# 

# ***Every life matters***

*He tapu te oranga o ia tāngata*

# **The Suicide Prevention Strategy**

# **and Action Plan for Aotearoa New Zealand**

# **2020–2030**

# **The following groups of people, government agencies, organisations and services have worked together to bring you *Every life matters***

We have been overwhelmed by the generosity of those who have been involved in the development of *Every life matters*. A wide range of people, groups, organisations and government agencies have made a commitment to working differently and are boldly moving into a new future, forging new relationships, partnerships and ways of supporting suicide prevention efforts in New Zealand. We were also privileged to spend time with people and groups from a range of populations who shared their stories with us. This included people with lived experience of mental illness, addiction and suicidal distress (tangata whaiora); people bereaved by suicide; the Rainbow community and rural communities.

**[placeholder]**

|  |  |  |  |
| --- | --- | --- | --- |
| Government agencies:   * Ministry of Justice * Ministry of Youth Development * Ministry of Social Development * NZ Police * Ministry of Education * Department of Corrections * Ministry for Primary Industries * Te Puni Kōkiri * Oranga Tamariki * NZ Defence Forces * Ministry of Pacific Peoples * Department of Prime Minister and Cabinet Child Wellbeing Unit * State Services Commission * Treasury * Ministry of Business, Innovation and Employment * Ministry for Women * Social Investment Agency | Crown entities:   * Health Quality Safety Commission (HQSC) * Office of the Health and Disability Commissioner * Office of the Children's Commissioner * Mental Health Commissioner * Health Promotion Agency * Accident Compensation Corporation * DHB Suicide Prevention Coordinators | Stakeholder groups and agencies (or their representatives):   * Te Rau Ora * Le Va * Mental Health Foundation * Clinical Advisory Services Aotearoa (CASA) * Lifeline * Rural Support Trust * Farmstrong * Victim Support * Asian Family Services * NZ Psychological Society * Primary care clinicians * NGOs, Providers * Mental health, addiction and allied health professionals * Royal Australian New Zealand College of Psychiatrists * The Taranaki Retreat | Suicide prevention expertise  (Population groups and researchers)   * Matanga Mauri Ora- Māori Advisory Group to the Mental Health and Addiction Inquiry Response * Lived Experience Group, incl. Māori and Pacific * Mental Health Foundation Suicide Bereaved Advisory Group * Māori Suicide Bereaved Advisory Group * Men’s suicide Expert Group * Rainbow community * Rural community * Researchers from:   + Suicide & Mental Health Research Unit - University of Otago, Wellington and Dunedin staff   + Victoria University of Wellington   + University of Auckland   + Massey University |

|  |
| --- |
| *“Every life matters” is a global term being used by many to recognise the value and importance of every life. We recognise other works with this sentiment and offer this strategy as our contribution to the global response. “He tapu te oranga o ia tāngata” refers to the Māori belief that the wellbeing of all people is sacred.* |

**Contents**

[Contents 3](#_Toc11785094)

[Foreword 5](#_Toc11785095)

[Executive Summary 6](#_Toc11785096)

[Setting the scene 7](#_Toc11785097)

[What are we doing well? 7](#_Toc11785098)

[What do we need to do differently? 7](#_Toc11785099)

[What will it look like when we get there? 8](#_Toc11785100)

[The task ahead of us 8](#_Toc11785101)

[Addressing risk and protective factors 8](#_Toc11785102)

[Addressing inequity 9](#_Toc11785103)

[Addressing the wider determinants of health and wellbeing 9](#_Toc11785104)

[*Every life matters* – the Strategy 11](#_Toc11785105)

[Drivers for change 11](#_Toc11785106)

[The Enablers 11](#_Toc11785107)

[The Action Areas 11](#_Toc11785108)

[Drivers for Change 12](#_Toc11785109)

[Working together 12](#_Toc11785110)

[Doing things differently 12](#_Toc11785111)

[Partnering with Māori 13](#_Toc11785112)

[Tūramarama ki te Ora ‘Bringing Light to the Darkness’ 14](#_Toc11785113)

[Trauma-informed 15](#_Toc11785114)

[Collective ownership 16](#_Toc11785115)

[Our shared values. 17](#_Toc11785116)

[Seeing the future 18](#_Toc11785117)

[*Every life matters* *Suicide Prevention Action Plan 2020–2025* 19](#_Toc11785118)

[Understanding the Action Plan 20](#_Toc11785121)

[Action Area outcomes 21](#_Toc11785123)

[The Enablers 22](#_Toc11785155)

[Enabler 1: Establish national leadership 22](#_Toc11785156)

[Enabler 2: Using evidence to make a difference 23](#_Toc11785157)

[Enabler 3: Developing workforce capacity and capability 24](#_Toc11785158)

[Enabler 4: Monitoring and evaluating *Every life matters* 25](#_Toc11785159)

[The Action Areas 26](#_Toc11785160)

[Action Area 1: Promoting wellbeing 26](#_Toc11785161)

[Action Area 2: Responding to suicidal distress 28](#_Toc11785163)

[Action Area 3: Responding to suicidal behaviour 30](#_Toc11785165)

[Action Area 4: Supporting individuals, whānau and communities impacted by suicide 32](#_Toc11785166)

[What can I do to help prevent suicide? 34](#_Toc11785167)

[Individuals, family, whānau and communities can promote wellbeing 34](#_Toc11785168)

[Individuals, family, whānau and communities can learn to recognise suicidal distress and provide support 37](#_Toc11785172)

[Supporting individuals, family, whānau and communities impacted by suicide 39](#_Toc11785173)

[Appendix 1: Definitions for terms used throughout this document 40](#_Toc11785174)

[Appendix 2: Risk and protective factors relating to suicide 41](#_Toc11785175)

[Appendix 3: Considerations for specific population groups in Aotearoa New Zealand 42](#_Toc11785176)

[Appendix 4. References 47](#_Toc11785177)

**Appendix 5. Bibliography……………………………………………………………………………….48**

# **Foreword**

**[placeholder]**

# **Executive Summary**

Every year in Aotearoa New Zealand more than 500 people die by suicide, with many more people thinking about and attempting suicide. The impact of suicide is far-reaching, often touching the lives of many peers, friends, families, whānau, iwi, and wider communities.

Suicide is preventable and *Every life matters* provides us with a unique opportunity to reset our thinking. By using key drivers of change, we can make significant progress towards reducing our suicide rates. By working together, doing things differently, partnering with Māori and underpinning our work with a trauma-informed lens, we have the ability to establish a platform for a new way of working. We cannot continue to do as we have always done and expect to get different results.

Recent public consultations have given us a wealth of information about what we are doing well, and what we are not doing well. While we know that there are many strong programmes, impactful initiatives and a compassionate workforce in suicide prevention, we also know that there are key features of a strong suicide prevention foundation that are currently missing or need attention. *Every life matters* aims to guide new ways of working and providing national leadership, a national suicide prevention research plan, ongoing workforce development and meaningful evaluation will offer a solid platform for addressing these gaps.

*Every life matters* requires leadership and direction for the collective ownership and actions needed to better prevent suicide and support people affected by suicide. No single person, organisation or agency can do this alone, but every person can make a difference.

***Every life matters* has two parts**

1. **The New Zealand Suicide Prevention Strategy** which outlines the framework for the direction of suicide prevention efforts in New Zealand.
2. **The New Zealand Suicide Prevention Action Plan** which identifies specific areas for action to achieve our vision.

This document may contain terms you are not familiar with. **Appendix 1** has a list of terms and their definitions used throughout this document.

**The vision**

**Ka kitea te pae tawhiti, kia mau ki te ora See the broad horizon, hold on to life**

**We believe that every life matters and by working together, we can achieve a future where there is no suicide.**

# **Setting the scene**

## **What are we doing well?**

Much of the work we are doing in suicide prevention is moving in the right direction. We are training communities and people who work with at-risk populations to recognise and respond to suicidal distress; we have a long-term anti-discrimination campaign which reduces stigma around asking for help for mental distress; we provide programmes in schools and workplaces that promote wellbeing and help-seeking; and we have a range of skilled services and supports available to empower families, whānau and communities to support each other. We offer a number of services and programmes by Māori, for Māori. We have done some work to prevent particular methods of suicide and are working to better understand more ways to do this. Both primary and specialist mental health and addiction services are providing services for many people which keeps them safe and supports their recovery. For the most part, many of these activities, programmes and services are working well and achieving positive outcomes for people experiencing distress.

## **What do we need to do differently?**

Best practice in suicide prevention agrees that all of the activities we do are a vital and important part of suicide prevention[[1]](#endnote-2). The World Health Organization, amongst other international leaders, gives clear direction on action that needs to occur to prevent suicide[[2]](#endnote-3). Much of the work that we already do is in keeping with best practice resulting in a relatively stable suicide rate over the last 10–15 years, but if we are to reduce the rate of suicide we need to do better. Every life matters and every death by suicide is one too many.

We need to ensure all of our suicide prevention actions are carried out to their full potential, are efficient and effective. This means ensuring services and supports are sufficiently resourced and accessible for people and communities when and where they need them. Services must be well-integrated, flexible and be adequately monitored and evaluated. Most importantly these services need to be supported by a compassionate, culturally-responsive and trauma-informed workforce.

## **What will it look like when we get there?**

Having a shared vision of what the future should look like will enable everyone to play a role in preventing suicide. We want to achieve a future where every person in Aotearoa New Zealand knows and believes that their life matters; where each person has a strong sense of identity, is connected and included; where suicidal distress is met with compassionate, culturally-safe and trauma-informed responses which support healing and recovery and where people whose lives have been impacted by suicide are surrounded by supportive services.

# **The task ahead of us**

## **Addressing risk and protective factors**

A common way of understanding suicide and opportunities to prevent suicide is centred on reducing factors known to increase the likelihood of suicide (risk factors) and factors that are known to reduce the likelihood of suicide (protective factors)[[3]](#endnote-4) . These exist at the individual, relationship, community and societal level as outlined in Appendix 2. Strategies to counter these risk factors cover three levels of impact[[4]](#endnote-5).

1. *Indicated* strategies target specific vulnerable individuals for example community support; follow-up for people who have attempted suicide; workforce education and training, and improved identification and management of mental and substance use disorders.
2. *Selective* prevention strategies target vulnerable groups such as persons who have suffered trauma or abuse, the Rainbow and Refugee communities, and persons bereaved by suicide through supports such by training others to recognise and respond to suicidal distress or using accessible helplines.
3. *Universal* prevention strategies, which are designed to reach an entire population, may aim to increase access to health care, promote mental wellbeing or promote responsible media reporting.

We need a mix of all types in order to make a difference. More importantly, we also need to make sure that the actions we undertake address the needs of the population in question – for example, suicide prevention activities for middle-aged men will look different to those for Rainbow youth, and vice versa[[5]](#endnote-6).

*The Every life Matters* Action Plan has a wide range of actions which fall across this continuum of action, from gatekeeper training to addressing specific vulnerable populations, to increased support options for people who are distressed and improved response, to whānau and communities who have been impacted by suicide. Certain populations or people may have more risk factors than others, and many experience cumulative risk factors; or may have less ability to increase protective factors. In order to fully understand and respond to the needs of these populations, we need to understand the wider determinants which drive inequitable outcomes.

## **Addressing inequity[[6]](#endnote-7)**

Suicide affects everyone but some populations such as Māori, youth, men and people who use mental health and addiction services are more likely to die by suicide. Pasifika and Rainbow communities, and people who are bereaved by suicide are also disproportionately affected.

We know there are also population groups that may be at higher risk of suicide because they experience a large number of risk factors and have fewer protective factors, for example difficulty accessing wellbeing and suicide prevention supports and services. These groups include Asian communities, refugees and migrants to Aotearoa New Zealand, people living rurally, people with disabilities, older people, children and young people in care, and people in prison.

## **Addressing the wider determinants of health and wellbeing**

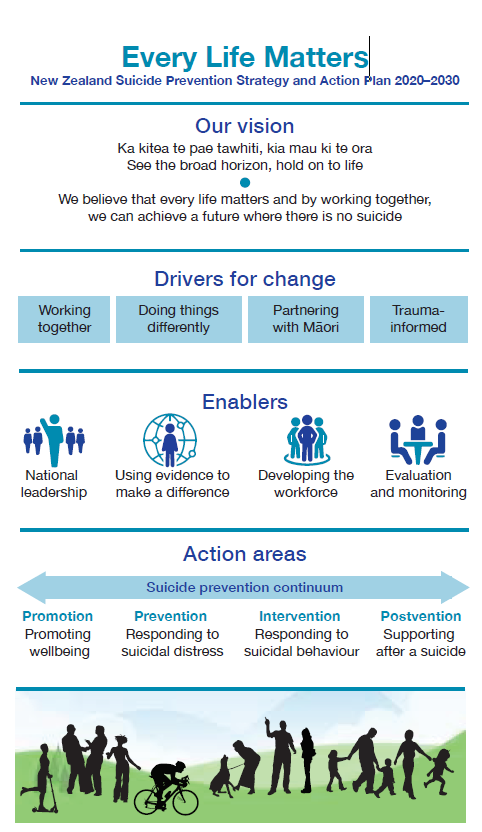
Many of the risk and protective factors for suicide are linked to broader determinants of health and wellbeing. To successfully prevent suicide we need to think broadly about addressing these factors. Our Government is committed to improving wellbeing and living standards for everyone in Aotearoa New Zealand. This has seen record levels of investment into Aotearoa New Zealand’s long term challenges including child poverty, family and sexual violence, homelessness and mental health. New commitments are supporting services to break the cycle of harm, enabling whānau to support their children and additional funding for crisis and peer support services, including those catered to male victims and survivors of sexual violence.

Aotearoa New Zealand already has a range of services and programmes that contribute to reducing the risk factors for suicide or increasing protective factors. The wider transformation of Aotearoa New Zealand’s approach to mental health and addiction is part of the Government’s response to *He Ara Oranga, Report of the Inquiry into Mental Health and Addiction.* There are also several strategies and plans that guide the way we deliver health services in Aotearoa New Zealand, including: the New Zealand Health Strategy; the New Zealand Disability Strategy; He Korowai Oranga – Māori Health Strategy; the Pacific Health Action Plan; and the Child and Youth Wellbeing Strategy.

