A Strategy to Prevent Suicide in New Zealand

Submission to the Ministry of Health

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Contact

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About the New Zealand Nurses Organisation

NZNO is the leading professional nursing association and union for nurses in Aotearoa New Zealand. NZNO represents over 47,000 nurses, midwives, students, kaimahi hauora and health workers on professional and employment related matters. NZNO is affiliated to the International Council of Nurses and the New Zealand Council of Trade Unions.

NZNO promotes and advocates for professional excellence in nursing by providing leadership, research and education to inspire and progress the profession of nursing. NZNO represents members on employment and industrial matters and negotiates collective employment agreements.

NZNO embraces te Tiriti o Waitangi and contributes to the improvement of the health status and outcomes of all peoples of Aotearoa New Zealand through influencing health, employment and social policy development enabling quality nursing care provision. NZNO's vision is *Freed to care, Proud to nurse*.

EXECUTIVE SUMMARY

1. The New Zealand Nurses Organisation (NZNO) welcomes the opportunity to comment on the Ministry of Health draft strategy (the strategy) to prevent suicide in New Zealand and thanks you for the extension.

2. NZNO has consulted its members and staff in the preparation of this submission, in particular members of the Neonatal Nurses College Aotearoa (NNCA), NZNO Gerontology Section, Te Rūnanga o Aotearoa, NZNO Midlands Regional Council, and policy advisers.

3. We are extremely concerned that the draft strategy does not have a clear focus, and does not cover the lack of investment on workforce capacity, resourcing and research. Further, we are concerned that there are no concrete solutions proposed, or proactive implementation programmes aimed at preventing

suicide and improving our excessively high rates, particularly of youth suicide.

4. We agree that the high level of suicide in Aotearoa New Zealand is not acceptable, and that the harmful impact of suicide and suicidal behaviour on families, whānau, and communities is devastating, and strategies to address it will have a positive impact on our society.

5. It is also unacceptable that Māori have such high incidences of suicide, in particular the rates of young Māori men who are 2.5 times more likely affected by suicide than non Māori[i], and recommend implementing culturally appropriate services to support our tamariki and their whānau.

6. As health professionals, we support any initiatives that promotes and provides access to on call expert professionals team who can provide direct care and support to individuals, their families or whānau who have concerns about suicidal behaviours.

7. The contention that Iwi and non-governmental organisations (NGOs) should provide funding to address the incidence of suicide is outrageous and shameful in a document purporting to be a national health strategy aimed at addressing a significant public health cost inequitably born by Māori.

8. It is alarming that the strategy does not identify pregnant woman as an at-risk group, or include maternity services as a core service to receive targeted funding for prevention and treatment. We recommend that this is immediately amended.

9. We wish to raise the following issues which the Strategy either does not address, or addresses poorly:

    - right to good health;

- funding the strategy;
- Māori youth suicide';
- care of pregnant women;
- inclusion and visibility of older people; and
- specific member comments.

DISCUSSION

Right to good health

10. Māori, have an equal right to the highest standards of health, and the State is responsible for ensuring this is achieved under article 24.2 of the United Nations Declaration on the Rights of Indigenous peoples[ii]. We also acknowledge the rights under te Tiriti o Waitangi of Māori to good health that encompasses wellness in its fullest sense and including the physical, spiritual and cultural wellbeing of Māori as individuals and collectively[iii].

Funding the strategy

11. NZNO is extremely concerned that the draft strategy does not have a clear focus or address the lack of investment on workforce capacity or future needs, funding, resourcing and research.

12. The government should be providing comprehensive wrap-around services that allow for regional diversity, to support communities' needs.

13. Implementing strategy to address the impact of suicidal behaviour will be costly; however, adequate resourcing of proactive, comprehensive approaches is essential if the Aotearoa New Zealand is to reduce the high incidence of suicide that has a

lasting and devastating effect on families and whānau and undermines social and economic wellbeing.

14. The document, to its shame, suggests that iwi should provide funding to address the incidence of suicide. This is unacceptable. Iwi Treaty Settlements are designed to address historical grievances, not to provide day-to-day funding to bolster the Crown's responsibilities to provide social and health services! Does the government expect the same of other wealthy minorities?

15. The suggestion is particularly outrageous in view of the fact that the Crown's failure to deliver equitable services, including mental health services as per te Tiriti articles, is a contributing factor to disproportionately poor outcomes for Māori in almost all areas of health, including suicide. The same attitude, we note, applies to the continued underfunding (via the underfunding of district health boards (DHBs)[iv]) of Māori and iwi health services where health practitioners are paid up to 25% less than their DHB counterparts.

