Implementation and monitoring

12. NMH has concerns about the proposed framework as the action areas have not been clearly defined with targets, implementation strategies and monitoring. Without defining the parameters of the Strategy, it will be difficult to see whether the Strategy will meet its objectives. NMH notes that the Ministry of Health commissioned an external provider to create *The New Zealand Suicide Prevention Outcome Framework.*[5] NMH recommends that MOH adopts the type of methodology that was used in the framework to clearly identify the targeted populations, population indicators, the outcomes, strategies, and monitoring for each of the proposed action areas. Adopting this outcome framework will mean that there is

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[2] World Health Organization and Calouste Gulbenkian Foundation. (2014). *Social determinants of mental health*. Geneva, World Health Organisation, p. 43

[3] Ashfield, J., Smith, A., Macdonald, J. (April 2017). *A Situational Approach To Suicide Prevention.* Australian Institute of Male Health and Studies

[4] Defined by the Strategy to mean people are doing well and feeling well, and are able to cope and adapt when things happen or change in their lives

[5] Haggerty & Associates. (2016). A refreshed New Zealand Suicide Prevention Outcome Framework - applying the outcome framework and service landscape tool. Wellington

a clear coordinated suicide prevention strategy with prioritised actions that are measurable and deliverable which will result in a reduction in suicide rates and improved quality of life.

13. NMH considers that the Strategy needs to mandate government agencies to work together to deliver and fund coordinated suicide prevention programmes. This mandate is imperative for the Strategy to work successfully. It is important that government agencies and NGOs be adequately resourced so that they are able to achieve the actions within the Strategy. It is unclear from the Draft Strategy how the activities will be funded. This information would assist DHBs and non government organisations with the delivery of suicide prevention programmes

Recommendation

14. That the Strategy incorporates an outcome framework that contains measurable actions, targets and implementation strategies.
15. That the Strategy provides detail on the funding of suicide prevention activities.

Existing activities

16. The Strategy does not explicitly reference the suicide prevention activities that are currently occurring across New Zealand. Acknowledging the work that has been occurring over the past decade would help build context for the Strategy and provide future direction.

Recommendation

17. That the Strategy incorporates references to projects and actions that are underway.

Specific Comments

Areas we need to work in (page 11)

18. The Strategy states that almost three-quarters of the people who die by suicide are male however the strategy does not include specific prevention measures targeted at males. Gender is a social determinant of suicide risk. Research suggests that most suicide prevention strategies are more effective at preventing female suicide than male suicide.[6] Strategies that target people who are thinking about suicide and invite them to talk are more effective at helping women. Male-friendly approaches to suicide prevention generally recognise that men are less likely to report having suicidal thoughts, but men will respond positively to practical, self-directed, problem-solving approaches to health promotion and suicide prevention[7]. Therefore more investment needs to given to targeting support services for men who are experiencing the situational distress that is known to increase their risk of suicide such as issues with relationships, work and money.[8]

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[6] Lester D. (2014) *Preventing Suicide in Men Versus Women, Chapter 23 of Suicide In Men: How Men Differ in Expressing Their Distress*, Charles C Thomas Publisher, Ltd

[7] Ibid

[8] Poole, G. (2016) *The need for Male-friendly approaches to Suicide Prevention in Australia,* Australian Men's Health Forum

19. The Strategy identifies population groups with markedly higher rates of suicidal behaviour that it proposes to target first. The groups include Maori and Pacific peoples (particularly of a certain age and/or those living in areas of high socioeconomic deprivation, mental health service users and those admitted to hospital for intentional self-harm, and young people.
20. NMH supports these groups being targeted as a priority but considers that the Strategy should also include suicide prevention activities specific to the population groups identified under recommendations below in order to adequately capture these groups and cater for their special needs.

Recommendation

21. That the Strategy includes an appropriate balance of approaches that make it easier for both men and women at risk of suicide to access the help and support that they need.
22. That the Strategy also includes suicide prevention activities specific to the following population groups:
    - Migrants and refugees
    - Lesbian, gay, bisexual, transgender and intersex (LGBTI) population
    - The elderly population
    - Individuals serving custodial sentences
    - Rural communities and farmers
    - Military personnel and first responder personnel
    - People with disabilities
    - Children up to age 14

Potential Action Area 1 - Support positive wellbeing throughout people's lives)

23. NMH supports the inclusion of activities related to school based and education programmes that build positive wellbeing for students. NMH recommends that these activities are fully integrated into the New Zealand Health Education curriculum, as supported by evidence.[9][10] This key area of learning provides the context for critical thinking on identity, culture, gender, relationships and social and economic determinants of health and wellbeing from year one. NMH recommends this curriculum strand be better supported by being explicitly built into Positive Behaviour for Learning.
24. NMH notes that there is no inclusion of activities for rural communities. Rural communities can be very vulnerable to economic downturns and the effects of climate change, strategies are needed to address their specific needs.