Not all of these services and programmes are outlined in *Every life matters* but are being or will be implemented over the coming years as part of other strategies, policies and programmes. This wider work aims to improve people’s wellbeing and respond more effectively to the unique and complex needs of all individuals, families, whānau and communities. These all contribute to a change in how we approach suicide prevention and respond to people needing support.

***Every life matters* – the Framework**

The *Every Life Matters* Framework outlines the task ahead. It is necessary to underline our future with an aspirational goal, a clear sense of direction, by building a strong platform for change and taking actions that will achieve the goal.



# ***Every life matters* – the Strategy**

## **Drivers for change**

The framework for the strategy provides a clear direction for the next 10 years. Change will not happen on its own and if we are to achieve the vision we must all commit to the strategy to guide our work moving forward. If we are to have greater impact, **working together** towards a shared vision, is paramount.

Our suicide rates remain stubbornly high. We cannot continue to do as we have always done and expect different results. *Every life matters*signals our commitment to **doing things differently** and changing the direction of suicide prevention.

**Partnering with Māori** to address suicide preventionis critical to setting the foundation for pae ora (healthy futures for Māori) and achieving equitable health outcomes for Māori. The principles of partnership, participation and protection will underpin the way Government and hapū, whānau and Māori communities work together to prevent suicide in Aotearoa New Zealand.

**Trauma-informed responses** take a mana-enhancing, strengths-based approach that creates opportunities for people experiencing suicidal distress to have their past experiences acknowledged through services which promote healing and recovery.

## **The Enablers**

Outlined in the accompanying Action plan, the enablers will help to establish a solid platform for our work within suicide prevention. These include the establishment of the Suicide Prevention Office to support **national leadership** and the delivery, **evaluation and monitoring** of *Every life matters.* Ensuring that our service responses are compassionate, culturally responsive and trauma informed will need to be underpinned by **using evidence to make a difference** and **developing the workforce** to have the capacity and capability to respond.

## **The Action Areas**

Also detailed in the Action plan, the four action areas cover the suicide prevention continuum and aim to increase protective factors and reduce risk factors for the population of Aotearoa New Zealand. This includes **promoting wellbeing, responding to suicidal distress** and **suicidal behaviour**, and ensuring that we are **supporting individuals, whānau and communities after a suicide.**

Together these new ways of working offer an opportunity to not only reduce our rates of suicide, but to offer people in distress responses which support their healing and recovery.

# **Drivers for Change**

## **Working together**

Suicide is complex and preventing suicide requires a multi-system, integrated and collaborative approach. *Every life matters* recognises that everyone has a role in preventing suicide. The Government has a responsibility to lead some components of this work but we also need to support services and communities to lead other components.

Working together benefits everyone. It is important that people seeking help in times of distress are able to access services and supports that are working together to deliver a seamless and cohesive response. Navigating services can be confusing and stressful for individuals and their family and whānau. At every point in their patient journey, people should be able to expect and receive coordinated, quality care.

Working together and sharing information between different services removes the need for people to retell their stories of distress to different staff members and helps people and their families and whānau feel culturally safe.

In a mental health sector with limited resources and staff, working together also ensures that both financial and practical resources can be shared and unnecessary duplication removed. Improvements in working together and sharing information will be key as we transition more to whānau and community based responses.

Media (including print, online and social media) can both enhance access to positive key messaging, services and provide hope. Stories of recovery, of ‘finding a way through’ and getting help, contribute to preventing suicide.

## **Doing things differently**

Suicidal distress is a sign that someone has become overwhelmed by life experiences – often, responses that people need to help them through the tough times do not require intervention by mental health and addiction services. Like all mental distress, thoughts of self-harm and suicidal behaviour are best managed in the least restrictive way, ensuring at all times that a person has opportunity to share their distress and receive support that mitigates the reasons behind the distress. This will look different for every person and may require support across a number of life issues.

Making sure that people can find the help they need, when and where they need it is a key vision of this strategy. *Every life matters* is about enabling whānau and communities to provide this level of support. We want to change our direction of care, so that people are able to be within their homes and communities and access the most impactful, and least intrusive support.

*Every life matters* aims to strengthen existing support services, while increasing the range of responses and support available across primary and secondary services. Greater access to services when needed, and responses thatacknowledge the expertise and lived experience of both the distressed person and their whānau are needed.

It is also important that a wide range of responses are available, as every person will want and need different responses, at different times. Having the option of access to several different supports, particularly culturally-responsive and trauma-informed supports ensures that the needs of every person are met. We know too, that there are many services that are providing innovative solutions to families, whānau and communities in need and supporting and promoting this work is a key part of doing things differently.

*Every life matters* also signals a greater commitment to addressing the specific needs of different population groups, especially those at highest risk of self-harm or suicidal distress. We will bring these voices to the table, co-designing, offering insight and walking alongside us. This has already begun with the collective ownership of *Every life matters* and will continue to drive our implementation of the Action Plan.

## **Partnering with Māori**

While *Every life matters* is a strategy for all people in New Zealand, it recognises that Māori leadership of suicide prevention will be critical to achieving these aspirations and reducing the unacceptably high Māori suicide rate.

Māori make a significant contribution to suicide prevention – as tangata whaiora involved in their own recovery, as whānau supporting each other, as key members of the health workforce, and as contributors to decision-making and service delivery.

Effective Māori leadership is essential to ensuring culturally responsive suicide prevention services and supports that achieve high standards of care for Māori and involve continuous quality improvement.

To enable Māori leadership we need to support individuals, whānau, rangatahi, Māori communities and iwi leaders, as well as leaders in mental health and addiction services to champion suicide prevention and achieve positive outcomes for Māori. Strong community engagement by Ministries, Crown agencies and district health boards (DHBs) will provide the foundation for robust partnerships with Māori. This will unlock community leadership, which in turn will support effective whānau, hapū, iwi and community responses.

Achieving better outcomes for Māori is the responsibility of the whole of the mental health and addiction sector. In addition to a culturally responsive sector, kaupapa Māori approaches to mental wellness will be essential in building community and whānau capacity to prevent suicide. As the foundation to Māori society, whānau can provide a significant source of strength and support essential to Māori mental wellbeing. It is important that we invest in Māori whānau to enable them to support each other to achieve pae ora and equity. Investment in building the capacity and capability of the Māori health workforce is also vital to fostering effective Māori leadership.

## **Tūramarama ki te Ora ‘Bringing Light to the Darkness’**

*Every life matters* upholds, and builds on, the Māori vision and solutions outlined in *Tūramarama ki te Ora ‘Bringing Light to the Darkness’ National Māori Strategy for Addressing Suicide 2017-2022[[7]](#endnote-8)*.

*Tūramarama ki te Ora* was developed by Māori organisations and communities and has been endorsed by the National Iwi Chairs Forum. *Tūramarama ki te Ora*’s visionis for ‘all Māori to flourish and to live well into old age.’ To achieve this vision, it sets out the following aims:

* reduce Māori suicidal behaviour with focused support for Māori and their whānau who suffer disproportionately;
* support communities to reduce suicide related suffering, trauma and unresolved grief associated with suicide on whānau, friends and community members; and
* increase Māori wellbeing and resilience in mana enhancing ways.

*Every life matters* partners with and supports these aims by:

* promoting Māori ownership of Māori wellbeing, suicide prevention and postvention
* building on the strengths of Māori whānau, hapū, iwi, and communities
* delivering culturally safe supports and services
* prioritising treatment and management models that take into account preferences for whānau involvement and whānau ora
* using a trauma-informed approach that takes into consideration issues of unresolved grief and/or loss of mana (cultural status)
* providing a suicide bereavement response which reflects and protects the continuation of whakapapa, hapū and iwi structures
* building the evidence-base of what works for Māori whānau, hapū, iwi, and communities to prevent suicide, through promoting research carried out by, with and for these groups.

**Trauma-informed care**

While there are many risk factors which are linked to heightened risk of suicide, experiencing trauma and/or adverse childhood events are seen as the most impactful, particularly where these occur in conjunction with other risk factors[[8]](#endnote-9). Experiencing trauma and/or adverse childhood events impacts on the capacity of individuals to manage additional cumulative stresses, especially where early trauma has obstructed the development of protective factors.

Many people living in Aotearoa New Zealand have experienced, and continue to experience, trauma which may contribute to suicidal distress and behaviours. This may include:

* trauma which is linked to racism and discrimination
* adverse childhood experiences and high rates of family violence and sexual violence
* stigma, discrimination and bullying reflecting cultural, ethnic or identity differences, mental illness, addiction and physical disabilities
* natural disasters including earthquakes, droughts and serious weather events which have impacted people and their environments.

Trauma-informed care is an approach that changes the question of *“What is wrong with you?* to “*What has happened to you?”* This approach validates every person as unique, with strengths and challenges that have developed through their specific life experiences. Another way of looking at this, which encapsulates additional cultural meaning, is using *“What matters to you?”* rather than *“What is the matter with you?* Trauma-informed care is a holistic approach that takes into account the impact of previous lifetime experiences and acknowledges the strengths and challenges that have developed as part of a trauma-informed response[[9]](#endnote-10),[[10]](#endnote-11).

Working with people who have experienced trauma requires a skilled and empathic understanding of the impact of trauma and how this may affect the thinking and actions of different people. It requires the establishment of trusting relationships, supporting a person’s safety and enabling them to lead decisions about their care, to prevent further harm.

International evidence is clear that a trauma-informed workforce which is trained to support people who are experiencing suicidal distress increases the likelihood of positive outcomes including a reduction in the rates of suicide amongst this population[[11]](#endnote-12). Ensuring that the suicide prevention and postvention workforce, and both primary and secondary care workforce are skilled and confident in providing trauma-informed responses is a key action of *Every life matters*.

# **Collective ownership**

By agreeing to collective ownership of *Every Life Matters*, many government agencies, organisations and programmes have made commitments towards Actions and Outcomes of *Every Life Matters*. This brings a wealth of shared knowledge, experience, drive and passion to the work we have ahead of us. As a new way of working, this gives us the best possible opportunity to bring change and positively impact our suicide rates. While government agencies continue to collaborate at the funding, policy and practice level to drive change, many others have a role to play.

**District Health Boards**

While working together is paramount, there is opportunity and at times, a requirement for key stakeholders to take ownership of suicide prevention. DHBs are responsible for the oversight of suicide prevention and postvention responses within their respective populations. They are uniquely placed to understand the risk and protective factors most present in their communities, to see and respond to wider social determinants and to provide services which mitigate the impacts of these challenges. Each DHB is responsible for having a suicide prevention and postvention plan which addresses the needs of their population.

**Non-government health and social agencies**

Providing a range of responses to people who are experiencing suicidal distress is key and ensuring a wide range of compassionate, culturally-responsive and trauma-informed responses is required. Making use of innovative, evidence-informed and impactful services provided by community groups, non-government agencies (NGOs) and Primary Health Organisations (PHOs) will support the changes we need to see moving forward. Other health and social agencies will also need to become a larger part of suicide prevention activities across DHB populations as they work to address risk and protective factors for everyone. As we move more towards greater community-led responses, local government agencies and councils will be called on to respond through the provision of resources and support for community-led initiatives.

**Business and commercial sector**

Workplaces have the ability to be both places of stress and places of support. Initiatives that support a workforce by promoting a culture of wellbeing, educating and training their staff about mental health and suicide, and providing opportunities for compassionate support are key. Ensuring bully-free and inclusive workplaces that enhance connection make a significant contribution to developing a strong and resilient workforce. In some places, specific programmes for specific populations are useful. For example, mental wellbeing and suicide prevention programmes designed specifically for male-dominated workplaces show considerable impact and success amongst this population.

## **Our shared values.**

Working together is important to achieve the vision of *Every life matters*. The values outlined below have been agreed as the foundation for working together to prevent suicide in Aotearoa New Zealand. They outline how we should interact with each other, how we should deliver our services and how we evaluate our work.

**Achieving equity *Oritetanga o te, tika, te pono me te aroha***

Equity recognises that different people with different levels of advantage require different approaches and resources to get equitable health outcomes. We will ensure that we provide fair, just and honest services that are measurable, monitored and evaluated with a view to achieving equitable outcomes for all.

**The Treaty of Waitangi *Te Tiriti o Waitangi***

The special relationship between Māori and the Crown under the Treaty of Waitangi will underpin the way we work with iwi, hapū, whānau, and Māori communities to develop strategies for promoting wellbeing and preventing suicide and support Māori leadership and participation in all areas of suicide prevention, from service design to implementation and evaluation.

**Everybody working together Mahi *kotahi***

Suicide prevention needs a whole-of-society and whole-of-government approach. We recognise the power of working together and the importance of collective community leadership in addressing the causes behind suicide and preventing all suicides.

**People powered *Rangatiratanga***

All people and communities decide what is best for them and determine how health & social services are designed and delivered to meet their needs. A range of services is available to support individual choices.

**Family centred *Whānau ora***

Each community, whānau, family and individual have their own sense of identity and connection that affirms confidence, safety and security. We will include family and whānau in decision making about their care and support them to achieve their maximum health and wellbeing.

**Healthy environments *Wai ora***

We acknowledge that the environments in which people live, work, play and learn have a significant impact on their health and wellbeing. We will work across government to address the broader determinants of health.

**Treating people with dignity *Whakamana tangata***

We will provide services that are respectful of each person’s unique identity, human rights and needs. It is about shared respect, meaning, knowledge and experience of learning, living and working together with dignity and truly listening.

**Trauma informed responses *Poipoia ngā mamae***

Using a strengths-based approach that is grounded in an understanding of, and responsiveness to, the impact of trauma; that emphasises the cornerstones of safety and healing; and creates opportunities for individuals and communities to lead and achieve mauri ora (wellbeing)

**Evidence informed *Mātauranga Māori***

We acknowledge both the expertise of lived experience and of those working in the sector; as well as the best practice evidence, including scientific evidence and mātauranga Māori (Māori knowledge).

## **Seeing the future**

On this journey ahead, it is always important to see the future. Below are options for new ways of working that have been developed using the voices of those with lived experience of suicidal distress, behaviour and suicidal bereavement.

