ZERO SUICIDE AOTEAROA

July 2020

ACKNOWLEDGEMENTS

This report has been commissioned by the cross-party Mental Health and Addiction Wellbeing Group to highlight the issue of suicide in New Zealand and to stimulate some debate about possible policy settings that might reinforce local, regional and national efforts to prevent suicide. The terms of reference for the cross-party group can be found on the following page.

The cross-party group acknowledges those who have died by suicide and also recognises the pain and hurt of family, friends and whānau who are bereaved by suicide.

Special mention is given to William Larnach, a New Zealand businessman and politician, who died in 1898.

The report has been written by Phillipa Gaines and an earlier version was reviewed by Le Va, the national Suicide Mortality Review Committee (Health Quality & Safety Commission), the national Suicide Prevention Office and the Initial Mental Health and Wellbeing Commission for the report's technical content. No organisations were asked to endorse the recommendations or concepts within this report.

The national Suicide Prevention Office was established in 2019 to provide leadership on suicide prevention, to implement the national Suicide Prevention Strategy and Action Plan[1] and to monitor progress on cross-agency efforts to prevent suicide in New Zealand.

[1]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.

TERMS OF REFERENCE FOR THE CROSS-PARTY MENTAL HEALTH AND ADDICTION WELLBEING GROUP

PURPOSE

The group aims to achieve cross-party dialogue to develop a collective vision about the future direction of mental health and addiction wellbeing in New Zealand.

The cross-party group will provide members of Parliament with information, evidence and knowledge exchange to support longer-term thinking around mental health and addiction and its wider impacts in New Zealand.

BACKGROUND

He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction[2] has indicated that the next period of change for the mental health and addiction support system will be complex, requiring long-term and consistent attention. It is now widely recognised that we need to think beyond a health response to mental health and addiction support to more of social model. This will require changes for all, and at every level of the system. One of the vehicles to achieve change was a recommendation that suggested the establishment of a cross-party working group within Parliament as a tangible demonstration of collective and enduring political commitment to improved mental health and wellbeing in New Zealand.

To expedite the development of a cross-party mental health and addiction group, Platform Trust[3] offered to provide a secretariat function.

PRINCIPLES

The cross-party Mental Health and Addiction Wellbeing Group will have a steering group made up of a representative from each political party. They will prepare a work plan and host meetings open to all members of Parliament. These will be closed to media and other external organisations unless specifically invited. The cross-party Mental Health and Addiction Wellbeing Group will work collaboratively, taking responsibility to ensure their own accountability.

Platform will use its networks and connections to serve the cross-party Mental Health and Addiction Wellbeing Group.

PROPOSED ACTIVITY

The cross-party Mental Health and Addiction Wellbeing Group will host regular meetings to give members of Parliament insight into the diverse issues within the mental health and addiction landscape. This will include emerging issues, examples of good practice and evidence, including the views of opinion leaders that will support better understanding and possible responses within New Zealand.

The cross-party Mental Health and Addiction Wellbeing Group may prepare reports and discussion papers to stimulate discussion, knowledge and wider understanding.

[2]*Government Inquiry into Mental Health and Addiction. (2018). He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction. Wellington: Government Inquiry into Mental Health and Addiction.*

[3]*www.platform.org.nz*

LOUISA WALL
MP for Manurewa, New Zealand Labour Party

Our decision to prioritise suicide in our first report recognises our higher rates of death by suicide in Aotearoa New Zealand. This report provides consolidated information to our colleague parliamentarians so we can collectively come to understand how to better support initiatives that could prevent the taking of lives by suicide. One life lost to suicide is one too many, and it is our hope that we can work together to improve mental health and addiction wellbeing for all New Zealanders.

To expedite the development of a cross-party mental health and addiction group, Platform Trust[3] offered to provide a secretariat function.

CHLÖE SWARBRICK
Member of Parliament, Green Party of Aotearoa New Zealand

The cross-party Mental Health and Addiction Wellbeing Group is a decision to do politics differently, bringing a united approach to the serious mental health problem in Aotearoa New Zealand. This report recognises what so many New Zealanders live with and are affected by. I am proud that it will assist in designing initiatives to support struggling New Zealanders, and shrink our unacceptable suicide rate.

MATT DOOCEY
MP for Waimakariri, New Zealand National Party

I am privileged to be a part of the cross-party Mental Health Group as I believe a cross party approach is important for addressing long term mental health issues by taking a view to policy development longer than our three year parliamentary cycles. I hope this research promotes debate in parliament on how all parties can take more of a bipartisan approach to suicide prevention in New Zealand.

DAVID SEYMOUR
MP for Epsom, ACT Leader

I am heartened that this project exists and has started to bear fruit in the form of this report. It shows that MPs can reach across the political aisle to address one of New Zealand's most difficult and sensitive challenges.

JENNY MARCROFT
Member of Parliament, New Zealand First

This first report from the cross-party Mental Health and Addiction Wellbeing group embodies our aspirations to nurture our people and drastically reduce Aotearoa's suicide rate. We have worked toward finding ways to meet the needs of all New Zealanders mental wellbeing, and ultimately drastically reduce our suicide rate. I hope that my fellow MPs will absorb the contents of this report and join together to create better mental health outcomes for all.

CONTENTS

SUMMARY OF KEY MESSAGE

THE CURRENT STATE

- New Zealand's suicide rate is unacceptably high.
- The human, social and economic toll of suicide is significant.
- Suicide affects people from all communities and walks of life, but some groups of New Zealanders are more affected than others – particularly Māori, young people and men.
- In the year ending 30 June 2019, more people died by suicide (685) than they did on New Zealand roads (353) over the 2019 calendar year.
- Suicide and self-harm are symptoms of poor wellbeing and almost always reflect a weakened mauri or life force.

THE IMMEDIATE FUTURE

- The New Zealand national suicide prevention strategy Every Life Matters is implemented.
- New Zealand adopts a multi-level, holistic response to suicide prevention that also addresses the wider determinants of mental health and wellbeing.
- Evidence-informed suicide prevention interventions are delivered that target multiple levels of the system at the same time.
- Suicide prevention solutions are focused on life-promoting and strengths-based approaches to health and wellbeing.
- Many individuals, groups and sectors work collaboratively with one another to support initiatives that could help save lives.

THE IDEAL FUTURE STATE

- Sustainable wellbeing.
- A cohesive and inclusive society.
- Zero suicide.

This paper outlines a systems approach to suicide prevention that recognises it takes many sectors, groups and individuals working together to save lives. It has been written at a time when the country is facing the worst public health crisis in a generation. The COVID-19 pandemic will leave a lasting impact on New Zealanders' health, social and economic status for a long time to come. There is a large body of scientific literature that shows that several factors related to an economic recession are associated with an increased risk of suicide - including unemployment, social isolation, increased social inequality, financial insecurity and the loss of property.[4] These factors will be experienced most acutely by the people in our local communities who are the most vulnerable and who have the least resources to weather an the the downturn – especially the poor and those who have recently lost income due to business closures and unanticipated unemployment.