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[9] Adrienne Alton-Lee (2003) *Quality Teaching for Diverse Students in Schooling: Best Evidence Synthesis* Ministry of Education, Wellington)

[10] Aitken, G. & Sinnema, C. (2008). *Effective Pedagogy in Social Sciences Tikanga ā Iwi Best Evidence Synthesis Iteration (BES)*. New Zealand Ministry of Education

Recommendation

25. That activities that build positive wellbeing for students are fully integrated into the New Zealand Health Education curriculum and explicitly built into the Positive Behaviour for Learning approach.
26. That activities are included in the Strategy that specifically address the needs of the rural community.

Potential Action Area 2 - Build social awareness of and well-informed social attitudes to suicidal behaviour

27. NMH strongly supports the inclusion of activities aimed at reducing stigma associated with suicide and mental illness.

Potential Action Area 3 - Encourage responsible conversations about suicidal behaviour

28. NMH supports the activities aimed at encouraging responsible conversations about suicidal behaviour.

Potential Action Area 4 - Increase mental health and suicide prevention literacy

Recommendation

29. That the specific activities are included to target different cultural groups and also different age groups to ensure people are able to receive information that clearly meets their needs in the most appropriate way.

Potential Action Area 5 - Support and partner with communities to develop and carry out activities that help to prevent suicidal behaviour

Recommendation

30. That an activity that creates opportunities for young people to be involved in community development projects is added in order to build youth leadership.

Potential Action Area 6 - Strengthen systems to support people who are in distress

31. People, in particular men, who are suffering from situational distress, must be able to access help and support to alleviate and resolve the situation that is causing them distress. Access to specialist support groups may be more appropriate than access to mental health workers in these instances. NMH recommends that there are a range of services available for males and females.
32. NMH supports the activity regarding changing the opening hours of services that provide care or support to people in distress so that they are open when people need them. Supporting those in distress requires adequately resourced crisis intervention services which are able to respond in a timely manner. Demand for services can often fall outside of work hours therefore help can be very difficult to obtain for people in distress, this is particularly true in smaller centres and rural areas. The coordination of suicide prevention

activities at a national level are vital to ensure individuals obtain the right service at the right time throughout the country.

33. NMH recommends inclusion of activities to increase access to counselling services extends beyond e-therapies and counselling services for youth. It is important that people are able to access to free community and counselling services as costs can be a barrier for many of those in need.

Recommendation

34. That specific support services catering for both men and women are in place to help people suffering from situational stress.
35. That resourcing is increased if service provision, in particular after hour service provision, is extended to meet identified need.
36. That people in need are able to easily access free community and counselling services.

Potential Action Area 7 - Build and support the capability of workforces

37. NMH recommends that basic suicide prevention training strategies be also offered to community agencies and non-governmental organisations. By extending the training, there would be more people able to support people in need as well as relieving the pressure on crisis resolution services.
38. It is important that people who are providing support services also have appropriate support and education for them to deal personally with the effects of suicide. Anecdotally many first responders who deal directly with suicides often have suicidal ideation. Therefore adequate support mechanisms are needed to help both professional and volunteer first responders.

Recommendation

39. That community agencies and non-governmental organisations have access to basic suicide prevention training.
40. That providing additional support for professional and volunteer first responders is given priority.

Potential Action Area 8 - Strengthen systems to support whanau, families, friends and communities

41. NMH supports making available culturally appropriate support for people who are supporting a person in distress and after suicidal behaviour.

Potential Action Area 9 - Strengthen and broaden collaboration among those working to prevent suicidal behaviour

42. NMH agrees that there needs to be better integration between agencies and organisations. In order to do this effectively, dedicated funding and staffing needs to be in place within in DHBs. Suicide Prevention Coordinators that are based within DHB could work across the

primary, secondary and public health units and community organisations to coordinate projects.

Recommendation

43. That the Strategy specifies that suicide prevention activities will be supported by central funding.

44. That each DHB is required to have a Suicide Prevention Coordinator who is resourced to provide regionally specific suicide prevention activities.

Potential Action Area 10 - Strengthen systems for collecting and sharing evidence

45. NMH supports the introduction of monitoring to improve understanding of how to prevent suicidal behaviour for the groups specified on page 22. NMH has identified other groups that would also benefit from this approach. See the recommendation below.

46. As stated in the Strategy, more information about suicidal behaviour can help our understanding of suicide and how we can prevent it. Therefore it would also be useful to monitor levels of alcohol and drug use, abuse, domestic violence and relationship crises in reference to suicidal behaviour as this will provide a broader picture of the determinants of health relating to suicide.

Recommendation

47. That the following groups are added to the list on page 22

- Migrants and refugees
- The elderly population
- Individuals serving custodial sentences
- Rural communities and farmers
- Military personnel and first responders
- People with disabilities
- Children up to age 14
- Men

48. That rates of alcohol and drug use, abuse, domestic violence and relationship crises in reference to suicidal behaviour are monitored

Conclusion

49. NMH is strongly supportive of the need to have a Suicide Prevention Strategy. The draft strategy currently does not provide a clear framework for action. By combining the methodology of *The New Zealand Suicide Prevention Outcome Framework* with the feedback from the submission process, the Strategy will have more focus to deliver actions that will reduce the number of suicides.

50. NMH thanks the Ministry of Health for the opportunity to comment on the Ministry of Health's Strategy to Prevent Suicide in New Zealand.

Yours sincerely

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