*Dean works on the mental health crisis team and takes a call from a young man Jo’s mum who says that Jo is distressed and suicidal. She doesn’t know how to help him. As he is currently safe, Dean notifies the suicide crisis outreach team who go to Jo, and spend time with his friends and family teaching them how to support Jo. The suicide crisis outreach team offer ongoing immediate contact until the period of distress has passed. Jo is intensively supported for a further two days and feels that his life matters*

*Margaret has becomes isolated and depressed at home since a fall last year, which prevents her from driving. Her GP suggests she contact the local council who provide a free pickup service for older people who are happy to help local primary schools with reading support*

*Daniel has disengaged with school following the death of his best friend in a car accident. Daniel’s school sees his need and links him up to free local counselling, a school-based mentor and provides information to his parents on how to support Daniel. This information includes how to recognise signs of suicidal distress*

*Mike has recently lost his partner to suicide. The DHB postvention team work with Mike to understand his immediate and long-term needs. They link him to counselling for himself and his teenage children, provide resources for his workplace to support him through the postvention period and ensure that he has a network of community provider supports*

*.*

*Steve is worried about Carter who is a few months into a new job working on Steve’s farm but seems isolated and lonely. Carter tends to binge drink on the weekends and has recently broken up his girlfriend. Steve contacts Young Farmers who offer networking opportunities and social events for Carter, including an event where young farmers are invited to bring along experienced work colleagues who can act as mentors*

*Jake’s whanau are distressed following a near-fatal suicide attempt by Jake, which was witnessed by his children. This is the third suicide within their whānau in two years. Jake and his whānau are supported by the local marae who are trained to address their bereavement needs. The local community centre helps the whānau to access several practical supports, which reduces everyday stress for Jake and his whānau*

*David provides evidence-based at-work training around wellbeing and suicide prevention, which includes education on how to recognise and respond to people experiencing distress. His team use the programme resources to develop a range of strategies to support each other*

*.*

*Michaela is a nurse in the Emergency Department and is seeing Kiriana, who has had depression since she was 15, following significant adverse childhood events. Kiriana sometimes uses self-harm to cope with overwhelming emotions and has a trauma-informed care plan that ensures she receives a safe, compassionate response when presenting for help. Michaela and the ED peer supporter work together to ensure the plan is followed. The peer supporter refers Kiriana to a peer-based education service*

*A group of young people who have lost 4 friends to suicide from within their community want to do something for their community around suicide. They use information from the Suicide Prevention Office website and the local DHB Suicide Prevention Coordinator to develop a safe, education-based event for their local community*

*Karla is struggling with her sense of identity and purpose following a move to a new city and to a large organisation. Karla’s has recently experienced homophobia and is reluctant to initiate friendships. Karla uses her workplace volunteer programme to volunteer with a Rainbow organisation who support her to build a new network of friends*

# ***Every life matters***

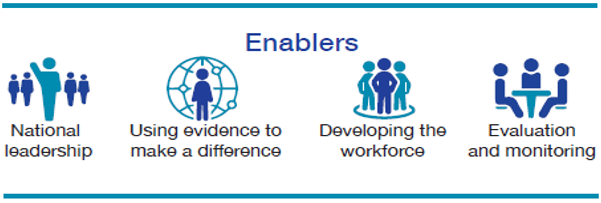
# **Suicide Prevention Action Plan**

# **2020–2025**

## **Understanding the Action Plan**

The Action plan is made up of two sections: the Enablers and the Action Areas. The Enablers are activities being taken to provide a solid foundation for suicide prevention across Aotearoa New Zealand. The Action Areas are specific actions taken to prevent suicide. Responsibility for most actions lie with more than one agency or organisation; and most are new or enhanced actions. Some of the existing and ongoing suicide prevention activities which are available for the general population are listed in the next *section, What can I do to help prevent suicide?*

**Enabler Outcomes**



**Enabler 1: Establishing national leadership**

*Outcome: A national Suicide Prevention Office is established*

**Enabler 2: Using evidence to make a difference**

*Outcome: A national information, data and research plan is developed and implemented*

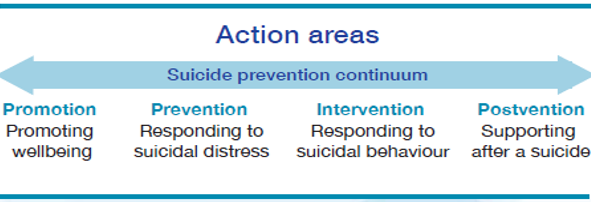
**Enabler 3: Developing workforce capacity and capability**

*Outcome: The suicide prevention and postvention workforce is capable and strengthened*

**Enabler 4: Monitoring and evaluating**

*Outcome: The outcomes of Every life matters are achieved*

**Action Area Outcomes**



## **Action Area outcomes**

**Action Area 1: Promoting Wellbeing**

*Outcome: Programmes which enrich our sense of identity, increase connection and foster inclusion are supported*

* All people can access information about programmes that support identity, connection and inclusion
* Children and young people feel accepted, connected, are active and enjoy positive relationships at school
* Young people are supported through life transitions; and feel connected to communities around them
* Young people build resilience and have a positive future
* Additional digital media and online self-help tools are available for help-seeking
* All media relating to suicide is published within Suicide Media Guidelines

**Action Area 2: Responding to people experiencing suicidal distress**

*Outcome: People experiencing suicidal distress receive compassionate, trauma-informed and culturally safe responses that maintain their mana and safety, and support their recovery*

* Places where we learn, work and live recognise suicidal distress and provide access to support
* Investment in Māori and Pacific suicide prevention programmes
* Increased range of responses for Māori experiencing suicidal distress
* Increased range of responses for Pacific peoples experiencing suicidal distress
* Inclusive practice for the Rainbow community
* People presenting with self-harm are supported to maintain wellbeing
* People experiencing suicidal distress have access to effective early intervention

**Action Area 3: Responding to people experiencing suicidal behaviour**

*Outcome: People experiencing suicidal behaviour receive compassionate, trauma-informed and culturally safe responses that maintain their mana and safety, and support their recovery*

* Māori healing practices are recognised and supported within suicide prevention and mental health services
* Pacific healing practices are recognised and supported within suicide prevention and mental health services
* Management of safety in times of suicidal distress
* People who have attempted suicide have ongoing peer-led support
* People who have attempted suicide have ongoing clinical support
* People experiencing suicidal behaviour are supported within their own whānau and communities
* People in rural populations have access to support when experiencing suicidal behaviour

**Action Area 4: Supporting individuals, whānau and communities impacted by suicide**

*Outcome: Individuals, whānau and communities impacted by suicide are supported*

* Immediate DHB postvention responses are streamlined, collaborative and supportive
* People bereaved by suicide have access to free counselling services
* Schools and places of learning have access to postvention support.
* Cluster and contagions are well managed
* Postvention responses are culturally safe and appropriate for all people of Aotearoa New Zealand
* The Coronial Data Sharing Service works seamlessly
* Information from adverse events is used to inform best practice
* Postvention resources are available for specific groups
* People bereaved by suicide are supported throughout the coronial process

**The Enablers**

Responsibility for the implementation of the enablers will sit not only with the Suicide Prevention Office, but also with the wider suicide prevention sector, including those who have signalled their role in collective ownership of *Every life matters*.

**Enabler 1: Establish national leadership**

A national Suicide Prevention Office will provide a central place for oversight and stewardship for suicide prevention and postvention work across Aotearoa New Zealand.

The Suicide Prevention Office will lead, coordinate and monitor the implementation of *Every life matters*for New Zealand*.* The Suicide Prevention Office will work closely with communities across Aotearoa New Zealand, including populations experiencing high numbers of suicides, such as Māori, young people and people with lived experience of suicidality and other mental health and addiction problems (tangata whaiora), to drive, implement and monitor the Strategy and Action Plan.

|  |
| --- |
| Enabler 1: Establish national leadership |
| Suicide Prevention Office   * Establish a Suicide Prevention Office website * Establish Advisory Groups to lead the work of the Suicide Prevention Office including a Population-based and a Māori Advisory Group * Develop a national communications framework for the SPO, including an SPO webpage with information and resources on suicide prevention. * Work alongside other national and international suicide prevention organisations to develop opportunities for local and national collaboration and integration   Collective ownership   * Streamline existing suicide prevention programmes and reduce unnecessary duplication across government and communities * Work towards joint funding options to enable better cross-government coordination and support for community participation in preventing suicide * Consider current whānau-centred national programmes to identify opportunities for collaboration * Work together to address the broader social determinants of suicide and suicidal distress * All new programmes and initiatives are co-designed with Māori and people with lived experience of mental distress, addiction and / or suicidality. Representation from populations who are at higher risk of suicide are sought and used within programme development, implementation and evaluation. This includes programme specific to Māori, Pacific peoples, men, youth, rural and Rainbow communities, people bereaved by suicide and children and youth in care. |

## **Enabler 2: Using evidence to make a difference**

Access to information at the right time will support the delivery of better services to distressed people, and ensure that their families and whānau are included in their care and recovery. Real time data and expanded research will allow a greater understanding of what is working well and what is not.

The Suicide Prevention Office will be a central place for information on suicide prevention for individuals, families and whānau, community groups and service providers. It will support best practice, and provide information on available services for people in need.

Ongoing research and the development of evidence are critical to improving our response to suicide. We have growing evidence of a range of strategies that work in suicide prevention. What we need to do is better connect the research to our practice, and ensure our work is coordinated across New Zealand while also being relevant to local communities

|  |
| --- |
| Enabler 2: Using evidence to make a difference |
| Suicide Prevention Office   * Set up a Research Advisory Group with membership from people with lived experience, suicide prevention experts, Māori academics and academic institutions. The Research Advisory Group will support the following:   + Develop and implement a national research plan that identifies and addresses gaps in suicide prevention information, data and research   + Work with Māori mental health experts and researchers to develop and implement a Māori research plan   + Set up a research portal for sharing current research and research gaps   + Identify and promote research funding streams   + Publish and disseminate information and research to individuals, whānau and communities * Develop and publish guidance on trauma-informed suicide prevention for service providers   Collective ownership   * Identify and address gaps in current suicide prevention data collection and sharing * Identify opportunities for data integration to support suicide prevention research and development of best practice * The development of new activities, programmes and initiatives is evidence –informed and evaluated * Information sharing amongst the suicide prevention sector is supported by intentional collaborative relationships * Support the Crown’s response to the Waitangi Tribunal Health Services and Outcomes Inquiry (Wai 2575) specific to suicide prevention and postvention. |

## 

## **Enabler 3: Developing workforce capacity and capability**

There are many people working in roles which support suicide prevention and postvention across Aotearoa New Zealand. For the most part, these roles are delivering services which are supportive of best practice.

We also have an untapped peer and whānau workforce, whose roles and expertise are invaluable and needs to be acknowledged.

As a general rule, suicide prevention and postvention training received by people in roles that are in a position to help is variable and inconsistent. Furthermore, as we seek to enhance community-driven responses the workforce will change, creating new areas of training need.

We need a workforce that has the skills and capacity to meet current and future needs, is trauma-informed and culturally responsive. This means both developing new skills and strengthening or enhancing others.

|  |
| --- |
| Enabler 3: Developing workforce capacity and capability |
| Suicide Prevention Office   * Alongside workforce centres and expertise, develop a suicide prevention and postvention workforce plan with a focus on increasing the peer and Māori suicide prevention workforce * Utilise new and existing training programmes and resources (including e-learning tools) to build the competency of the mental health, addiction and suicide prevention workforce (including community and clinical champions, peer support workers and whānau, hāpu and iwi) * Consider opportunities for a national suicide prevention qualification for the community suicide prevention workforce * Develop a suicide prevention workforce competency-based framework   Collective ownership   * Support development and implementation of the suicide prevention workforce plan * Additional focus on growing the Māori and Lived Experience workforce is apparent and intentional * All primary and secondary mental health and addiction service staff have access to suicide prevention training appropriate to their role * All suicide prevention training is culturally responsive, trauma-informed and is co-developed with people with lived experience of suicidality * All frontline government agencies (including Emergency Services and NZ Defence Force) have access to mental health literacy and suicide prevention training and development. * The cumulative trauma of the first responder roles is recognised and supported by first responder agencies. These agencies provide traumatic incident support, access to psychological services and supervision to all staff |

## **Enabler 4: Monitoring and evaluating *Every life matters***

Accountability for monitoring the ongoing implementation of *Every life matters* will sit within the Suicide Prevention Office, however responsibility for the delivery of Every life matters lies across multiple organisations and agencies. We are committed to the fulfilment of each outcome and progress or completion is expected on all associated activity by the end of 2024.

Evaluation of the success of *Every life matters* will be developed using a range of measures. While the ultimate success of *Every life matters* will be seen within the suicide rate, this is not the only measure we need to look at to understand progress and changes in suicidal distress and behaviour.

In order to ensure a meaningful evaluation of *Every life matters*, the Suicide Prevention Office will work alongside research expertise, Māori and people with lived experience to develop meaningful outcomes. For example a range of measures which indicate changes in knowledge, attitudes and behaviours relating to suicide, feedback on the care they received or the cultural safety of responses.

It is important to note that the wider transformation of mental health and addiction services, has a range of proposed services changes which will contribute to the outcomes of *Every life matters* and not all changes will be attributable to one specific activity. However, there are a number of discrete measurements which will be used such as self-harm presentations/ suicide attempts, waiting times and discharge planning. The Suicide Prevention Office will produce an annual report on suicide prevention activities and progress against the actions outlined in *Every life matters*.

|  |
| --- |
| Enabler 4: Monitoring and evaluating *Every life matters* |
| Suicide Prevention Office   * Co-design a monitoring and evaluation plan for *Every life matters* with the SPO Advisory Groups (or other representative groups and experts) which determines individual organisational responsibility where appropriate * Work alongside key agencies and organisations to gather data, information and evaluative reports which contribute to the monitoring and evaluation of *Every life matters* * Produce an annual report on the implementation of *Every life matters*   Collective ownership   * All agencies with responsibility for actions in the Action Plan provide an annual update to the Suicide Prevention office feed into the annual report on *Every life matters* * Evaluation of activities, programmes and initiates is co-designed with people with lived experience of suicidality. * Utilise information provided by the DHB quality improvement programmes which contributes to better outcomes for people experiencing suicidal distress * NGOs, PHOs and DHBs provide timely accurate data to support the ongoing monitoring of suicide and suicidal behaviour |

# **The Action Areas**

**Fund programmes which enrich sense of identity, connection and inclusion**

**Provide increased support for children and young people in places of learning**

**Support programmes and activities which reduce bullying in schools and workplaces**

**Promote safe, positive media stories of recovery**

**DHBs lead service-based and community-based suicide prevention and postvention within their populations**

**Key Actions**

## **Action Area 1: Promoting wellbeing**

Mental wellbeing is more than just good mental health. Good health is made up of four key cornerstones: physical health; mental health; family and whānau health and spiritual health[[12]](#endnote-13). Good mental health includes being resilient or able to bounce back from stressful or challenging experiences. Having both individual and community strength, resilience, capacity and cohesion provide the best possible environment for wellbeing to flourish.