On a more positive note, an increase in the number of suicides is not inevitable. COVID-19 provides the country with a unique opportunity to reflect on its past and to plan for a better future. A discussion paper developed by Koi Tū[5] asks important questions about how New Zealand wants to shape its future as it starts to emerge out of the shadow of the pandemic. Will this global event trigger a major change in the way that New Zealand organises both its public and private sectors? Is there an opportunity to aspire to a flourishing Aotearoa where its citizens have ready access to the things that determine their good health and wellbeing – namely positive relationships, quality housing, good education, secure employment and a safe, clean physical environment?

New Zealand could become a society where people/families/whānau have what they need in order to shape their own futures. It could become a society where a kaupapa Māori approach is normalised and where Māori are able to participate in cultural practices and pursuits in order to maintain hauora. In short, it could become a cohesive and inclusive society that has eliminated the risk factors for suicide.

With the unknown impacts of COVID-19 in mind, it is important that the country takes immediate steps to further strengthen and prioritise its suicide prevention activities to help mitigate the possible increase in mental distress in the days, months and years that lie ahead. These activities cannot be centrally driven. They must be politically anchored within the knowledge and skills that already exist in local communities and supported by a range of stakeholders – including politicians. Zero Suicide Aotearoa outlines the possible role of politicians as stewards of the overall system. It is also a call to action to everyone who is in a position to make a difference.

[4]Oyesanya, M., Lopez-Morinigo, J., & Dutta, R. (2015). Systematic review of suicide in economic recession. World Journal of Psychiatry, 5(2), 243–254.

[5]Gluckman, P., & Bardsley, A. (2020). The future is now: Implications of COVID-19 for New Zealand. Auckland: Koi Tū: The Centre for Informed Futures, The University of Auckland.

All political parties will relentlessly pursue a future for Aotearoa New Zealand that is built on sustainable wellbeing and zero suicide.

POLITICAL CONTEXT

The final report of the Inquiry, He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction[6], was presented to the Government by the Inquiry Panel in November 2018. The report contained 40 recommendations, four of which pertained to the prevention of suicide – as follows.

#	HE ARA ORANGA RECOMMENDATION
30	Urgently complete the national suicide prevention strategy and implementation plan and ensure the strategy is supported by significantly increased resources for suicide prevention and postvention.
31	Set a target of 20% reduction in suicide rates by 2030
32	Establish a suicide prevention office to provide stronger and sustained leadership on action to prevent suicide.
33	Direct the Ministries of Justice and Health, with advice from the Health Quality and Safety Commission and in consultation with families and whānau, to review processes for investigating deaths by suicide, including the interface of the coronial process with DHB and Health and Disability Commissioner reviews.

In May 2019 the Government accepted, in principle, recommendations 30, 32 and 33. However, it rejected recommendation 31 on the basis that a reduction in suicide rates implied that the remaining deaths were acceptable.

"We're not prepared to sign up to a suicide target because every life matters, and one death by suicide is one too many."

— Minister David Clark (May, 2019)

In September 2019, the Ministry of Health published the national Suicide Prevention Strategy *Every Life Matters*,[7] which outlined a number of actions to reduce the number of suicides in New Zealand. The actions in the national strategy target both individual and collective/structural levels - with the ultimate aim being zero suicide. It is important to note that many suicide prevention initiatives are already underway across the country and have been further strengthened with the establishment of the national Suicide Prevention Office in November 2019.

The recommendations in this paper are intended to:

1. further reinforce the actions in the national Suicide Prevention Strategy Every Life Matters.
2. stimulate debate about possible future policy directions and;
3. foster a cross-party consensus on the political levers that Parliament could apply to help prevent suicide in Aotearoa New Zealand.

[6] *See foootnote 2.*

[7] *See footnote 1.*

ZERO SUICIDE

- The foundational belief of Zero Suicide is that suicide deaths are preventable. The concept presents both a bold goal and an aspirational challenge.
- The Zero Suicide Framework was launched by the National Action Alliance for Suicide Prevention in the United States in 2012[8]. The approach was inspired by health care systems that had dramatically reduced the number of suicides by adopting a system-wide, organisational commitment to zero suicide.
- The Zero Suicide Framework applies a quality improvement and safety approach to the prevention of suicide throughout the entire health system.
- The initiative promotes the adoption of 'zero suicides' as an organising goal for all health care service providers and seeks to transform the delivery of health services to people with suicidal behaviour by making improvements to leadership, policies, practices, and outcome measurement.
- Subsequently, a number of health organisations around the world have successfully adopted the Zero Suicide Framework - including Michigan (United States), Mersey Side NHS (Liverpool, England) and Gold Coast Health (Australia).
- The Zero Suicide Framework has been evaluated and the efficacy and effectiveness of the approach has been demonstrated in a number of different countries.
- In New Zealand there are a couple of District Health Boards that have included Zero Suicide as a key component of their local Suicide Prevention and Postvention Action Plan.
- Building an effective national response to mental distress and suicide prevention cannot be the sole responsibility of the health system. Internationally, the concept of zero suicide is increasingly being extended to include other agencies that are external to the health system. There are a number of public and private agencies that must join forces, capabilities and resources with local communities in order to achieve the greatest impact.
- Whatever we do, we must ensure that we 'do no harm', especially as there is undeniable and mounting evidence that seemingly well intentioned suicide prevention programmes can actually increase suicide risk and deaths.

[8] *https://www.zerosuicidealliance.com/*

SUICIDE IS A SIGNIFICANT HEALTH AND SOCIAL PROBLEM IN NEW ZEALAND

- New Zealand's suicide rate is unacceptably high.
- The human, social and economic toll of suicide is significant.
- Suicide affects people from all communities and walks of life, but some groups of New Zealanders are more affected than others – particularly Māori, young people and men.
- Every year, an estimated 150,000 people in New Zealand think about taking their own life. Approximately 50,000 of these people make a suicide plan, 20,000 attempt to take their own life and over 500 people die by suicide.[9]
- In the year ending 30 June 2019, more people died by suspected suicide (685) than they did on New Zealand roads (353).[10]
- While New Zealand has made some progress towards reducing the suicide rates since the late 1990s, the annual suicide rates for young people aged 15-19 years have increased significantly over the last three years, driven by a nearly 50% increase amongst young men.[11]

[9] See footnote 8.

[10] This figure is based on the number of deaths in the 2019 calendar year, not the financial year.

[11] The Salvation Army Social Policy & Parliamentary unit (2020). Tangata Whenua, Tangata Tiriti, Huia Tangata Kotahi: People of the land, People of the Treaty, Bring Everyone Together (page 16).

SUICIDE RATE IN 1990 VS. 2017

Suicide rate measures the number of suicide deaths per 100,000 in a given population.