16. Essential funding should be available to provide more resources in schools, trauma response services, and for parental skills programmes, (eg "Are you ok?" which explains how a parent can have a conversation with a child about strong feelings) to improve awareness and knowledge about what to do and where to go for help.

17. Funding is also required for rural services to have stronger connections to the communities they serve. For example, Kaitaia and Whangarei, have diverse rural services, and have their own action plans to respond to their unique needs of their communities.

18. Suicide prevention training should be made free to all communities; this would help to prevent external agencies

inflating the cost to attend some of the suicide prevention courses (eg approximately $250 dollars per person in Northland).

Māori Youth suicide

19. We are distressed at the alarmingly high rates of youth suicide in Aotearoa New Zealand. In 2011, Aotearoa New Zealand had the second highest youth suicide rate for both males and females in the report of the Organisation for Economic Cooperation and Development (OECD) countries[v], with Māori youth suicide rates 2.4 times higher than the equivalent rate for non Māori youth[vi].

20. This is an unacceptable rate of preventable death for our tamariki. We recommend that culturally appropriate youth mental health services aimed at building cultural identity, supportive caring community and better recognition of symptoms at primary health care level, are available to identify and help our young people and their whānau who are in distress[vii].

21. Māori have the right to self-determination in combating this risk. However they also have the right to equitable access to public funding and resources, particularly considering the alarming disparities for Māori.
22. Funding, must allow iwi to hui collectively, as this is a vital component in Māori action against suicide. Role modelling services, (NGO's and Iwi providers) who are achieving amazing outcomes and supporting whānau in high deprivation areas would be a good way to promote access to appropriate services for Māori youth.
23. Implementing a mental health literacy, or suicide prevention literacy, programme that focuses on cultural responsive training would benefit Māori communities.

Care of pregnant women

24. The NNCA executive committee are concerned about the alarming rates of suicide in pregnant women which is outside the normal neonatal scope. Equally alarming is the fact that the strategy does not identify pregnant women as an at-risk group, or include maternity services as a core service to receive targeted funding for prevention and treatment.

25. The recent Health Quality and Safety Commission (2016) *Tenth Annual Report Perinatal and Maternal Review Committee reporting mortality 2014*[viii] highlighted that the most common cause of maternal death in New Zealand is suicide. Many of these women had two or more risk factors for major depression, but these factors were not always recognised as maternal suicides, and that communication between services was not always adequate for pregnant women.

26. Further, relationship stress was a feature of almost all new mums who had committed suicide[ix], which is another area where more research is needed.

Inclusion and visibility of older people

27. The NZNO Gerontology Section's recommend including the '*visibility of older people'* as a high risk population group in the discussion table for suicide prevention. The incidence of suicides amongst over 65 years old is high and with the ageing population, is accelerating. The strategy must address and implement interventions for preventing suicide in this population group.

28. In addition, the relationship between ageing and suicide trends, show complexities in older people making them very vulnerable to self-harm. These complexities include health and socio-economic factors like stress, health decline, living alone, changing living arrangements and poverty. These factors, when

left unrecognised, lead to depression in older adults increasing the likelihood of suicide.

29. Recent research from Cheung[x] (2017) indicates the increase numbers of older people who self-harm are at high risk of repeat self-harm and suicide. It would be beneficial to implement routine screening for depression and suicide risk assessments in older people with chronic medical conditions as part of any primary care and hospital specialist service appointments.

Specific member comments

Pathways

Members have provided specific comments relating to the consultation questions, pathways and prioritising actions.

- We believe that all three of the pathways are vitally important, we want these addressed simultaneously rather than in isolation. We don't like the wording of wellbeing and prefer "resilience".

- We support consistent access to free counselling services for anyone who is feeling suicidal. For example, school students have free access to school counsellors, deans and crisis teams, but other groups have to pay for services which disadvantages those vulnerable people and families on a tight budget.

Prioritising actions

- School programmes should be funded to include relevant visiting speakers. We suggest that any on-line tool development should ensure that younger children be supervised and protected with appropriate resources aimed to better improve problem-solving skills.

- Many of the younger generation no longer watch television, so any social media campaign needs to include Facebook, Twitter

and Snapshot. We support having poems in waiting rooms and in pamphlets and suggest that similar pamphlets and posters be developed and be visible in prominent public places, e.g. the backs of buses, bus stops, pubs etc.