There are multiple ways that promoting wellbeing reduces the risk of suicidal distress. Many programmes and activities are available to support overall wellbeing, however three distinct protective factors have been voiced by the people of Aotearoa New Zealand as being fundamental to reducing suicide risk. **To prevent suicide, we need to strengthen our sense of identity; reinforce our connection to others, to land and to place; and feel accepted and included by others.**

Young people, in particular, need safe, strong personal relationships, a sense of purpose for the future and a surrounding community that promotes and supports their wellbeing. Young people often experience multiple life transitions including moving to different schools, entering the workforce or further education and moving away from their family home. Providing support to navigate these changes reduces stress and supports successful transitions to new life stages. There is growing evidence of the need for specific programmes for some populations groups which are tailored to their specific audience. For example, using specific programmes for men or transgender people, which are better able to support identity, connection and inclusion within that population group[[13]](#endnote-14),[[14]](#endnote-15).

Those experiencing tough times need to access help early and know that such help exists and that it can make a difference. Media (including print, online and social media) can play a key role in driving a positive narrative around suicide.

| Action Area 1: Promoting wellbeing | | | |
| --- | --- | --- | --- |
| Outcome | 2020–2021 | 2022–2023 | 2024 |
| All people have information about programmes which support identity, connection and inclusion | The SPO website shares programmes and initiatives which support a strong sense of identity, connection and inclusion. DHB Suicide Prevention Coordinators work with local government agencies, Māori and community groups to identify and promote wellbeing activities for youth and adults | The SPO promotes wellbeing websites to support stories of people with strong self-identity, connection and inclusion**.** Community-based initiatives are providing programmes with a focus on populations such as men and Rainbow communities | The SPO develops a register of programmes on the website. Community-based programmes are occurring |
| Children and young people feel accepted, connected, are active and enjoy positive relationships at school | Resources are provided for teachers and communities which support inclusive education. Enhancement of *School Based Health Services (SBHS)* in all publicly-funded decile 1–4 secondary schools and expansion of SBHS to select decile 5 schools | Ongoing enhancement of resources provided for teachers and communities which support inclusive education. Ongoing monitoring, evaluation and enhancement of *SBHS*, supported by improved data collection and workforce training | Uptake of resources is promoted, monitored and evaluated (ongoing). Evaluate, monitor and enhance *SBHS* (ongoing). |
| Young people are supported through life transitions; and feel connected to communities around them | The *School Leavers Toolkit* supports students to transition from high school into further opportunities. Establishment of a relationship-based transition response service for young people transitioning from care and youth justice to provide them with practical and emotional support for their wellbeing | Ongoing availability of the *School Leavers Toolkit,* while considering opportunities to further support student transitions. Implementation of a relationship-based transition response service for young people transitioning from care and youth justice services | Evaluation of uptake of the *School Leavers Toolkit* (ongoing). Ongoing evaluation of the care and youth transition response service. |
| Young people build resilience and have a positive future | Delivery of a range of programmes by community-based organisations which employ a youth development approach supporting the wellbeing of young people, especially Rainbow and rural youth. | Ongoing delivery and enhancement of programmes by community-based organisations support the wellbeing of young people | Ongoing evaluation and monitoring |
| Additional digital media and online self-help tools are available for help-seeking | The SPO considers and promotes digital media and online self-help tools through the website. DHBs and Primary Health Organisations provide access to online tools for patients. | Ongoing promotion of a wide range of digital media and online self-help tools through the SPO webpage that respond to the needs of different population groups | Assess programme uptake and evaluation |
| All media relating to suicide is published within Media Guidelines | Develop new Suicide Media Guidelines with an additional focus on social media and entertainment | Implement and monitor the new Suicide Media Guidelines with an additional focus on social media and entertainment | Stocktake of programme uptake and evaluation |
| DHBs manage suicide prevention | Every DHB has a population-based suicide prevention and postvention plan in place, which addresses current need, gaps and future suicide prevention direction | Every DHB has a population-based suicide prevention and postvention plan in place, which addresses current need, gaps and future suicide prevention direction | Plans are implemented and evaluated |

## **Action Area 2: Responding to suicidal distress**

**Empower individuals to recognise and support someone experiencing suicidal thinking**

**Develop programmes that support cultural healing practices**

**Develop appropriate resources to support people who use self-harm to manage distress**

**Increase the range of early intervention responses**

**Enable whānau and community-led support for people experiencing suicidal distress**

**Key Actions**

It is not uncommon for people to be overwhelmed, to see no way out, or to have no hope that things can be different. Sometimes people are scared of their suicidal thoughts, or worried that they will act on them. While thinking about suicide is common, not everyone who thinks about suicide goes on to develop a plan or carry it out. Being able to recognise that someone is distressed and thinking about suicide and having the confidence to talk to them can open a door to early intervention and support before things become even more difficult.

Being able to easily access culturally-safe services is key to reducing suicidal distress. Kaupapa Māori services and services by Pasifika, for Pasifika provide responses which continue to foster identity and connection, while offering culturally-based healing practice provide the best possible opportunity for services which maintain the dignity and rights of individuals.

Every person who experiences suicidal distress needs to receive compassionate and caring responses that show their life matters. Acknowledging that self-harm and suicide attempts are a sign of distress can lead to a compassionate response, rather than one which draws shame and guilt. Appropriate responses at this point in time, can lead to a reduction in future risk factors.

Early intervention when someone is experiencing distress is important. Options for support need to be wide-ranging, flexible and responsive to the needs of each person seeking help. Primary Care Organisations and DHBs have a responsibility to provide pathways of support which are accessible at the earliest opportunity. For example, having immediate mental health and support services available within PHOs, seamless transitions to secondary services if needed and a range of secondary care options such as home based treatment, peer respite and community-based services.

| Action Area 2: Responding to suicidal distress | | | |
| --- | --- | --- | --- |
| Outcome | 2020–2021 | 2022–2023 | 2024 |
| Places where we learn, work and live recognise suicidal distress and provide access to support | Co-design a programme of activity to recognise and support the needs of young people in schools experiencing suicidal distress.  Ensure young people in care and people in correctional facilities have access to intervention and support when experiencing self-harm or suicidal distress  National suicide prevention and mental health literacy programmes are available. | Ensure school-based suicide responses are streamlined, appropriate and meeting the needs of all children.  Young people in care and people in correctional facilities continue to access intervention and support  Workplaces provide suicide prevention training.  National suicide prevention and mental health literacy programmes are targeted at people working alongside high-risk populations. | Evaluate school-based services (ongoing).  Evaluate in-care and correction-based programmes  Monitor suicide prevention training programmes. |
| Investment in Māori and Pacific suicide prevention programmes | Work with Māori and Pacific peoples to review current government investment in Māori and Pacific DHB and NGO suicide prevention services | Ensure future investment in Māori and Pacific suicide prevention is evidence-informed and achieving improved outcomes for Māori and Pacific peoples | Monitor ongoing investment (ongoing) |
| Increase responses for Māori experiencing suicidal distress | Develop additional evidence-informed programmes to support Māori experiencing suicidal distress, which provide a wider range of options. | Implement, monitor and enhance evidence-informed Māori suicide prevention services | Evaluate services (ongoing) |
| Increase responses for Pacific people experiencing suicidal distress | Develop additional evidence-informed programmes to support Pacific peoples experiencing suicidal distress, which provide a wider range of options. | Implement, monitor and enhance the evidence-informed Pacific suicide prevention services | Evaluate services (ongoing) |
| Inclusive practice for the Rainbow community | Work with the Rainbow community to develop guidance on inclusive practice | Work with the Rainbow community to implement guidance on inclusive practice | Evaluate implementation |
| People presenting with self-harm are supported to maintain wellbeing | Co-design self-harm prevention resources and guidelines with people with lived experience, for whānau, schools and health services. | Publish self-harm prevention resources and guidelines online. Enhance support for health services to respond to people presenting with self-harm | Consider options to develop digital resources to prevent self-harm |
| People experiencing suicidal distress have access to effective early intervention | District Health Boards are supported to develop or enhance a wide range of early intervention options for people experiencing suicidal distress, which address service gaps and future suicide prevention direction. | District Health Boards provide a range of early intervention and care responses to meet the needs of people experiencing suicidal distress, which address services gaps and future suicide prevention direction | Monitor, evaluate and enhance responses (ongoing) |
| People experiencing suicidal distress are supported within their whānau & communities | District Health Boards begin work towards the development and implementation of whānau and community-led responses for people experiencing suicidal distress. | District Health Boards provide ongoing support for and implementation of whānau and community-led service models for those experiencing suicidal distress | Monitor, evaluate and enhance whānau and community-led service models (ongoing) |

## **Action Area 3: Responding to suicidal behaviour**

**Support increased use of Māori and Pasifika healing practices within suicide prevention and mental health service responses**

**Engage with people with lived experience to develop key guidance for services on how to manage safety when someone is at risk of suicide**

**Provide better support for rural communities to access support**

**Support innovative, community-led responses for people at risk of suicide**

**Enhance post-suicide attempt telehealth support, including use of peer support**

**Promote safe, positive media stories of recovery**

**Key Actions**

Having timely access to appropriate, high-quality clinical services and care is critical when someone’s safety is at risk. This contact presents an opportunity to intervene early and to avoid crises from escalating further. Clinicians and frontline staff need to be supported to undertake suicide prevention training and cultural safety training to ensure the delivery of quality services. This training needs to be accessible and shared across the health system – not just within mental health services.

While individual services in each DHB can make progress in suicide prevention, the implementation and sharing of best practice and innovation will ensure that DHB services are responsive to the changing needs of their populations.

People with lived experience of a suicide attempt or people bereaved by suicide have unique insights to share about the causes and effects of suicide and suicidal thinking. Peer support workers provide highly-valued insights about the experience of people with mental illness and people bereaved by suicide and are a unique form of support in mental health services. Working with people with lived experience to develop guidance on how to manage safety when someone is at risk of suicide will be a key feature of providing better person-centred responses.

The peer support workforce is an essential and growing component of the mental health system. Making greater use of this workforce, for example to provide post-attempt telehealth support, will ensure that people with distress are connected to a compassionate empathic workforce and positive stories of recovery from suicidal distress.

| Action Area 3: Responding to suicidal behaviour | | | |
| --- | --- | --- | --- |
| Outcome | 2020–2021 | 2022–2023 | 2024 |
| Māori healing practices are recognised and supported within services | Work with Māori to develop resources for DHB, NGO, whānau and community which recognises and supports Māori healing practices. | Work with Māori to develop training resources which recognise and support Māori healing practices. | Monitor and evaluate uptake and use of training resources (ongoing). |
| Pacific healing practices are recognised and supported within services | Work with Pacific peoples to develop resources for DHB, NGO, whānau and community which recognises and supports Pacific healing practices. | Work with Pacific peoples to develop training resources which recognise and support Pacific healing practices. | Monitor and evaluate uptake and use of training resources (ongoing). |
| Management of safety in times of suicidal distress | Co-design with people with lived experience of suicidal distress, national guidelines for the management of risk | Promote guidelines for the management of risk and safety during suicidal distress. | Comprehensive evaluation, review and enhancement of guidelines for the management of risk and safety |
| People who have attempted suicide have ongoing clinical support | Complete a stocktake of current supports available for people who have been discharged from ED or inpatient services | Provide a clear pathway of clinical support for people who have been discharged from ED or inpatient services Peer-led services are prioritised | Evaluate and enhance services, informed by client feedback (ongoing). Review service transitions as part of HQSC work programme |
| People who have attempted suicide have ongoing peer-led support | Design and implement a peer-led telehealth support for people who have attempted suicide and have been discharged to community services | Ongoing delivery and monitoring of peer-led telehealth support for people who have attempted suicide and have been discharged to community services | Evaluate and enhance the peer-led telehealth services (ongoing) |
| Quality-based, evidence-informed approaches are evident | Development of a national quality-based, evidence-informed culturally safe approach to managing suicidal distress within NGO and DHB services | Implementation of a national quality-based, evidence-informed approach to managing suicidal distress within NGO and DHB services | Evaluate and monitor new quality-based approach to managing suicidal distress within NGO and DHB services |
| People are supported within their own whānau and communities | Review current community-led programmes for people experiencing suicidal distress with a focus on programmes supporting those at-risk | Support and promote whānau and community-led programmes for people experiencing suicidal behaviour | Evaluate and enhance whānau and community-led programmes (ongoing) |
| People in rural populations have access to support | Scope additional support for the assessment and monitoring of suicidal behaviour within the rural population | Provide additional support for the assessment and monitoring of suicidal behaviour within the rural population | Monitor and evaluate additional support initiatives (ongoing) |

## **Action Area 4: Supporting individuals, whānau and communities impacted by suicide**

**Implement a free national suicide bereaved counselling service**

**Develop Māori guidance on cultural safety following a death by suicide for a wide range of audiences**

**Increased DHB postvention response to support greater community-led postvention responses**

**Carry out a review of the coronial investigative process, ensuring the voices of families and whānau; and develop a better case management system**

**Key Actions**

The primary purpose of suicide postvention (that is, support provided after suicide) is to support the emotional recovery of the suicide bereaved while preventing contagion or imitative suicidal behaviour. A planned response to support friends and others can be effective in reducing psychological, physical and social difﬁculties in the suicide bereaved. The friends, family, whānau and communities affected by a suicide need supports which walk alongside them and ensure they receive services which optimise opportunities for healing.