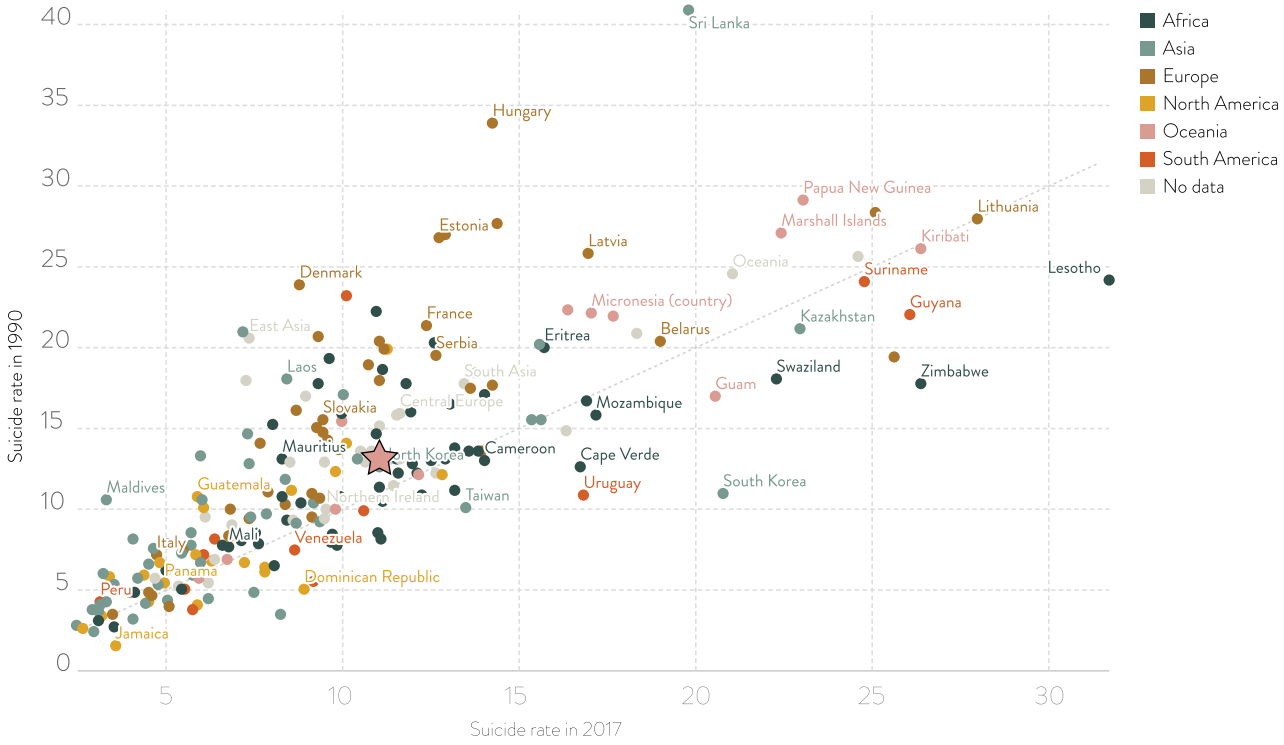


Figure 1: Suicide rates across countries in 1990 versus 2017[12]

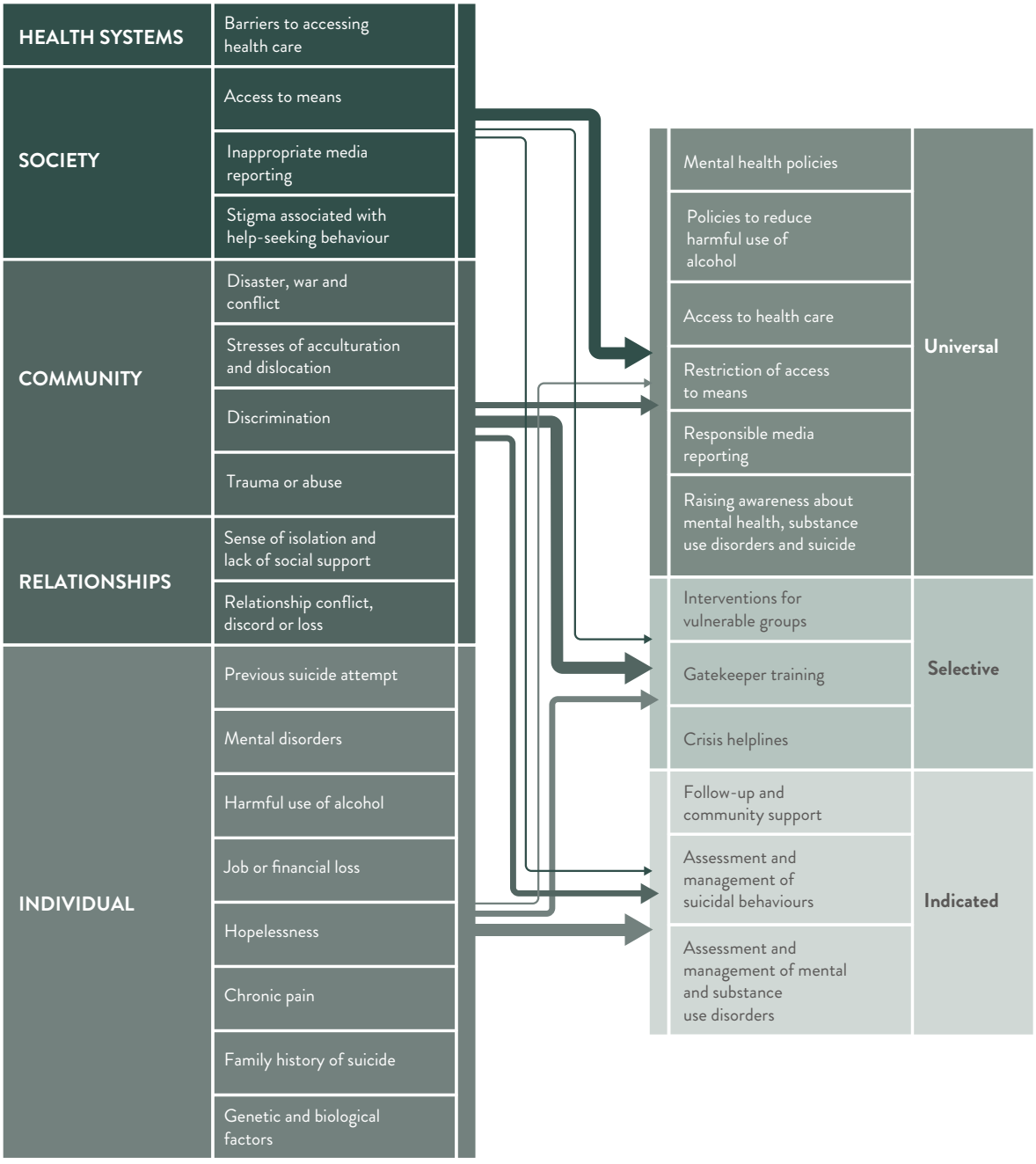
- The above scatterplot shows how suicide rates compare across countries based on the rate in 1990 (shown on the y-axis) and in 2017 (on the x-axis). The grey dotted line represents parity – ie, the countries that lie along this line have the same rates in 2017 as they did in 1990.
- Whilst this scatter plot would appear to indicate that New Zealand (marked with a ☆) has seen a modest decrease in the suicide rate over the two time periods, it excludes the data from the last three years, which shows a sharp increase. In addition, the aggregated data also obscures what is happening for different parts of the population. For example, New Zealand has one of the highest rates of youth (aged 15-24 years) suicide when compared to other OECD countries[13].
- It is important to note that comparisons between countries is made difficult because of a number of contextual factors - including different socio-economic structures, population size, culture, religion, quality of the published statistics and substantial historical developments such as war, famine and political upheaval.