- We have concerns with the last activity in the section which "promotes system change". While we applaud this concept, if it would led to a culture change that reduced the suicide rate, we questioned the practicality of this.
- The implementation of the DHBs action plans must be relevant to the communities they serve. For example, they must include assistance for farming community which can be hit hard by natural disasters and financial recession, as well as the youth, cultural, elderly, maternal and rural risk groups.
- We have concerns that this strategy is to be initiated by the DHB, as DHB's are often too large, and their scope is very broad. This may make it hard to implement effectively.
- We note that it is increasingly difficult to get people involved in volunteering, and organisations cannot always rely on goodwill of its members. Whilst mentoring is an appropriate activity, sometimes people relate better to age-appropriate or peer support.
- We agree, that providing information to schools to deal with bullying is a positive concept, but sometimes teaching staff have to acknowledge that there is a problem, such as a sporting and/or homophobic culture which they don't address.
- We agree with the last three of these activities.
- We need to insist that the DHB's provide adequate staffing for all Emergency Departments, so that people presenting as a suicide risk can be treated and monitored appropriately.

- We seek clarification with *"promoting ways to restrict access… "*, as we are not clear how this be achieved. For example, reinforcing the parapets of a bridge is not a deterrent, nor is fencing off a cliff-face.

- We seek clarification with *"supporting people with alcohol and drug problems…,* again this is extremely broad and there is no mention whatsoever of the amount of funding required to undertake all of these proposed activities.

- We have concerns with the logistics of training community workers how will this be achieved.

- Suicide prevention training should not be limited to paramedics, who at present constitute an unregulated workforce. We recommend, that police, school counsellors, teachers and health professionals should also be given this training. We noted that psychologists and counsellors are already working with local schools, with the involvement of social workers.

- Training toolkits should be developed for teachers to talk to at risk teenagers, as well as clear escalation plans for staff and students to access to the school counsellor and faculty Dean, as well as knowing where to access resources suitable for the needs of the students.

- We seek clarification with *"Communities providing support …"* who are these, and how are they identified? One would need, perhaps, some degree of anonymity vs geographical community.

- We agree that collaboration of services and agencies is important, especially between government agencies and NGO's and should balance the sharing of information with a person's privacy.

- We agree that all research and data collections should be monitored and supervised.

Support positive wellbeing throughout people's lives

- We agree that this must have a wider reach than just family, or whānau as many members do not have the functional ability to undertake this burden and it should also extend to include schools, churches and the community, e.g. marae based programmes, or through the Pacifica church communities. Plunket and Māori and Iwi provider services must be strengthened, to provide community based programmes as well and inputting at an individual level to those families or whānau at-risk. Women's Refuges and migrant and refugee centres are other avenues to target, as the service aims to support women and children who are at risk.

- The concept of a community hub could be used in a suicide prevention campaign, where local groups (Ministry of Social Development, Health Boards, Primary Health Organisations, Education sectors, Police, Mental health representation from whānau, hapū and iwi) meet regularly to discuss suicide prevention action plan across sectors within their regions and feedback to MOH/ other regions to provide sharing of information to combat this disease.

- Provide not just counselling services, but many other community -based programmes, such as well child clinics, free hearing checks, drop in centres, e.g. for art expression. By utilising other activities and multi services agencies, there is no stigma attached to attending just for counselling services.

- We reiterate that this activity should be undertaken in conjunction with other key determinates that lay the foundations for a positive outlook, including:

- increasing job opportunities for the unemployed;
- addressing the acute accommodation crisis, and the unhealthy homes issue;
- providing more readily accessible and affordable educational opportunities for everyone;
- increasing health literacy;
- providing nutrition information in an appropriate manner to improve our diets, thus reducing the need for fast food options and review the cost of fresh food, (e.g. removal of GST on these items) milk etc.;
- addressing any underlying health problems. These appear to be increasing, despite research demonstrating that unhealthy homes, poor diet and low socio-economic status contribute to chronic health conditions in New Zealanders;
- improving public transport and access to services for those without their own vehicles; and
- increasing access and the availability of home visits for those unable to attend appointments. We need to make this the 'norm' which would reduce extra stress or humiliation to those receiving this care.

CONCLUSION

In conclusion NZNO recommends that you:

- **note** our submission;
- **note** we are extremely concerned with the draft strategy as it does not have a clear or concise focus or any investment on workforce capacity, resourcing or research;
- **urgently implement** culturally appropriate services to support our tamariki and their whānau;
- **urgently amend** the suggestion that iwi and non-governmental organisations should provide funding for this strategy;
- **urgently amend** pregnant woman as an at risk group, and include maternity services as a core group to receive targeted funding for prevention and treatment; and

- **urgently amend** to include the 'visibility of older people' as a high risk population group in the discussion table for suicide prevention.

Nāku noa, nā

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