Postvention supports can also be preventive, reducing suicide risk by addressing the emotional and mental health needs of those impacted by suicide. People bereaved by suicide, particularly those with a history of previous trauma, suicidal behaviour or depression, may be at-risk in the aftermath of another’s suicide.

Additional funding to support postvention responses within DHBs will be used to support community-led responses. Rebuilding community resilience will in turn work towards the reduction of contagion and cluster events.

A review of the coronial investigative process will provide opportunity for the voices of families, whānau and communities to drive change, and move to a process which validates the impact of suicide and supports healing and closure. Supporting work to provide a responsive, support and compassionate case management system will further address this outcome. This project, a recommendation of He Ara Oranga, will require significant coping and development, and is expected to take 1-2 years to complete. Families, friends, peers and whanau will be invited to be part of this review process.

| Action Area 4: Supporting individuals, whānau and communities impacted by suicide | | | |
| --- | --- | --- | --- |
| Outcome | 2020–2021 | 2022–2023 | 2024 |
| Immediate DHB postvention responses are streamlined, collaborative and supportive | DHB suicide postvention plans promote utilisation of a DHB interagency group to manage postvention activities. Support for community-led responses is promoted and resourced | Continue to implement DHB suicide postvention plans and utilise interagency groups to manage postvention activities. Additional activities are underway which for community–led postvention initiatives | Monitor and evaluate current postvention responses across DHBs (ongoing). Monitor, evaluate and enhance additional activities implemented to support community-led postvention responses (ongoing) |
| Free counselling services are available | Develop a national Suicide Bereavement Counselling Service | Implement and monitor the Suicide Bereavement Counselling Service | Evaluate and enhance the Suicide Bereavement Counselling Service (ongoing) |
| Schools and places of learning have access to postvention support. | Traumatic Incident teams work with schools to maintain positive learning environments following a traumatic incident. | Traumatic Incident teams work with schools to maintain positive learning environments following a traumatic incident. | Traumatic Incident responses are evaluated against best practice (ongoing) |
| Cluster and contagions are well managed and meet current best practice | Develop additional guidance for specific populations groups, e.g. Māori, Pasifika and school-based for the management of cluster and contagion | Implement and monitor suicide cluster and contagion responses | Evaluate and enhance suicide cluster and contagion responses. Monitor the number and location of deaths by suicide (ongoing) |
| Postvention responses are culturally safe and appropriate for all people of Aotearoa New Zealand | Develop national resources to support culturally-safe responses for different populations groups impacted by suicide including Māori, Pacific, refugee, youth, school, rainbow and rural communities. | Promote resources across New Zealand to ensure services are culturally-safe for Māori in the period following a suicide | Evaluate uptake and use of national resources |
| The Coronial Data Sharing Service works seamlessly | Review the Coronial Data Sharing Service | Ensure the Coronial Data Sharing Service provides ongoing information in the most effective and efficient way possible | Monitor and enhance the efficiency and effectiveness of the Coronial Data Sharing Service (ongoing) |
| Information from adverse events is used to inform best practice | The Suicide Mortality Review Committee (SuMRC), continue to investigate suspected self-inflicted deaths to inform best-practice | The Suicide Mortality Review Committee (SuMRC), continue to investigate suspected self-inflicted deaths to inform best-practice | The Suicide Mortality Review Committee (SuMRC), continue to investigate suspected self-inflicted deaths to inform best-practice |
| Specific postvention resources are available | Develop postvention resources for funeral celebrants | Develop postvention resources for workplaces | Refresh resources as needed (ongoing) |
| People bereaved by suicide are supported throughout the coronial process | Scope a government review of the process for investigating deaths by suicide in New Zealand | Review the process for investigating deaths by suicide in New Zealand | Implement recommendations outlined in the review |

# **What can I do to help prevent suicide?**

***We believe that every life matters and by working together, we can achieve a future where there is no suicide.***

Everyone can contribute to suicide prevention and to supporting people when they are distressed. Taking part in programmes which focus on inclusion and connection, and learning to recognise the signs when someone is experiencing suicidal distress, are two ways to better understand how to respond to when people are struggling.

Knowing where you can access help means that you’re also equipped to help others and provide information that may prevent increased distress. It’s important too, to understand the impact of a suicide on another person, and if you see that they need help with their grief and loss, to point them in the direction of further help.

Remember though, that simple, human acts of kindness don’t need training, or qualifications to make a difference. Often people who are distressed are feeling overwhelmed with the challenges life has thrown at them, and being able to share that load with someone else can make a difference.

Below are a range of services and programmes that anyone can access, support, be a part of or let others know about. This is by no means an exhaustive list, and it’s worth keeping an eye out in your community to see if other opportunities are available. The Suicide Prevention Office will continue to foster opportunities for individuals, family, whānau and communities to play their role in suicide prevention.

## **Individuals, family, whānau and communities can promote wellbeing**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Mental health and wellbeing support activities you can be part of*** | ***Te Waka Hourua***  ***for Māori*** | Te Waka Hourua is the national Māori suicide prevention programme, which offer a range of programmes and initiatives to support mental health and wellbeing. This includes education and training, research and community events and supporting rangatahi to lead local initiatives. | [**www.terauora.co.nz**](http://www.terauora.co.nz) |
| ***Te Waka Hourua for Pasifika*** | Te Waka Hourua is the national Pasifika suicide prevention programme, which offer a range of programmes and initiatives to support mental health and wellbeing. This includes education and training, research, community events and supporting young people to lead local initiatives. | [**www.leva.org.nz**](http://www.leva.org.nz) |
| ***Pink Shirt Day*** | Pink Shirt Day is about working together to stop bullying by celebrating diversity and promoting positive social relationships. It’s about creating a community where all people feel safe, valued and respected, regardless of age, sex, gender identity, sexual orientation, ability, or cultural background. | **www.pinkshirtday.org.nz** |
| ***Like Minds, Like Mine*** | Like Minds, Like Mine is a public awareness programme to increase social inclusion and end discrimination towards people with experience of mental illness or distress. We do this through public awareness campaigns, community projects and research. | **www.likeminds.org.nz** |
| ***All Right?* Campaign** | The All Right? campaign supports people to become more aware of their mental health and wellbeing, and to take small and regular steps to improve it. The campaign was launched in February 2013 to support Cantabrians as the region recovers from the earthquakes and has continued to provide support for both the Canterbury and New Zealand ever since. | **www.allright.org.nz** |
| ***Farmer and rural wellbeing*** | ***Farmstrong*** | Farming is a job with a unique set of challenges – many are hard to predict or control. We share farmer-to-farmer tips, supported and informed by wellbeing science. These will help you increase your wellbeing so you can cope better with the ups and downs of farming. | **www.farmstrong.co.nz** |
| ***GoodYarn*** | GoodYarn farmer wellness workshops help participants recognise and respond appropriately to friends, family, farming colleagues or customers suffering from stress or mental illness. | [**www.dairynz.co.nz/people/wellbeing/goodyarn-farmer-wellness-workshops/**](http://www.dairynz.co.nz/people/wellbeing/goodyarn-farmer-wellness-workshops/) |
| ***Rural Support Trusts*** | Are times a bit tough? We are local rural people that know from experience that severe weather, finances, relationships, and work pressures can all mount up. Contact us for a confidential chat about you, your business, the weather, your finances; or a neighbour, partner, friend, family member, or worker. | **www.rural-support.org.nz** |
| ***Getting more information or***  ***help for yourself***  ***when you’re struggling*** | ***The National Depression Initiative*** | We all face challenges to our mental health. Depression and anxiety changes the way we think, feel and deal with tough times. You can follow other people’s journeys to wellness or explore the site to find your own way to a better place  The National Depression Initiative for Māori[**www.depression.org.nz/Māori**](http://www.depression.org.nz/Māori)  The National Depression Initiative for Pasifika **www.depression.org.nz/pasifika** | [**www.depression.org.nz**](http://www.depression.org.nz) |
| ***Mental Wealth*** | The Mental Wealth Project is a mental health literacy education programme for young people. The aim is to equip young people and their families with knowledge, tools and skills to reduce stigma, improve wellbeing, spot warning signs of mental distress, and enhance access to the right care and support when they need it. | [**www.mentalwealth.nz**](http://www.mentalwealth.nz) |
| ***Online support and e-therapy for youth and adults*** | ***The Lowdown*** | The Lowdown is a website to help young New Zealanders recognise and understand depression or anxiety. However you may be feeling, the Lowdown is full of ideas and people who can help you get unstuck and get to a better place. | **www.thelowdown.co.nz** |
| ***Aunty Dee*** | If your problems are getting you down, messing you up or just plain muddling with your brain, talk to Aunty Dee. Aunty Dee is a free online tool for anyone who needs some help working through a problem or problems. It doesn’t matter what the problem is, you can use Aunty Dee to help you work it through. | **www.auntydee.co.nz** |
| ***SPARX (Smart, Positive, Active, Realistic, X-factor thoughts)*** | SPARX is an online e-therapy tool that helps young people with mild to moderate depression. It can also help if you’re feeling anxious or stressed. It was developed with the help of young people and is based on a type of ‘talking therapy’ called Cognitive Behavioural Therapy, or CBT for short. You can do CBT with a counsellor or a psychologist but you can also learn CBT skills from SPARX. | **www.sparx.org.nz** |
| ***The Journal*** | The Journal is a free, personalised online programme. It’s easy to use and all you need is access to a computer or mobile device. John Kirwan, alongside mental health experts, will take you through a series of online lessons to cover everything you need to know: How to stay positive; How to create lifestyle changes that improve mental health, and 3-steps to problem solving | **www.**[**depression.org.nz/get-better/the-journal/**](https://depression.org.nz/get-better/the-journal/) |
| ***Beating the Blues*** | Beating the Blues® is the most widely used and evidence-based online CBT programme for the treatment of depression. It is a way of helping people to learn to cope with anxiety and depression and is available as part of your treatment from your GP. | **www.beatingtheblues.co.nz** |
| ***Supporting wellbeing in workplaces*** | ***Five Ways to Workplace Wellbeing at Work toolkit*** | Mental wellbeing is one of the most valuable business assets. Workplaces that prioritise mental health have better engagement, reduced absenteeism and higher productivity, while people have improved wellbeing, greater morale and higher job satisfaction. | [**www.mentalhealth.org.nz/home/our-work/category/42/five-ways-to-wellbeing-at-work-toolkit**](http://www.mentalhealth.org.nz/home/our-work/category/42/five-ways-to-wellbeing-at-work-toolkit) |
| ***Worksafe*** | The Worksafe Bullying site has a quick guide with advice for workers about what bullying at work can look like, and what they can do if they think they are being bullied, or are accused of being a bully. | [**worksafe.govt.nz/topic-and-industry/bullying-prevention-toolbox/bullying-at-work-advice-for-workers/**](https://worksafe.govt.nz/topic-and-industry/bullying-prevention-toolbox/bullying-at-work-advice-for-workers/) |

## **Individuals, family, whānau and communities can learn to recognise suicidal distress and provide support**

|  |  |  |  |
| --- | --- | --- | --- |
| ***Education and training to upskill your knowledge of mental health and suicide prevention*** | ***LifeKeepers*** | LifeKeepersis New Zealand’s national suicide prevention training programme, created especially for New Zealand communities. You can think of it like first aid training, giving people the skills to recognise and support those at risk of suicide. | [**www.lifekeepers.nz**](http://www.lifekeepers.nz)  **(Online and face to face training)** |
| ***Mana Akiaki*** | Mana Akiakiis New Zealand’s national suicide prevention training programme, created especially for Māori communities. You can think of it like first aid training, giving people the skills to recognise and support those at risk of suicide. | [**www.lifekeepers.nz**](http://www.lifekeepers.nz)  **(Available online and face to face)** |
| ***MH101*** | MH101 is a one-day workshop for New Zealanders who want to learn how to recognise mental illness and distress; relateto those experiencing mental illness or distress and respond appropriately. Specific rural workshops are also available. How to recognise and respond to someone who is experiencing suicidal thinking is also included in the workshop. | [**www.mh101.co.nz**](http://www.mh101.co.nz) |
| ***Flo Talanoa*** | *FLO Talanoa* is a Pasifika suicide prevention education programme for Pasifika communities that is evidence informed, culturally safe and designed to be led by the community for the community. It is a call to action and aligned with the Pasifika values of love, respect and reciprocity. | [**www.leva.co.nz/training-education/flo-talanoa**](http://www.leva.co.nz/training-education/flo-talanoa) |
| ***Getting help for someone who is distressed and/or suicidal and needs to talk*** | ***1737 Need to talk*** | Need to talk? [1737](tel:1737) is designed to meet the needs of anyone who 'wants to talk' to a counsellor. 1737 is not tied to a specific mental health issue or condition and [1737](tel:1737) is free to call or text from any landline or mobile phone, 24 hours a day 7 days a week. Trained mental health professionals are available to respond to calls, texts, webchat and emails. 1737 can also provide connections to other mental health and addiction helplines (depression, gambling and alcohol drug helplines) who will be on hand to support people in need. | **Call or text 1737 any time for 24/7 helpline** |
| ***Lifeline (incl. Suicide Crisis Helpline Tautoko and Kidsline)*** | Lifeline’s mission is to reduce distress and save lives by providing safe, accessible, effective, professional and innovative services. We work specifically to increase awareness and understanding of suicide prevention in New Zealand and reduce the associated stigma and to work with others to make a positive contribution to the health and social sector. | [**0800 LIFELINE (0800 54 33 54)**](tel:0800543354)**or free**[**text HELP (4357)**](sms:4357)  [**0508 TAUTOKO (0508 82 88 65)**](tel:0508828865)  [**Kidsline**](https://www.lifeline.org.nz/services/kidsline)**|**[**0800 54 37 54**](tel:0800543754) |
| ***Samaritans*** | ​Whatever you're going through, call us any time on [**0800 726 666**](tel:0800726666). Samaritans offer confidential, non-religious and non-judgemental support to anyone who may be feeling [depressed](http://www.samaritans.org.nz/issues/depression), [lonely](http://www.samaritans.org.nz/issues/loneliness), or even be contemplating [suicide](http://www.samaritans.org.nz/suicide). We are available 24 hours a day, 365 days a year to chat for any reason. | **24/7 Helpline**  **0800 726 666** |
| ***OUTLine*** | OUTLine welcomes your call to discuss topics around sexuality, gender identity and diverse sex characteristics. They can help you find sources of trusted information, connection to community or peers, and medical or mental health services that welcome LGBTIQA+ /Rainbow people. All calls and callers are confidential and anonymous. Calls are welcomed from LGBTIQA+/Rainbow people, friends and whānau, or professionals who care for them. | **Call us on 0800 688 5463 10am to 9pm weekdays, 6pm – 9pm weekends**  ***Answered by volunteers, leave a message if we can’t answer and we can call you back*** |
|  | ***Youthline*** | Youthline works with young people from all walks of life, from all cultures and with all sorts of things going on in their lives. This can be anything from just wanting to [talk](https://wellington.youthline.co.nz/services/talk-with-someone/) something through (big or small, via TXT, email or phone), to working [face to face](https://wellington.youthline.co.nz/services/talk-with-someone/) with a young person or even their whole family. | **Free call**[**0800 376 633**](tel:0800376633) **Free text**[**234**](tel:234)[**talk@youthline.co.nz**](mailto:talk@youthline.co.nz) |