[12]*Hannah Ritchie, Max Roser and Esteban Ortiz-Ospina (2015). Suicide. Published online at OurWorldInData.org. Retrieved from: 'https://ourworldindata.org/suicide' [Online Resource].*

[13]*UNICEF Office of Research (2017). Building the Future: Children and the Sustainable Development Goals in Rich Countries. Innocenti Report Card 14. Florence.*

Figure 2 below summarises the key risk factors for suicide and the relevant interventions based on the World Health Organisation's analysis of the available international evidence.

Figure 2: Key risk factors for suicide aligned with relevant interventions[14]



The message is clear. In order to prevent suicide, a multi-sectoral, holistic, public health approach is required, which targets multiple levels of the system at the same time. A one-size-fits-all approach is likely to be ineffective.

[14]*World Health Organization. (2014). Preventing suicide: A global imperative. Geneva, Switzerland (p. 31).*

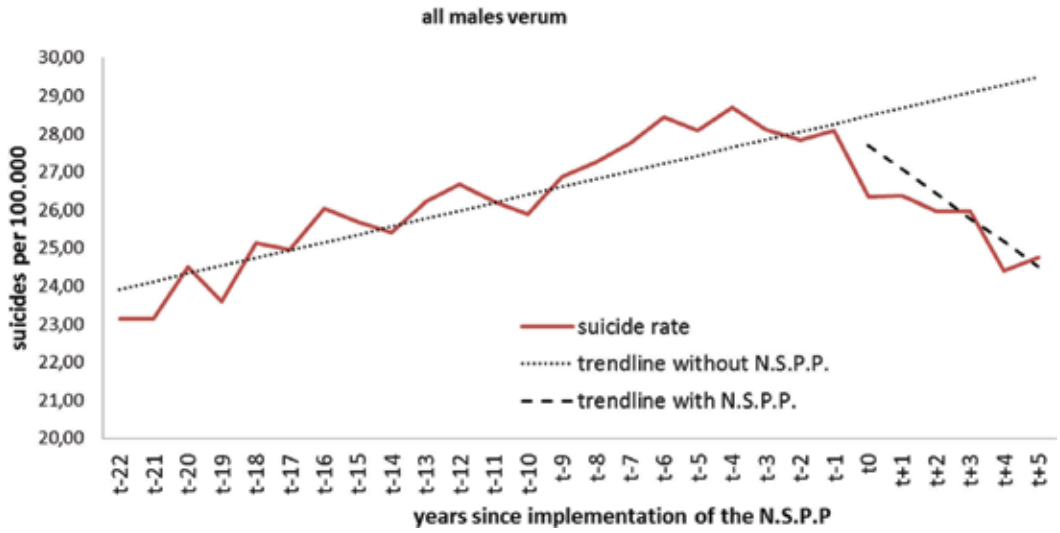
HOW EFFECTIVE ARE SUICIDE PREVENTION STRATEGIES?

As of 2017, New Zealand is one of 40 countries that is known to have developed a national suicide prevention strategy (NSPP) that has been adopted by government. A national strategy is important as it indicates a government's clear commitment to prioritising suicide prevention activities and providing leadership and guidance on the key evidence-based suicide prevention interventions.[15] However, there are relatively few studies that have investigated the effectiveness of national suicide prevention strategies.

A recent study by Lewitzka et al. (2019)[16] collated the data from four verum countries that had a comprehensive national suicide prevention strategy in place for more than five years during a 30 year period (ie, Australia, Finland, Norway and Sweden). The data from these countries was compared with the data from a control group of four comparable countries that did not have a national strategy in place for more than five years (ie, Canada, Austria, Switzerland and Denmark). Note that New Zealand was not included in the verum group because the country's first national suicide prevention strategy (1998)[17] was only focused on young people and not the whole population.

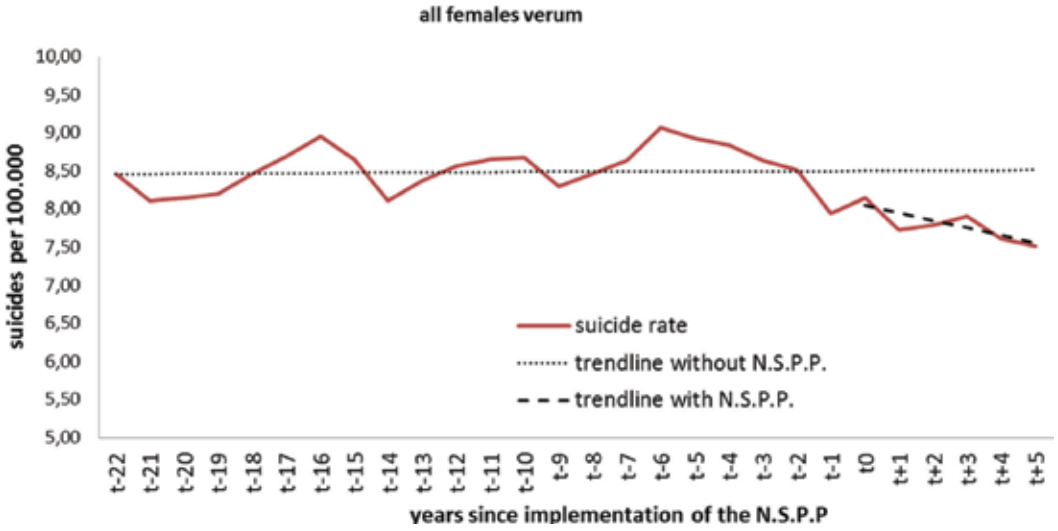
The findings from the research showed that those countries that did have a comprehensive NSPP in place had a statistically significant decline in suicide rates for men, with the strongest effects in groups aged 25-44 years and 45-64 years (see figure 3).

Figure 3: Level change in the all males of the verum group of countries



There was also a significant effect in females aged 45-64 and >65 years, although the effect was not as strong as it had been in males.

Figure 4: Level change in the all females of the verum group of countries



NOTE:
The findings of this research are not generalisable as the researchers identified a few countries that had managed to reduce their suicide rates without implementing an NSPP. However, they have still endorsed the overall effectiveness of a national suicide prevention strategy, albeit with an effect that seems to correlate with age and sex. This effect indicates that any national programme of activity needs to pay special attention to different sub-groups of the population, particularly with regard to age and sex, as well as some other factors (eg, ethnicity).

[15] *See footnote 13.*

[16] *Lewitzka et al. (2019). Are national suicide prevention programs effective? A comparison of 4 verum and 4 control countries over 30 years. BMC Psychiatry. 19: 158. p2-10.*

[17] *Ministry of Youth Affairs, Ministry of Health, Te Puni Kōkiri (1998). The New Zealand Youth Suicide Prevention Strategy. In our hands: Kia piki te ora o te taitamariki. Wellington.*

THE SCOTLAND EXPERIENCE – A QUALIFIED SUCCESS STORY

Over the past 18 years the Scottish Government has worked with a wide range of national and community partners to prioritise efforts to prevent suicide – resulting in a 20% reduction in their suicide rate. The World Health Organisation (WHO)[18] profiled the suicide prevention achievements of Scotland in their 2018 report on global progress and noted the key ingredients of their success - as follows:

- A comprehensive nationwide strategy aimed at helping people 'Choose Life'.
- A devolved government, with key national partners having ease of access to the suicide prevention policy team and Government ministers, and the creation of a new post of Minister for Mental Health in 2016.
- Dedicated leadership and a common vision from the Scottish Government and national agencies - involving public and third-sector agencies at local government level.
- Commitment to a broad public health approach to suicide prevention, combining population-based action and a focus on equity with interventions targeted at high-risk groups and individuals, incorporating but going beyond traditional (mental) health service responses.
- Improvement of the capability of the health and social care system to respond effectively and compassionately to individuals in emotional distress/at risk of suicide.
- Collaborative work across national agencies in gathering, analysing, disseminating and action on research and experiential evidence about what works in suicide prevention.
- Raising awareness in the general population.
- Tackling problem drinking, especially through alcohol brief interventions delivered in primary care, accident and emergency services and antenatal care settings, and increased attention to the identification and treatment of depression in primary care.
- Improvements in local patient safety – in particular the work on discharge planning.