## **Supporting individuals, family, whānau and communities impacted by suicide**

|  |  |  |
| --- | --- | --- |
| ***Support for suicide bereaved*** | The Mental Health Foundation provides information and advice to help people support themselves and each other after a suicide death. We can link people directly to information about the support available, so no one has to go through suicide bereavement alone. | **www.mentalhealth.org.nz/get-help/suicide-bereavement** |
| ***Skylight Trust*** | We support people of all ages throughout New Zealand who are facing any kind of tough life situation, but we specialise in grief, loss and trauma**.** Skylight also provides counselling services for people going through difficult times in life including grief and bereavement. | **0800 299 100**  **9am-5pm weekdays.**  **www.skylight.org.nz** |
| ***Victim Support*** | Victim Support provide immediate post-suicide response for the suicide bereaved. They are a 24/7 free community response who help victims of serious crime and trauma. They provide emotional and practical support, information, referral to other support services. | **0800 842 846**  **0800 VICTIM**  **www.victimsupport.org.nz** |
| ***Waves*** | Waves is an eight week programme that aims to support adults aged 18 and older who have been bereaved by suicide. The programme combines learning about suicide and bereavement, with group discussion and support. | [**www.skylight.org.nz/build-resilience/waves**](http://www.skylight.org.nz/build-resilience/waves) |
| ***Coronial Services*** | National Initial Investigation Office Co-ordinators manage the cases from the time the death is reported to the Duty Coroner until the person is released from the mortuary. They keep families informed about what’s happening with the post mortem and any body tissue samples, and when the person is released from the mortuary. Coronial Case Managers manage the case once the case has been assigned to a regional coroner until the coroner's finding is sent out to everyone involved. | [**coronialservices.justice.govt.nz/the-familys-rights/**](https://coronialservices.justice.govt.nz/the-familys-rights/) |

# **Appendix 1: Glossary**

**Bereaved by suicide.** When someone has lost a loved one to a suicide.

**Lived experience (also known as tangata whaiora).** This is a term used to describe people who have their own personal experience of mental distress, illness, substance use or addiction. Tangata whaiora means a ‘person seeking wellness’.

**Suicide postvention.** Activities developed by, with or for those bereaved by suicide to support recovery after suicide and to prevent adverse outcomes, including suicidal behaviour.

**Suicide prevention.** Activities undertaken to prevent or reduce risk of the suicide. These activities often focus on increasing protective factors and reducing risk factors.

**Peer support**. A response provided to someone how needs support by people with their own personal lived experience of mental illness or addiction. In suicide prevention, this may also refer to a person with lived experience of suicide bereavement.

**Protective factors.** A range of biological, psychological, social, spiritual, family or community factors that reduce the likelihood of suicide.

**Rainbow community.** An umbrella term used to describe people with diverse sexualities, gender identities and sex characteristics. This includes people with sexual orientations other than heterosexual (for example gay, lesbian, bisexual, takatāpui , queer, pansexual); diverse gender identities (for example trans, transgender, transsexual, takatāpui, whakawahine, tangata ira tane, fa'afafine, fa’afatama, genderqueer, fakaleiti, leiti, akava'ine, fakafifine, vakasalewa, FtM, MtF, non-binary) and diverse sex characteristics (intersex).

**Risk factors.** A range of biological, psychological, social, spiritual, family or community factors that increase the likelihood of suicide.

**Suicide.** When someone has intentionally taken their own life.

**Suicide attempt.**  When someone has attempted to intentionally take their own life. A suicide attempt may or may not result in actual injury.

**Suicidal behaviour.** Behaviours which may occur as a result of suicidal distress and includes, suspected self-injury (self-harm), suicidal distress, suicidal behaviour and suicide.

**Suicidal distress.** When someone is experiencing thoughtsof ending their life which is distressing to them. People may experience either fleeting suicidal ideation or long periods of suicidal ideation. This does not always end in a suicide attempt.

**Suicide cluster.** Multiple deaths occurring more closely together geographically and in time than would be expected for a given community, or linked by established familial, psychological or social connections.

**Suicide contagion.** Suicide contagion refers to the spread of suicidal thoughts, behaviours and deaths after exposure to suicide or suicidal behaviour. Contagion can result following exposure to suicide or suicidal behaviours within one’s family, one’s peer group, community, or through media reporting.

**Tangata whaiora (also known as people with lived experience).** This is a term used to describe people who have their own personal experience of mental distress, illness, substance use or addiction. Tangata whaiora means a ‘person seeking wellness’.

**Trauma-informed care.** Trauma-informed care is a holistic approach that takes into account the impact of previous lifetime experiences and acknowledges the strengths and challenges which have developed as part of a trauma-informed response[[15]](#endnote-16),[[16]](#endnote-17).

# **Appendix 2: Risk and protective factors relating to suicide**

|  |  |  |
| --- | --- | --- |
| **Protective factors** |  | **Risk factors** |
| Problem solving and conflict resolution skills; positive cultural or religious beliefs; financial and employment stability; engagement in bullying-free schools and workplaces, access to secure housing; support for physical health issues; supported life transition | **Individual** | Isolation; loss of cultural identity, language or land; loss of a loved one, job, status or relationship; financial stress; adverse childhood events or trauma, mental illnesses or addiction; chronic health conditions; previous suicide attempt; racism; bullying |
| Stable family routine; good emotional family / whanau relationships; practical and emotional family support connectedness with a specific network, i.e., sports team, work colleagues; freedom from family and sexual violence | **Relationship**  Image result for men sports team silhouette | Exposure to family and sexual violence; sense of isolation and lack of social support; family/whānau/loved one’s history of suicide; difficult work/employment relationships; a sense of isolation, lack of support; bereavement by suicide |
| Community support and connectedness; easy access to various clinical interventions and support; restriction of access to means of suicide; coordinated local prevention and postvention responses; mental health & suicide literacy programmes | **Community**Image result for images community silhouette | Inadequate community connectedness, stigma and discrimination from community, barriers to health care (e.g., within a rural population), communities characterised by deprivation and geographical isolation |
| Anti-discrimination programmes; work and employment programmes addressing stress and bullying; suicide prevention education programmes; funded access to mental health and addiction services; positive media of suicide recovery | **Society**  Image result for images beehive nz silhouette | Poverty, inequality and inequity; discrimination; high unemployment; poor understanding and response to intergenerational trauma (e.g., the impact of colonisation); poor restriction of access to means; stigma associated with seeking help and mental illness |

# **Appendix 3: Considerations for specific population groups in Aotearoa New Zealand**

**Māori**

Recognised risk factors for suicidal behaviour are compounded for Māori by a history of tribal dispossession and trauma resulting in the loss of resources, rangatiratanga (self-determination) and access to the places of importance to their overall wellbeing. Traditional roles for Māori as a collective culture involved leadership or protection, and guardianship of tribal resources and social groups.

Māori are more likely to die by suicide than non-Māori. While rates have steadily declined for non-Māori over time, we have not seen the same progress in Māori rates. In particular, statistics show that the rates for Māori youth remain significantly higher than for non-Māori youth. Explanations for suicidal behaviour among Māori often confirm recognised risk factors, but suggest that we need to place these factors in a wider social, cultural and historical context.

Māori also experience barriers to accessing support services and are also more likely to receive different responses than other cultures. For example, Māori are more likely to experience discrimination through institutional racism, to be secluded in mental health services and to be placed into compulsory care[[17]](#footnote-2). Māori are also often cared for by services which do not take into account interpretations of wellness and healing practices which are relevant for Māori. Collective notions of Māori identity often mean that individualistic services are inappropriate for some Māori. For this reason, Māori are less likely to seek support when it is needed.

**Males *Tāne***

Across the globe, men continue to have some of the highest rates of death by suicide. Expectations about masculine identity and behaviour can make it harder for men to share that they aren’t coping, or need help. While strong and capable traits can help men get through challenging situations, it can also leave them trapped into a cycle of not feeling able to say that they are not doing okay.

Nearly three-quarters of all deaths by suicide in New Zealand are male, especially those aged 25-44. Rates are also high for young Māori and Pacific men and elderly men aged over 85.

New Zealand men don’t tend to talk about their mental health and can be slow to get help. Men often feel societal pressure to handle the problem alone or ‘harden up’ and get over it. To be seen as strong, resilient, and in control has been identified as masculine or manly. In contrast, mental health problems and suicidal distress can leave men feeling weak, powerless and vulnerable. As a result, men are less likely to admit that they’re feeling a bit shaky or vulnerable and reach out for help.

There is also a frequent lack of awareness among men of available support services, or a sense that these services do not adequately cater to their needs.

Men tend to experience suicidal distress differently and yet our responses are more heavily weighted to more stereotypical presentations. Men do not tend to use the same words to describe their distress, or to ask for help, if they do at all. Men both young and old, struggle in a different way when they experience transition points in their lives such as encountering relationship issues or unemployment. It is vital that we understand how men think about themselves and their relationships to those around them. Our services are often not equipped to support men in the same way they offer support to other population groups and this needs to change if we are to show men that their lives matter.

**Youth *Rangatahi***

The way that young people live their lives has changed greatly over recent decades and this has created a range of poorly understood but critical pressures that affect their mental wellbeing and behaviour. The pace of social and technological changes is unprecedented and it is not surprising that for many young people, particularly those with less resilience and social supports, it can leave them with a growing sense of dislocation.

Factors relating to family and whānau, trauma and related issues play a stronger role for youth than they do in older populations. Young people may experience additional problems and stressors within the family-including parental separation, difficult relationships with parents, lack of parental control, a high level of responsibility for younger siblings, social deprivation, and domestic violence and abuse.

In Aotearoa New Zealand, suicide is the single leading cause of death for young people aged 15–24. We also have one of the highest youth suicide rates in the developed world. We know that for young Māori, Pacific, Rainbow and disabled people, and for those children and young people in care, suicide rates are even higher. New Zealand data also show that considerably more than half of youth suicides involve alcohol or illicit drug exposure. For young people, exposure to suicide attempts amongst peers, truancy, disciplinary problems at school, youth offending and sexual abuse and assault can also be risk factors for suicide.

**Pacific peoples *Tangata Moana***

Pacific peoples in New Zealand are diverse, predominantly youthful and largely urban. Of the nearly 300,000 Pacific peoples in New Zealand, many are New Zealand-born (60 percent), live in the North Island (93 percent) and are ‘trans-national’ in their cultural identities – identifying both with ancestral Pacific Island homelands and contemporary New Zealand values.

Pacific peoples continue to experience unacceptable and long standing inequities across a range of health and socio-economic indicators. These inequities are complex and multi-faceted and impact directly on the relative poorer health status of Pacific peoples. Pacific people’s health status is impacted by the broader determinants of health (such as income, housing, education, and employment) which are having an increasing impact on Pacific people’s mental health and suicidal behaviours.

Many Pacific peoples report barriers associated with access to services when either they or their friend, family or extended family member was suicidal or self-harming. These barriers are interconnected and combine to create a system that is a significant barrier to suicide prevention. Mainstream approaches to suicide prevention and postvention for Pacific peoples are unlikely to be effective on their own, and community development in isolation does not necessarily deal with reducing suicidal behaviours.

Improving Pacific engagement in mental health services requires an environment and services that are culturally safe and employs strategies that increase Pacific access to, and utilisation of mental health services. Consequently, suicide prevention policies, programmes and services aimed at Pacific peoples need to include Pacific design and context. For instance, Pacific models of health apply a holistic approach to better the wellbeing of Pacific peoples, they ensure that Pacific values, experiences and aspirations are captured in policy and service design.

**People living with a mental illness or addiction (People with lived experience) *Tangata Whaiora***

Having a mental illness or an addiction is one of the strongest risk factors for suicide. In 2015, approximately 42 percent of those who died by intentional self-harm (among those aged 10–64 years) in Aotearoa New Zealand were people who had had contact with mental health services at some time in the previous 12 months[[18]](#endnote-18). The period when people seek services and the period after discharge are both times of increased vulnerability.

Just as it is important to understand that not all people who experience suicidality have mental health or addiction issues, it is also important to note that it is not always the presence of a mental disorder which is the main factor for suicidality. The diagnosis and treatment of a mental illness or addiction can also lead to questions about self-identity; about one’s place in the world and how to relate to others who don’t understand the distress being experienced.

Often the presence of a mental disorder or addiction increases the risk of stigma, discrimination and bullying from others; increases the risk of isolation and loneliness and reduces the likelihood of appropriate health services for physical health issues, in particular, those with long-term conditions.

In some cultures, talking about mental illnesses or addiction is forbidden or inappropriate and, coupled with high expectations, the pressure to hide symptoms of distress can increase suicidal risk.

While some people with lived experience are either not, or prefer not to work within their families and communities, where possible this is a key strength of recovery and managing through the tough times. Often services don’t include families and whānau in a way which can support and imbed the recovery journey across families and communities.

**The Rainbow community *Takatāpui***

Sexual orientation, gender identity and intersex status are not the cause of the elevated risk of mental health problems and suicidality among the rainbow population. Rather, the increased risk is due to discrimination and exclusion which is experienced amongst the Rainbow community. This discrimination is not only amongst their family and communities, but also amongst health services, which create additional barriers to seeking support.

Rainbow (sex characteristic, sexuality and gender diverse) communities and people currently experience higher rates of poor mental health and addiction issues including suicidal behaviour, depression and anxiety and other mental disorders.

For the most part, data relating to rainbow communities and suicide in New Zealand has been absent due to largely historic decisions about how data is captured including a lack of diversity when classifying gender during health and coronial processes. However we do know that suicidal distress is higher in these populations.

In Youth'12, a study of New Zealand secondary school students, rainbow students had by far the highest rates of depression and suicidality of any identified demographic population. The study found that 20 percent of same/both-sex attracted secondary school students had attempted suicide in the past year, compared with 4 percent of their opposite-sex attracted peers. The same study found that one in five transgender students had attempted suicide and nearly half had self-harmed in the previous year.

As well as experiencing higher rates of mental health problems and addictions, rainbow people have mixed experiences of support in mental health and addictions services, as well as in other settings and institutions that influence their mental health, especially wider health services including primary care, social services, education and justice settings.

**People and whānau bereaved by suicide**

Being bereaved by suicide is an experience of trauma that is likely to have devastating effects on many people including close family members, whānau, close friends, community members connected in some way with the person who has died, first responders attending the death scene, and others who are exposed to the death.

People bereaved by suicide are at significantly elevated risk of negative health and social outcomes. These include higher rates of suicidal behaviour as well as depression, anxiety, post-traumatic stress disorder and other adverse outcomes. Those impacted have an increased risk of negative health outcomes, including an increased risk of suicide. Research suggests that between forty and sixty people are impacted by every suicide and it is important to both recognise and support those who are affected. Suicide grief is often complicated by social rejection and blame, shame, secrecy and stigma[[19]](#endnote-19).

It is increasingly being recognised that suicide loss affects not only close family members, but can affect a wide range of people who had a relationship with the person who died: wider whānau, chosen family, friends, schools, workplaces, faith communities, sports organisations, and the communities where the person lived. In the case of a celebrity death, the range of people who may genuinely need support may include strangers[[20]](#endnote-20). Given the current number of deaths by suicide each year, there is a significant number of people in New Zealand who need ongoing support.

**Rural and farming communities**

Those who live amongst rural communities have unique risk factors including long working hours, isolation, unpredictability of situations which impact on their livelihood such as weather or adverse events, increasing legislative requirements, ongoing changes to the management of farms and inability to leave their farms for any extended period of time. This is coupled with limited access for some to health services or supports which are more readily available in urban spaces, such as access to counsellors.

High rates of alcohol use and loneliness have been evidenced amongst this population group, meaning that specific initiatives to address this will increase protective factors[[21]](#endnote-21). While rates of suicide amongst rural and farming communities is small in comparison to other populations groups, they are less likely to be able to access services or initiatives which support suicide prevention.

Of the 185 individuals in farm-related jobs who died by suicide in New Zealand between 2007 and 2015, 37% were aged less than 25 years and almost half were under 40[[22]](#endnote-22). These young farmers were also often characterized by living alone, alcohol problems or acute alcohol intoxication, and having easy access to means, including firearms. They tended not to visit primary healthcare providers.[[23]](#endnote-23) Access and support are key issues for this population and need to be considered in all suicide prevention work.

**Children and youth in state care**

In 2018, over 6000 children and young people were in state care and being supported by Oranga Tamariki[[24]](#endnote-24). Many of these children have had difficult, and at times, traumatic life experiences and many are within more than one of the priority populations groups, i.e. a young Māori male who has experienced trauma and is currently living in the care of the state.

Children and youth in care often have multiple risk factors – limited or difficult relationships with immediate family and whānau; little opportunity to form connections to whakapapa; often moving between schools inhibiting academic progress and strong school engagement; inability to form stable relationships with both peers and adults due to constant changes and at times, may even struggle to have their basic physical needs met.

# **Appendix 4. References**

1. World Health Organisation. 2014. *Preventing suicide: a global imperative*. Luxembourg. [↑](#endnote-ref-2)
2. Platt S, Arensman E and Rezasian M. 2019. Editorial. National Suicide Prevention Strategies – Progress and Challenges. *Crisis* 40(2) 75-82 [↑](#endnote-ref-3)
3. Ibid. [↑](#endnote-ref-4)
4. Ibid. [↑](#endnote-ref-5)
5. Centre for Suicide Prevention. 2019. *Transgender people and suicide.* Canadian Mental Health Association & Suicide Prevention Resource Center. 2016. *Preventing suicide among men in the middle years: Recommendations for suicide prevention programs.* Waltham, MA: Education Development Center. [↑](#endnote-ref-6)
6. Ministry of Health. 2017. *Office of the Director for Mental Health and Addiction Annual Report 2017* [↑](#endnote-ref-7)
7. Durie, M.H., Lawson-Te Aho, K.R., Naera. M.H and Waiti,J. 2017*. Tūramarama ki te ora: National Māori Strategy for Addressing Suicide 2017-2022*. Rotorua, New Zealand. [↑](#endnote-ref-8)
8. Atkinson, J. A., et al. 2018. The impact of strengthening mental health services to prevent suicidal behaviour *Australian & New Zealand Journal of Psychiatry.* [↑](#endnote-ref-9)
9. Te Pou of Whakaaro Nui. 2018. *Trauma Informed Care: Literature Scan*. Auckland [↑](#endnote-ref-10)
10. Te Rau Matatini. 2018. *Kia Hora te Marino Trauma Informed Care for Māori*. Wellington [↑](#endnote-ref-11)
11. Atkinson, J; Page, A; Heffernan, M; McDonnell, G; Prodan, A, Campos, B; Meadows, G; and Hickie, I. 2018. The impact of strengthening mental health services to prevent suicidal behaviour. *Australian & New Zealand Journal of Psychiatry*  [↑](#endnote-ref-12)
12. Durie, M. 1982. [↑](#endnote-ref-13)
13. Centre for Suicide Prevention. 2019. *Transgender people and suicide.* Canadian Mental Health Association. [↑](#endnote-ref-14)
14. Suicide Prevention Resource Center. 2016. *Preventing suicide among men in the middle years: Recommendations for suicide prevention programs.* Waltham, MA: Education Development Center. [↑](#endnote-ref-15)
15. Te Pou of Whakaaro Nui. 2018. *Trauma Informed Care: Literature Scan*. Auckland [↑](#endnote-ref-16)
16. Te Rau Matatini. 2018. *Kia Hora te Marino Trauma Informed Care for Māori*. Wellington [↑](#endnote-ref-17)
17. In 2017 Māori were 3.9 times more likely than non-Māori to be subject to a community treatment order and 3.4 times more likely to be subject to an inpatient treatment order, Māori males were the population group most likely to be subject to community and inpatient treatment orders (compared with non-Māori males and Māori and non-Māori females). Office of the Director for Mental Health and Addiction Annual Report 2017 [↑](#footnote-ref-2)
18. Ministry of Health. 2017. *Office of the Director for Mental Health and Addiction Annual Report 2017* [↑](#endnote-ref-18)
19. Mental Health Foundation. 2018. *Suicide bereavement and mental health: a submission to the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau*  Auckland. [↑](#endnote-ref-19)
20. Ibid. [↑](#endnote-ref-20)
21. Beautrais AL, Horwood LJ, McLeod G, and RHĀNZ. 2018. *Rural Health Needs Survey Report: Mystery Creek Fieldays 2018. Report to Ministry of Health, July 2018*. [↑](#endnote-ref-21)
22. Beautrais AL, Farm suicides in New Zealand, 2007–2015: A review of coroners’ records. *Australian New Zealand Journal of Psychiatry, 2017 1-9.* [↑](#endnote-ref-22)
23. Ibid. [↑](#endnote-ref-23)
24. <https://www.orangatamariki.govt.nz/assets/Uploads/20181214-Statistics-on-Children-in-State-Care.pdf>

    # **Appendix 5: Bibliography**

    Afzali MH, Sunderland M, Batterham PJ, et al. 2017. Trauma characteristics, post-traumatic symptoms, psychiatric disorders and suicidal behaviours: Results from the 2007 Australian National Survey of Mental Health and Wellbeing. *Australian & New Zealand Journal of Psychiatry* 51(11): 1142-51.

    American Foundation for Suicide Prevention, & Suicide Prevention Resource Center. 2018. *After a suicide: A toolkit for schools* (2nd ed). Waltham, MA: Education Development Center.

    Andrewes HE, Hulbert C, Cotton SM, et al. 2018. Patterns of non-suicidal self-injury and their relationship with suicide attempts in youth with borderline personality disorder. *Archives of Suicide Research* *22*(3): 465-478.

    Andriessen K, Krysinska K, Hill NT, et al. 2019. Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies of grief, psychosocial and suicide-related outcomes. *BMC Psychiatry* 19(1): 49.

    Asian Family Services. 2018. *Report on the Development of Suicide Prevention resources for Chinese People.* URL: <http://drivedirection.org/drive/wp-content/uploads/2018/11/Suicide-Prevention-Resources-Report.pdf>

    Baker STE, Nicholas J, Shand F, Green R and Christensen H. 2018. A comparison of multi-component systems approaches to suicide prevention. *Australasian Psychiatry* 26(2) 128-131

    Blosnich JR, Lytle MC, Coulter RW, et al. 2018. Suicide Acceptability and Sexual Orientation: Results from the General Social Survey 2008–2014. *Archives of Suicide Research* 22(4): 542-554.

    Bartlett A, Hollins S. 2018. Challenges and mental health needs of women in prison. *The British Journal of Psychiatry* 212(3): 134-6.

    Barzilay S, Apter A. 2014. Psychological models of suicide. *Archives of Suicide Research* 18(4): 295-312.

    Bauer BW, Capron DW, Ward-Ciesielski E, et al. 2018. Extracurricular activities are associated with lower suicidality through decreased thwarted belongingness in young adults. *Archives of Suicide Research* 22(4): 665-678.

    Bear BF, Fogliati VJ, Fogliati R, et al. 2016. Treating anxiety and depression in young adults: A randomised controlled trial comparing clinician-guided v. self-guided Internet-delivered cognitive behavioural therapy. *Australian & New Zealand Journal of Psychiatry* 52(7): 668-679.

    Beautrais AL. 2017. *Postvention guidelines for hospitals, primary care and organisations.* Christchurch: Mental Health Resources and information.

    Beautrais AL. 2018. Farm suicides in New Zealand, 2007–2015: A review of coroners’ records. *Australian & New Zealand Journal of Psychiatry* 52(1): 78-86.

    Briggs S, Linford H, Harvey A. 2012. Guests experiences of Maytree during and after their stay – Final report. United Kingdom: University of East London and Tavistock Clinic.

    Brodsky BS, Spruch-Feiner A and Stanley B (2018) The Zero Suicide Model: Applying Evidence-Based Suicide Prevention Practices to Clinical Care. *Frontiers in Psychiatry* 9:33

    Burstow P, Newbigging K, Tew J, et al. 2018. *Investing in a Resilient Generation: Keys to a Mentally Prosperous Nation*. *Executive Summary and Call to Action*. Birmingham: University of Birmingham.

    Campbell FR. 2006. Aftermath of suicide: The clinician's role. In Simon RI, Hales RE (eds). The American Psychiatric Publishing textbook of suicide assessment and management (p. 459-476). Arlington, VA, US: American Psychiatric Publishing, Inc.

    Christensen H. 2018 Three actions to reduce suicide deaths and attempts. *Australasian Psychiatry* 26(2) 125-127

    Clark TC, Robinson E, Crengle S, et al. 2011. Risk and protective factors for suicide attempt among indigenous Māori youth in New Zealand: The role of family connection. *International Journal of Indigenous Health* 7(1):16-31.

    Coleman D, Casey JT. 2011. The social nature of male suicide: A new analytic model. *International Journal of Men’s Health* 10 (3): 240-252.

    Collins J, Ward BM, Snow P, et al. 2017. Compositional, contextual, and collective community factors in mental health and well-being in Australian rural communities. *Qualitative Health Research* 27(5): 677-687.

    Commonwealth of Australia. 2008. *LIFE. A framework for prevention of suicide in Australia*. Canberra.

    Department of Health. 2017. *The Fifth National Mental Health and Suicide Prevention Plan.* Canberra: Department of Health.

    Department of Health. 20187 *Northern Territory Suicide Prevention Strategic Framework. 2018-2022* Northern Territory Government.

    Department of Health and Concordat signatories. 2014. *Mental Health Crisis Care Concordat: Improving outcomes for people experiencing mental health crisis.* London: UK Government.

    Department of Health and Social Services. 2019. *Cross-government Suicide Prevention Workplan.* HM Government.

    Durie MH, Lawson-Te Aho KR, Naera MH, et al. 2017. *Tūramarama ki te ora: National Māori strategy for addressing suicide 2017-2022.* Rotorua: Te Rūnanga o Ngāti Pikiao Trust.

    Fahey RA, Matsubayashi T, Ueda M, 2018. Tracking the Werther Effect on social media: Emotional responses to prominent suicide deaths on twitter and subsequent increases in suicide. *Social Science & Medicine* 219:19-29.

    Fleming TM, Merry SN, Robinson EM, et al. 2007. Self-reported suicide attempts and associated risk and protective factors among secondary school students in New Zealand. *Australian and New Zealand Journal of Psychiatry* 41(3): 213-221.

    Grad OT. nd. *Guidelines to assist clinical staff after the suicide of a patient.* URL:

    https://www.iasp.info/pdf/postvention/guidelines\_to\_assist\_clinical\_staff\_after\_suicide\_patient\_grad.pdf

    Getz P. 2018. Māori suicide rates–the high cost of historical trauma. *Kai Tiaki: Nursing New Zealand* 24(8): 11-3.

    Gibson S, Hamilton S, James K. 2016. *Evaluation of the Crisis Care Concordat Implementation. Final Report: Summary.* UK: McPin Foundation for Mind.

    Government of Canada. 2016. *Working together to prevention suicide in Canada. The Federal framework for Suicide Prevention.*

    Government of South Australia. 2017. *South Australian Suicide Prevention Plan 2017-2021* SA Health.