NOTE:
Unfortunately, after years of a continuous reduction in Scotland's suicide rates, the NHS Information Services Division[19] reported a 15 percent increase in the suicide rate in 2018. The increase for young people under the age of 25 years was particularly concerning and reflected a similar trend in New Zealand. This highlights the complexity of the issue and the importance of staying relentlessly focused on it. It also shows how important it is to closely monitor progress over time and to make quick adjustments to the approach - based on the emerging evidence.

[18] *World Health Organisation (2018). National suicide prevention strategies. Progress, examples & indicators.*

[19] *https://www.isdscotland.org/Health-Topics/Public-Health/Publications/2019-06-26/2019-06-26-Suicide-Summary.pdf*

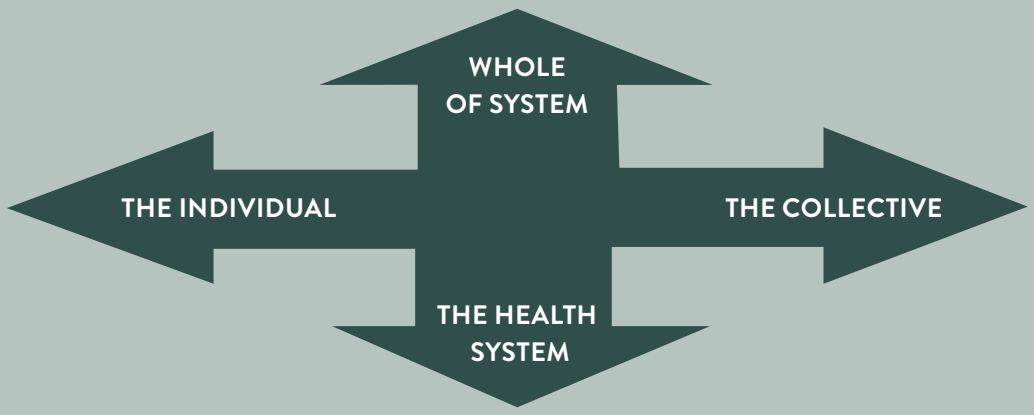
SELECTION OF EVIDENCE-INFORMED STRATEGIES

1. PRIORITISING SUICIDE PREVENTION INTERVENTIONS

There is accumulating evidence about the effectiveness of a number of suicide prevention interventions. The multilevel systems approach outlined in the WHO (2014) framework is the most promising in reducing the risk of suicide and involves a range of individual, selective and universal interventions that are implemented simultaneously in a localised region (see figure 5). The assumption is that the greater the number of suicide prevention interventions the greater the impact.

However, given that the availability of resources will influence the extent to which interventions can be implemented in local communities, key stakeholders may wish to focus their initial efforts on those strategies that have been predicted to have the greatest impact for those who are the most vulnerable.

Figure 5: Opportunities to intervene in the system with impact



Krysinska et al. (2016)[20] from the Australian NHMRC Centre of Research Excellence in Suicide Prevention calculated the impact of various evidence-based strategies and found the following:

- Taking prevalence of exposure to the intervention into consideration, the strategies likely to bring about the strongest reduction in suicide attempts were:
  - psychosocial treatments and;
  - co-ordinated / assertive aftercare.
- The greatest impact on reductions in suicide deaths was found for:
  - psychosocial treatment,
  - general practitioner training,
  - gatekeeper training and;
  - reducing access to the means of suicide.
- Potential synergistic effects between the strategies could further increase their impact.

2. RELEVANT INTERNATIONAL & NEW ZEALAND STUDIES ABOUT EFFECTIVE INTERVENTIONS

In 2016 the Ministry of Health published a rapid review of the international research and relevant New Zealand studies on suicide prevention that had been published from 2006 -2016. The findings from the rapid review included a summary of the current knowledge about the following:

- The risk and protective factors for suicidal behaviours.
- The effectiveness of various suicide prevention interventions.

A summary of the key findings from the review is included as appendix one to this paper.

3. WHAT COUNTS AS CREDIBLE EVIDENCE?

The strong interest on the part of government in using the evidence to inform decision-making has increased the potential for better programmes, better policy, improved governance and better outcomes for society. However, the increased level of interest has also meant that the adequacy of the evaluative methods and the value of the resulting evidence is subject to closer scrutiny.

Julnes & Rog (2009)[21] have argued that the evidence can be credible in one context, but of questionable relevance for guiding actions in other contexts. They maintain that the reframing of the evidence as whether it is relevant and 'actionable' rather than 'credible' makes the quality of the evidence less a matter of logic and more one that is concerned with the needs of the key stakeholders - particularly those people who have lived experience of suicidal behaviour.

4. CONTEXTUAL FACTORS

There is general recognition that context is key to the effective design and implementation of suicide prevention interventions. It is important to note that whilst some high-risk sub-groups of the population are able to benefit from activities that target the general population, a universal approach is unlikely to meet all of their needs. Dedicated strategies are still needed to account for age, sex and cultural differences in the population – especially those people who are known to have a higher risk of suicidal behaviour.

An example of effective engagement with a local community
Fusion, Te Tai Tokerau (2019)[22] highlights the potential of suicide post-vention work and demonstrates the effectiveness of suicide prevention activity that is led by the local community.

Dedicated strategies also need to account for local services that are either physically or economically inaccessible and/or culturally inappropriate. For these reasons, some of the strategies that are selected at the local level may vary from the universal strategies that are aimed at the general population.

KEY POINTS

- The multi-level systems framework outlined by the World Health Organisation (2014) offers the most promising approach for reducing the risk of suicide.
- There is accumulating evidence about the effectiveness of a number of suicide prevention interventions and their predicted level of impact.
- Decision-makers need to consider the contextual factors that influence the choice of the adequacy and the appropriateness of various suicide prevention interventions (eg, cultural factors).
- The full range of perspectives about 'the evidence' should be sought from a range of stakeholders, specifically those people who have lived experience of suicidal behaviour and those who have been bereaved by suicide.
- Te Tiriti o Waitangi should underpin all systems, structures, operating models and resourcing approaches for Māori.

[20]Krysinska, K., et al. (2016). Best strategies for reducing the suicide rate in Australia. The Australian and New Zealand journal of psychiatry, 50(2), 115–118.

[21]Julnes, G. & Rog, D. (2009). Evaluation Methods for Producing Actionable Evidence. In S.I. Donaldson et al. (Eds.), What counts as Credible Evidence in applied Research and Evaluation Practice? (p96-131.

[22]Suicide Mortality Review Committee. 2019. Suicide post-vention | An example: 'Fusion', Te Tai Tokerau. Wellington: Health Quality & Safety Commission

20 POPULATIONS OF INTEREST IN NEW ZEALAND

Suicide affects people of all ages and from all walks of life, but populations such as Māori, young people and males experience disproportionally higher numbers (See Table 1).

Table 1: Selected fast facts by population group in New Zealand[23]

COMPARATIVE SUICIDE RATE	WHAT WE KNOW
International rate	• The World Health Organisation indicated an annual global age-standardised suicide rate of 10.5 deaths per 100 000 population in 2016.[24]
New Zealand rate	• The highest rate in New Zealand on record was in 1998 at 15.00 deaths per 100,000 population. • From 1996 to 2016, the rate of suicide decreased significantly from 14.2 to 11.3 deaths per 100,000 population, a decrease of 20%. • The lowest rate between 1996-2016 was in 2014 (10.8 per 100,000). • The rate in 2017/18 was 13.67 deaths per 100,000 population.
NZ POPULATION GROUPS	**WHAT WE KNOW**
Māori	• The suicide rate for Māori rose from 23.72 per 100,000 in 2017/18 to the provisional rate of 28.23 per 100.000 in 2018/19. • Rangatahi are particularly at risk when compared to any other group.
Pasifika	• Across Pacific ethnic groups, suicides were most prevalent in young people aged 15–24 followed by those aged 25–39, except for Samoans where the order was reversed.[25] • Attempted suicide rates were three times higher for Pacific youth in comparison to non-Pacific and non-Māori youth in New Zealand.
Asian	• The rate of Asian suicide fluctuates, but has been slowly rising from 5.93 per 100,000 in 2007/08 to a high of 8.69 in 2017/18.[26]
Young people aged 15–19	• The provisional youth suicide rates are at near-record levels in 2019/20, especially amongst young Māori, which signals a significant problem.
People bereaved by suicide	• People who are bereaved by suicide are at significantly elevated risk of negative health and social outcomes. This includes higher rates of depression, anxiety, post-traumatic stress disorder and suicidal behaviour.
Men	• Suicide was the second leading cause of premature death for Māori males and the fourth leading cause of premature death for all non-Māori males.[27] • Men of working age (20–65) account for more than half of all suicides. • While older adults over 65 have a lower rate of suicide when considered as a homogeneous group, men aged 85 and older have the highest suicide rate of any age/gender group, with deaths linked to the loss of a spouse, loneliness, social isolation, dementia and depression.

People who experience extreme mental distress and/or addiction problems	• Whilst the majority of those who die by suicide do not have a diagnosed mental health problem, there is an increased risk of suicide or self-harm by people who experience mental health and/or substance abuse problems.
Farming-related suicide	• Elevated suicide rates amongst farmers are consistently reported in a number of countries, including New Zealand.[28] • Overall, risk factors for farm suicides differ little from the risk factors for suicide in the general population.[29] • A range of rural suicide prevention initiatives are needed to address various suicide risk profiles – especially for young, male farm labourers.[30]
Rainbow community	• Those who identify as lesbian, gay, bisexual, transgender or intersex (LGBTI) have higher rates of suicide attempts and suicide.

[23] *https://coronialservices.justice.govt.nz/assets/Documents/Publications/Provisional-Figures-August-2019.pdf*

[24] *Retrieved from https://www.who.int/gho/mental_health/suicide_rates/en/*

[25] *Tiatia-Seath, J., Lay-Yee, R., & von Randow, M. (2017). Suicide mortality among Pacific peoples in New Zealand, 1996–2013. New Zealand Medical Journal, 130(1454), 21–29.*

[26] *Suicide Mortality Review Committee. (2019). Understanding deaths by suicide in the Asian population of Aotearoa New Zealand. Wellington: Health Quality & Safety Commission.*

[27] *https://www.health.govt.nz/publication/mortality-2016-data-tables*

[28] *Beautrais, A. (2018). Farm suicides in New Zealand, 2007–2015: A review of coroners' records. Australian and New Zealand Journal of Psychiatry, 52(1), 78–86.*

[29] *Ibid.*

[30] *Ibid.*

KEY POLICY LEVERS FOR MAKING CHANGES TO THE SYSTEM

Governments have a restricted range of tools, or policy levers, at their disposal to implement changes to the system. They are able to apply a variety of policy levers at any one time, with the choice of lever(s) being influenced by a range of factors including the available evidence, the political climate and the legislative scope of the government's authority.

There is no universally accepted typology of policy levers, with various researchers advancing different classifications. This paper uses the typology proposed by Michie et al (2011)[31], which identified seven policy categories based on a systematic review of 19 different frameworks (see figure 6).

Figure 6: Government's key policy levers for making changes to the system

An improved understanding of the strategic targeting and appropriate utilisation of policy levers for the prevention of suicide may assist in the delivery and evaluation of evidence-informed changes to the system in the future.

[31] *Michie, S., van Stralen, M.M. & West, R. (2011). The behaviour change wheel: A new method for characterising and designing behaviour change interventions. Implementation Science 6, 42.*

CROSS-PARTY DECISION-MAKING PROCESS

1. CROSS-PARTY STEWARDSHIP ROLE IN ZERO SUICIDE

- The Cross-Party group works on behalf of the New Zealand public to hold each government to account for pursuing public policies that promote sustainable wellbeing and zero suicide.
- In doing so, priority is given to evidence-informed initiatives that rely on cross-portfolio collaboration.
- The distinctive role of the Cross-party group is to monitor, on behalf of Parliament, progress on the government's short-term priorities and the longer-term impacts of government investments.
- This role endures over time and clearly separates the short-term (3-year) management role of Government, from the long-term stewardship role of Parliament.

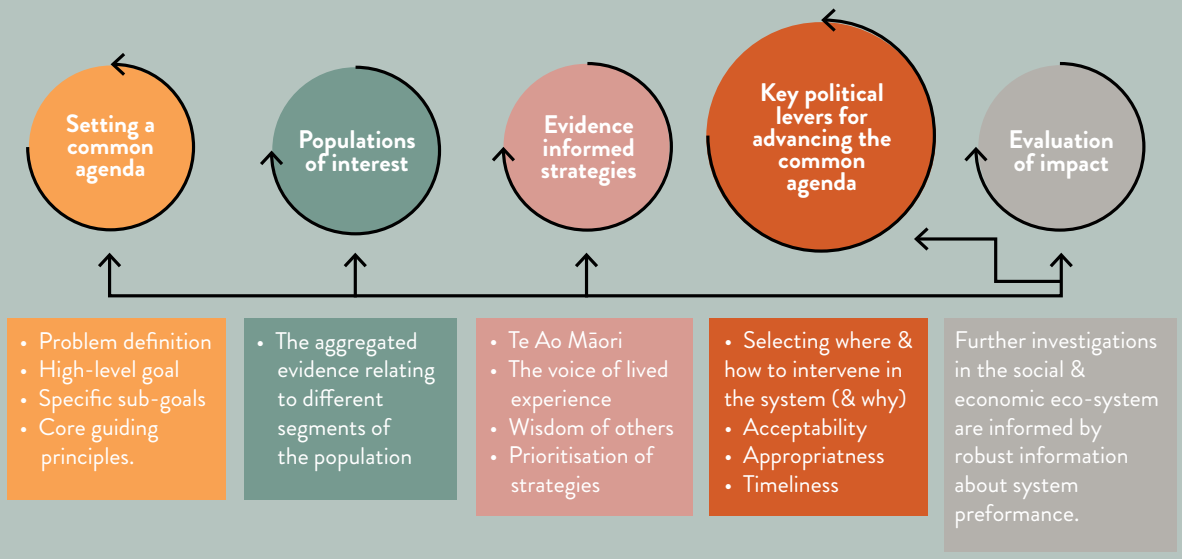
2. CORE GUIDING PRINCIPLES

- Meets government obligations under Te Tiriti o Waitangi
- Future-focused
- Equitable
- Evidence-informed
- Sustainable
- Transparent
- Supports social cohesion