    Government of Western Australia Mental Health Commission. 201*Suicide prevention 2020 Together we can save lives.*

    Hall A., McKenna B., Dearie V, Maguire T, Charleston R and Furness T. 2016. Educating emergency department nurses about trauma informed care for people presenting with mental health crisis: a pilot study. *BMC Nursing 15:21*

    Hart LM, Morgan AJ, Rossetto A, et al. 2018. Helping adolescents to better support their peers with a mental health problem: A cluster-randomised crossover trial of teen Mental Health First Aid. *Australian & New Zealand Journal of Psychiatry* 52(7): 638-651.

    Hasking PA, Heath NL, Kaess M, et al. 2016. Position paper for guiding response to non-suicidal self-injury in schools. *School Psychology International* 37(6): 644-663.

    Hazell T, Dalton H, Caton T, et al. 2017. Rural Suicide and its Prevention: a CRRMH position paper. Centre for Rural and Remote Mental Health, University of Newcastle, Australia.

    Headspace: National Youth Mental Health Foundation. 2015. *Grief after suicide: How school staff may be impacted.* URL: <https://headspace.org.au/assets/Uploads/Corporate/Grief-after-suicide-How-school-staff-may-be-impacted-web.pdf>

    Heady A, Pirkis J,Merner B,Vanden-Heuvel A, Mitchell P, Robinson J, Parham J and Burgess P. 2006. A review of 156 local projects funded under Australia’s National Suicide Prevention Strategy: Overview and lessons learned. *Australian e-Journal for the Advancement of Mental Health* 5:5 247-261

    Health Quality and Safety Commission. 2019. *Suicide Mortality Review Committee. Suicide Post-vention. An example: “Fusion’, Te Tai Tokerau* Wellington. New Zealand

    Hetrick SE, Bailey AP, Smith KE, et al. 2017. Integrated (one‐stop shop) youth health care: best available evidence and future directions. *Medical Journal of Australia* 207(S10): S5-S18.

    Holttum S. (2018). Research watch: men’s social inclusion and suicide prevention. *Mental Health and Social Inclusion* 22(4): 167-173.

    Horgan D, Malhi GS. 2018. Intensive suicide prevention: Provide intensive contact and start 2 antidepressants. *Australian & New Zealand Journal of Psychiatry* 52(11): 1023-5.

    Isaacs AN and Dudgeon P. 2016. Ground realities in building effective Aboriginal suicide prevention strategies*. Advances in Mental Health* 14:2 79-81

    Jacob KS. 2017. Suicide prevention in low-and middle-income countries: part perceptions, partial solutions. *The British Journal of Psychiatry* 211(5): 264-5.

    Kopua DM, Kopua MA and Bracken PJ. 2019. Mahi a Atua: A Māori approach to mental health *Transcultural Psychiatry* 0(0) 1-15

    Kryskinka K. Batterham PJ, Tye M, Shand F, Calear AL, Cockayne N and Christensen H. 2016. Best strategies for reducing the suicide rate in Australia. *Australian and New Zealand Journal of Psychiatry* 50(2) 115-118

    Larsen ME, Nicholas J, Christensen H. 2016. A systematic assessment of smartphone tools for suicide prevention. *PloS one* 11(4): 0152285.

    Litteken C, Sale E. 2018. Long-term effectiveness of the question, persuade, refer (QPR) suicide prevention gatekeeper training program: lessons from Missouri. *Community Mental Health Journal* *54*(3): 282-292.

    Local Government Association. 2018. *Public health approaches to reducing violence.* London: Local Government Association.

    Loomis B, Epstein K, Dauria EF, et al. 2019. Implementing a trauma-informed public health system in San Francisco, California. *Health Education & Behavior*, 46(2): 251-259.

    Malatest International. 2017. *Final report: Impact Evaluation of MH101.* Wellington: Malatest International.

    McKenna B, Furness T, Brown S, Tacey M, Hiam A and Wise M. 2015. Police and clinician diversion of people in mental health crisis from the Emergency Department: a trend analysis and a cross comparison study. *BMC Emergency Medicine 15:14*

    McLaughlin KA, Koenen KC, Bromet EJ, et al. 2017. Childhood adversities and post-traumatic stress disorder: evidence for stress sensitisation in the World Mental Health Surveys. *The British Journal of Psychiatry* 211(5): 280-8.

    McClatchey K, Murray J, Rowat A, et al. 2017. Risk Factors for Suicide and Suicidal Behavior Relevant to Emergency Health Care Settings: A Systematic Review of Post‐2007 Reviews. *Suicide and Life‐Threatening Behavior* 47(6): 729-745.

    McClintock K, Haereroa M, Brown T, et al. (2018). *Kia hora te marino* - *Trauma Informed Care for Māori*. Wellington, New Zealand: Te Rau Matatini.

    Mental Health Foundation. 2018. *Media guidelines: Portrayal of people living with mental health issues in Aotearoa.* URL: <https://www.mentalhealth.org.nz/assets/Media-guidelines-2918/MHF-Media-Guidelines-Interactive-300dpi.pdf>

    Miklin S, Mueller AS, Abrutyn S and Ordonez, K. 2019. What does it mean to be exposed to suicide?: Suicide exposure, suicide risk, and the importance of meaning-making. *Social Science and Medicine 223 21-27*

    Ministry of Health. 2003. *The assessment and management of people at risk of suicide.* Wellington: Ministry of Health.

    Ministry of Health. 2016. *Office of the Director of Mental Health Annual Report 2015.* Wellington: Ministry of Health.

    Ministry of Health. 2016. *A rapid review of the suicide prevention literature.* Wellington: Ministry of Health.

    Ministry of Health. 2016. *Preventing suicide: Guidance for emergency departments*. Wellington: Ministry of Health.

    Ministry of Health. 2017. *Office of the Director of Mental Health Annual Report 2016.*Wellington: Ministry of Health.

    Ministry of Health. 2019. *Office of the Director of Mental Health and Addiction Services: Annual Report 2017*. Wellington: Ministry of Health.

    Mokkenstorm JK, Kerkhof AJ, Smit JH, et al. 2018. Is it rational to pursue zero suicides among patients in health care? *Suicide and Life‐Threatening Behavior*, 48(6): 745-754.

    Morgan L. 2018*. Crisis Supports for the Autism Community.* URL: https://www.suicidology.org/Committees-Workgroups/Autism-Suicide-Committee

    Muehlenkamp JJ, Thoen SK. 2019. Short‐and Long‐Term Impact of an Undergraduate Suicidology Course. *Suicide and Life‐Threatening Behavior*. URL: https://onlinelibrary.wiley.com/doi/full/10.1111/sltb.12552

    National Action Alliance for Suicide Prevention: Transforming Health Systems Initiative Work Group. 2018. *Recommended standard care for people with suicide risk: Making health care suicide safe.* Washington, DC: Education Development Center, Inc.

    New Zealand Union of Students’ Association. 2017. *Kei Te Pai? Report on Student Mental health in Aotearoa.* New Zealand: New Zealand Union of Students’ Association.

    O'Dea B, Achilles MR, Larsen ME, et al. 2018. The rate of reply and nature of responses to suicide-related posts on Twitter. *Internet Interventions* 13:105-7.

    Office of the Commissioner for Children and Oranga Tamariki Ministry for Children. 2019. *What makes a good life? Children and young people’s views on wellbeing*. Wellington, New Zealand

    Oh DL, Jerman P, Boparai SKP, et al. 2018. Review of tools for measuring exposure to adversity in children and adolescents. *Journal of Pediatric Health Care* 32(6): 564-583.

    Page A, Atkinson JA, Campos W, et al. 2018. A decision support tool to inform local suicide prevention activity in Greater Western Sydney (Australia). *Australian & New Zealand Journal of Psychiatry* 52(10): 983-993.

    Page A, Atkinson JA, Heffernan M, et al. 2018. Static metrics of impact for a dynamic problem: The need for smarter tools to guide suicide prevention planning and investment. *Australian & New Zealand Journal of Psychiatry* 52(7): 660-7.

    Pihama L, Smith LT, Te Nana R, et al. 2017. Investigating Māori approaches to trauma-informed care. *Journal of Indigenous Wellbeing* 2(3):18-31.

    Pisani AR, Murrie DC, Silverman MM. 2016. Reformulating suicide risk formulation: from prediction to prevention. *Academic Psychiatry* 40(4): 623-629.

    Pitman A. 2018. Addressing suicide risk in partners and relatives bereaved by suicide. *The British Journal of Psychiatry* 212(4): 197-8.

    Pitman AL, Stevenson F, Osborn DP, et al. 2018. The stigma associated with bereavement by suicide and other sudden deaths: A qualitative interview study. *Social Science & Medicine* 198:121-9.

    Platt S, Arensman E and Rezasian M. 2019. Editorial. National Suicide Prevention Strategies – Progress and Challenges. *Crisis* 40(2) 75-82

    Pollock NJ, Naicker K, Loro A, et al. 2018. Global incidence of suicide among Indigenous peoples: a systematic review. *BMC Medicine* 16(1):145.

    Qiu T, Klonsky ED, Klein DN. 2017. Hopelessness predicts suicide ideation but not attempts: A 10‐year longitudinal study. *Suicide and Life‐Threatening Behavior* 47(6): 718-722.

    Rowe J, Jaye C. 2017. Caring for self-harming patients in general practice. *Journal of Primary Health Care* 9(4): 279-285.

    Roy P, Tremblay G, Duplessis-Brochu É. 2018. Problematizing men's suicide, mental health, and well-being: 20 years of social work innovation in the province of Quebec, Canada. *Crisis* 39(2): 137-143.

    Scottish Government. 2013. *Suicide Prevention Strategy 2013-2016.* The Scottish Government, Edinburgh.

    Scottish Government. 2013. *Every Life Matters* *Scotland’s Suicide Prevention Action Plan 2013-16* The Scottish Government. Edinburgh.

    Šedivy NZ, Podlogar T, Kerr DC, et al. 2017. Community social support as a protective factor against suicide: A gender-specific ecological study of 75 regions of 23 European countries. *Health & Place* *48*: 40-6.

    Shand FL, Batterham PJ, Chan JK, et al. 2018. Experience of health care services after a suicide attempt: results from an online survey. *Suicide and Life‐Threatening Behavior* 48(6): 779-787.

    Spillane A, Larkin C, Corcoran P, 2017. What are the physical and psychological health effects of suicide bereavement on family members? Protocol for an observational and interview mixed-methods study in Ireland. *BMJ Open* *7*(3): e014707.

    Stein DJ, Chiu WT, Hwang I, et al. 2010. Cross-national analysis of the associations between traumatic events and suicidal behavior: findings from the WHO World Mental Health Surveys. *PloS one* *5*(5): e10574.

    Struszczyk S, Galdas PM, Tiffin PA. 2019. Men and suicide prevention: a scoping review. *Journal of Mental Health* 28(1): 80-8.

    Suicide Prevention Resource Center. 2016. *Preventing suicide among men in the middle years: Recommendations for suicide prevention programs.* Waltham, MA: Education Development Center, Inc.

    Sweeney A, Taggart D. 2018. (Mis)understanding trauma-informed approaches in mental health. *Journal of Mental Health* 27(5): 383-7.

    Telfer MM, Tollit MA, Pace CC, et al. 2018. Australian standards of care and treatment guidelines for transgender and gender diverse children and adolescents. *Medical Journal of Australia* 209(3): 132-6.

    Te Rau Matatini. 2016. *Te Pātūtū Oranga: Successful initiatives to strengthening the protective factors for suicide prevention amongst tāne Māori – A Review of Literature.* Wellington: Te Rau Matatini.

    Te Rau Matatini. 2017. Investigating Māori approaches to trauma informed care. *Journal of Indigenous Wellbeing. 2:3*

    Todd C, Camic PM, Lockyer B, et al. 2017. Museum-based programs for socially isolated older adults: Understanding what works. *Health & Place* *48*: 47-55.

    Torok M, Calear A, Shand F, et al. 2017. A systematic review of mass media campaigns for suicide prevention: Understanding their efficacy and the mechanisms needed for successful behavioural and literacy change. *Suicide and Life‐Threatening Behavior* 47(6): 672-687.

    Ueda M, Mori K, Matsubayashi T, et al. 2017. Tweeting celebrity suicides: Users' reaction to prominent suicide deaths on Twitter and subsequent increases in actual suicides. *Social Science & Medicine* *189*:158-166.

    Van der Feltz-Cornelis CM, Sarchiapone M, Postuvan V, Volker D, Roskar S, Grum AT, Carli V, McDaid D, O’Çonnor R. Maxwell M,Ibelshauser A, Van Audenhove C, Scheerder G, Sisak M, Gusamo R and Hegerl U. 2011. Best Practice Elements of Multilevel Suicide Prevention Strategies. A Review of Systematic Reviews. *Crisis.* 32(6) 319-333

    Webb, L.S.I.D. 2010. Thinking about suicide: Contemplating and comprehending the urge to die. *Psychotherapy in Australia* 16(4): 29.

    Williams AD, Clark TC, Lewycka S. 2018. The associations between cultural identity and mental health outcomes for indigenous Māori youth in New Zealand. *Frontiers in Public Health* 6: 319.

    Witt K, Lubman DI. 2018. Effective suicide prevention: Where is the discussion on alcohol? *Australian & New Zealand Journal of Psychiatry* 52(6): 507-8.

    World Health Organization. 2014. *Preventing suicide: a global imperative*. Luxembourg. World Health Organization.

    World Health Organization. 2016. Preventing suicide: a community engagement toolkit. Pilot version 1.0. Geneva, World Health Organization.

    World Health Organization. 2018. *National suicide prevention strategies: progress, examples and indicators.* Geneva World Health Organization.

    Yakeley J, Burbridge-James W. 2018. Psychodynamic approaches to suicide and self-harm. *British Journal of Psychiatric Advances* 24(1): 37-45.

    Zalsman G, Hawton K, Wasserman D, et al. 2016. Suicide prevention strategies revisited: 10-year systematic review. *The Lancet Psychiatry* 3(7): 646-659.

    Zammit S, Lewis C, Dawson S, et al. 2018. Undetected post-traumatic stress disorder in secondary-care mental health services: systematic review. *The British Journal of Psychiatry* *212*(1): 11-8. [↑](#endnote-ref-24)