3. DECISION-MAKING PROCESSES

- The shift to a multi-dimensional model of suicide prevention means that Parliament will have to weigh up the evidence about the costs, benefits and value of various programmes, policies and strategies that target multiple points in the system.
- Some programmes, policies and strategies are more effective than others for certain population groups.
- The group will need to identify the best value opportunities for change.
- The evidence is incomplete and subject to change, so the decision-making processes will need to remain flexible to enable Parliament to quickly alter course based on the emerging evidence.
- The successful pursuit of zero suicide will rely on a number of key stakeholders – both public and private.

Figure 7: Overview of cross-party decision making process



4. EVALUATING SUCCESS

- The main indicators of success are a reduction in the rates of suicide deaths and suicide attempts over time - with the ultimate aim being 'zero suicide'.
- Whilst it is difficult to detect changes in the suicide rates that are attributable to the implementation of a national suicide prevention strategy, the World Health Organisation (2018)[32] recommends that countries adopt a programme logic approach that utilises a number of different indicators that target different areas in the system.
- Any evaluation of the success of a particular programme or strategy should always include the voices of people who have engaged in suicidal behaviour, as well as those who have been bereaved by suicide.

[32] *See footnote 17*

CASE STUDIES

1. RANGATAHI

The biggest inequity is evidenced in the percentage of Māori suicides, which are much higher than for any other ethnic group in New Zealand and are concentrated in the young.

The report Te Mauri: The Life Force (2020)[33] adopts a Māori lens to examine the issue of suicide and seeks to understand why rangatahi have higher rates of death by suicide when compared to non-Māori young people in New Zealand.

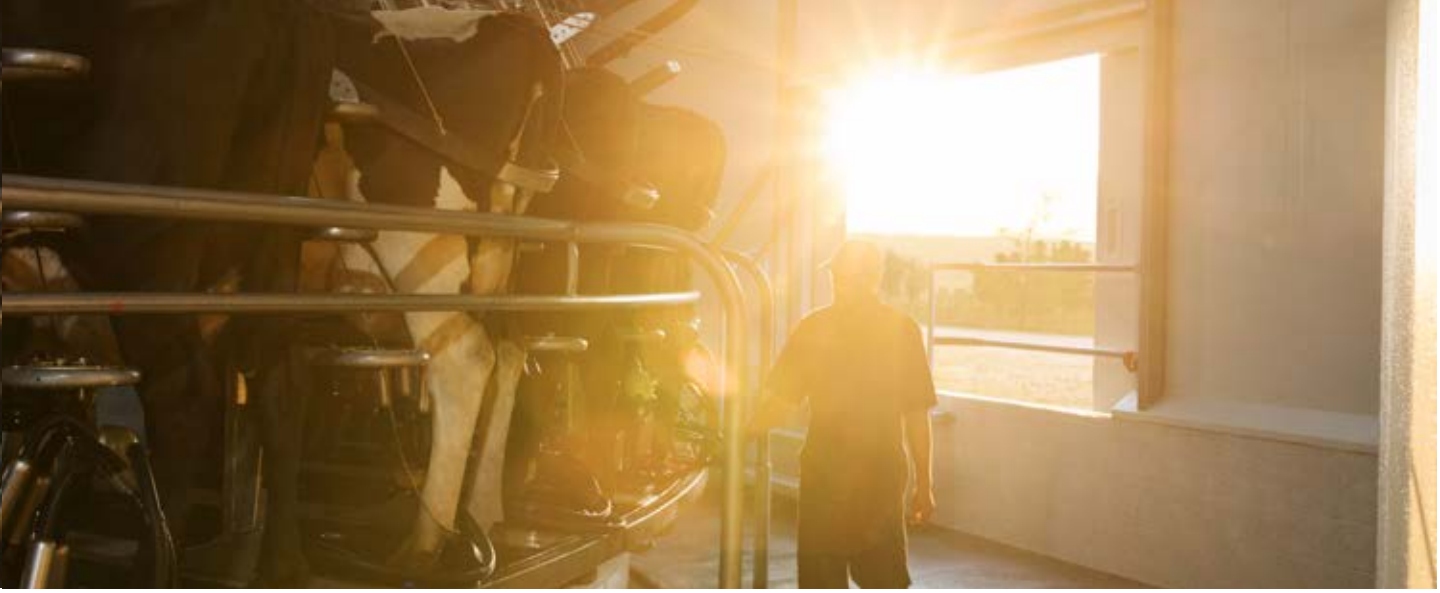
It describes Māori approaches to suicide prevention and reports on what Māori whānau and communities say they need in order to prevent suicide in rangatahi.

In order to achieve the policy changes that are needed, the report makes the following four major system-level recommendations for all of government:

1. Embed and enact Te Tiriti into all policy and practice to support mana motuhake (autonomy, self-determination, sovereignty, self-government), accelerating this process for rangatahi within the education and health sectors.
2. Urgently address the impact of socioeconomic determinants of health on whānau, including poverty, alcohol, racism, housing and unemployment.
3. Invest in what works for Māori, iwi, hapū and whānau – invest in, fund and build communities to lead initiatives that support communities in suicide prevention and postvention.
4. Work collectively, national and locally to leverage government investment in what works for Māori.

Under each of these system-level recommendations, there is a range of more specific actions that are recommended for individual government agencies with regard to their role in reducing rangatahi deaths by suicide. Central to this advice is the need for Te Tiriti o Waitangi to underpin all systems, structures, operating models and resourcing approaches.

[33]*Ngā Pou Arawhenua, Child and Youth Mortality Review Committee & Suicide Mortality Review Committee (2020). Te Mauri – the life force: Rangatahi suicide report. Wellington: Health Quality & Safety Commission.*



CASE STUDIES

2. FARM-RELATED SUICIDES

"Suicide prevention programmes to benefit farmers and rural areas need to be implemented as part of broader rural health and mental health strategies. Within this rural context, this study reinforces the critical need for sound demographic and risk evidence to underpin investment decisions to ensure that the limited funding for rural suicide prevention is well targeted".

Beautrais, A. (2018)[34]

In 2018 Annette Beautrais undertook an analysis of the coronial records for the period 2007 and 2015 to examine the trends in farm-related suicides. The findings revealed that whilst the suicide rates are typically higher in farm workers, the risk factors for suicide differ little from the risk factors in the general population.

The study also highlighted the fact that farm-related suicides were a highly heterogeneous group, which could be represented by six broad profiles as follows:

1. A young farm labourer.
2. A young labourer or farm manager, aged in 20s and early 30s, often with a young partner & children.
3. An older farmer in his 50s, usually married, with an existing serious health problem.
4. An often (part) retired farmer, with concerns about their physical symptoms or decline.
5. Male with a risk profile dominated by severe, enduring mental illness - including depression, anxiety, psychosis and alcohol/drug problems.
6. Women who work on farms, often in casual or part-time labouring jobs.

[34]*Beautrais, A. (2018). Farm suicides in New Zealand, 2007-2015: A review of coroners' records. ANJP. Vol 52 (1) 78-86.*

These six risk profiles indicate that a range of rural suicide prevention initiatives are needed to address the needs of the different groups of people. For example, twice as many farm labourers as farm owners or managers have died by suicide. For many young men, relationship losses, acute alcohol intoxication and ready access to a firearm formed a common constellation of factors. These young men also tended to have no contact with health services prior to their death, suggesting that rural suicide prevention efforts need to be positioned within community, farming and sports organisations, as well as health and social services.

Table 2 offers an example of how the different policy levers might be applied to help mitigate the risk of suicide for young farm labourers and to ensure that the investment in rural suicide prevention activities is well-targeted.

Table 2: An example of how the cross-party group might apply their decision-making framework to help address the issue of suicide amongst young farm labourers.

#	POLITICAL LEVER	POSSIBLE ACTIONS	THE EVIDENCE
1	Fiscal measures	Increase the level of investment in the Rural Health Trusts with the expectation that they will co-ordinate a range of evidence-informed suicide prevention activities for the rural sector – ie, mental health promotion, early intervention to prevent suicide and the development of suicide postvention programmes.	Increase access to healthcare
2	Regulation	NIL	
3	Service provision	Prompt the development of a rural mental health and addiction policy (within a broader rural health policy) that includes suicide prevention as a key priority area, and which recognises the different needs of the six sub-groups of people in the farming sector. Invest in the development of evidence-informed programmes that are specifically designed to reach young farm labourers in their work places, in their local communities and at farming-related events.	Mental health & addiction policies Interventions for vulnerable young people.
4	Legislation	Amend the Sale and Supply of Alcohol Act 2012 to reduce the availability of alcohol, especially for young people. Ensure that the provisions of the proposed Cannabis Legalisation and Control Bill prevents young people from accessing cannabis.	Legislation to reduce the harmful use of alcohol and other drugs
5	Public communication campaign	Invest in a targeted public health campaign that aims to increase awareness around alcohol and/or drug use in this target group. The campaign should encourage the uptake of harm minimisation alcohol policies for rural social activities as part of the response.	Raise awareness
6	Environmental and social planning	NIL	
7	Guidelines	Restrict on-farm access to lethal means of suicide, especially firearms. It is noted that an emphasis on 'safety' is more acceptable than regulation.	Restrict access to means

SUMMARY OF INSIGHTS

"A strong consensus exists among mental health professionals that the time is right for a paradigm shift away from mental illness towards mental wellbeing. There needs to be a broader focus on preventative actions and measures designed to keep individuals, families and communities well".

Poulton, R. et al. (2020)

The world has been fundamentally changed by COVID-19. The level of disruption is so significant that it offers New Zealand a unique opportunity to pause and reconsider how the country might want to do a number of things differently in the future.

If we accept that the ideal approach to suicide prevention is to invest in a comprehensive, multi-sectoral approach that involves central government agencies, local communities and whānau/families, then the country should consider positioning the issue of mental health, wellbeing and suicide prevention as an integral part of the economic and social recovery of Aotearoa New Zealand - and prioritise its efforts accordingly.

KEY POINTS

- The pathways to suicide are complex and differ between population groups.
- Suicide is preventable, but preventing suicide is complex.
- Suicide affects people of all ages and from all walks of life, but some groups are disproportionally affected.
- A comprehensive, multi-sectoral approach is required in order for a national suicide prevention response to be effective.
- Those countries that invest in a comprehensive range of targeted selective, indicated and universal interventions have been demonstrated to make more progress than those that do not.
- The insights of people who have lived experience of suicide is critical to the success of any suicide prevention activities.
- Te Tiriti o Waitangi should underpin all systems, structures, operating models and resourcing approaches for Māori.

SUMMARY OF RECOMMENDED ACTIONS

Table 3 summarises the recommended actions – with a specific focus on what Parliament could do to introduce changes to the wider system that would enhance the wellbeing of individuals, families/whānau and local communities and reinforce the aspirational goal of zero suicide.

Table 3: Summary of recommended actions

1. Strengthen the national stewardship role and functions of Parliament in relation to suicide prevention.
2. Strengthen the local and national infrastructure supporting the implementation and monitoring of the national Suicide Prevention Strategy Every Life Matters and its associated Action Plan.
3. Identify one or more high-priority population groups to focus on in the coming year.
4. Identify some evidence-informed strategies for these high priority population groups, which can be supported by all political parties.
5. Identify any additional strategies for the coming year that are applicable to the general population - such as supporting a strong population health response to help mitigate the psychosocial risk factors associated with the COVID-19 pandemic.

Southern Cross

The cross-party group would like to thank Southern Cross who supported the development and production of this report.

TYPE OF SUICIDE PREVENTION INTERVENTION		INTERVENTIONS
Prevention	Universal	• National suicide prevention programmes • Means restriction policies • Media guidelines • Public messaging programmes • Alcohol control policies • Social welfare policies and employment policies
	Selective	• Suicide prevention centres • Community based suicide prevention programmes • School-based suicide prevention programmes • Tertiary education/campus-–based programmes • Child welfare/juvenile justice-based programmes • Workplace-based suicide prevention programmes • Courts/prisons-based suicide prevention programmes • Programmes for defence force personnel • Rural programmes • Alcohol/drug misuse programmes • Parenting support and Early Start programmes • Programmes to strengthen cultural identity/continuity
	Indicated	• Training for health and social service providers • Support to primary care providers and health service planners • Providing education and support to carers of high-risk individuals • Telephone-based (crisis) suicide prevention services • Internet- and m-health-based programmes • Postvention
Treatment	Case identification	• Primary care screening programmes • Emergency Department (ED) screening programmes • Follow-up and ongoing contact after ED/hospital discharge
	Standard treatment for known disorders	• Psychotherapy and psychosocial programmes • Pharmacotherapy • Intensive care plus outreach • Home-based therapy • General hospital admission • Neurosurgery • ECT • Multiple/combined therapies
Maintenance	Adherence	• Follow-up and ongoing contact • Crisis (green) cards • Caring contacts • Safety and support plans • Inpatient admission • Treatment adherence programmes • Motivational interviewing
	Aftercare	• Long-term therapy • Service delivery/organisation and case management models

Source: Ministry of Health. (2016). A rapid review of the suicide prevention literature. Wellington: Ministry of Health. (p. 9).

REPORT PREPARED FOR THE CROSS-PARTY MENTAL HEALTH AND ADDICTION WELLBEING GROUP

BY PLATFORM TRUST