The New Zealand Psychological Society

Te Rōpū Mātai Hinengaro o Aotearoa

Submission on the Ministry of Health's 'Strategy to prevent suicide in New Zealand'

prepared by the
New Zealand Psychological Society
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1.0 Introduction

1.1 The New Zealand Psychological Society welcomes the opportunity to comment on the Ministry of Health's Strategy to prevent suicide in New Zealand. The NZPsS is the largest professional association for psychologists in Aotearoa New Zealand with over 1700 members and subscribers. The NZPsS aims to improve individual and community wellbeing by representing, promoting and advancing the scientific discipline of psychology and psychology practice. Many of our members are engaged in work across the health sector.

1.2 It is useful to see how the Ministry of Health is thinking about this very important issue, and what steps they are proposing that the government and country can take to manage and mitigate this challenge. We understand the significant amount of work that has gone into preparing this draft Strategy. There are a number of positive developments within this draft plan relative to the previous plan, namely,

- The inclusion of cultural (mātauranga Māori) and clinical knowledge in the framework development
- The recognition of the broader context of wellbeing and the factors that contribute to this and therefore also to suicide.
- The shift away from censorship to encouraging 'responsible conversations'
- The recognition of community engagement (rather than just professionals) as central to tackling the problem.
- Recognition that different populations require different strategies, specifically for high needs groups such as Māori men and young people.

1.3 Despite all of this work, we believe that the Strategy outlined is lacking in detail and evidence that the action proposed will assist in preventing suicide. It is our view that the Vision, Pathways and Actions are so broad that they fail to specifically address many (if any) of the important factors that we already understand as contributing to suicide risk (United Nations, 1996; WHO, 2014). There is a wealth of scientific evidence available, some excellent guiding documents have been produced in other countries and by international organisations (e.g. Mann et al., 2005; Royal College of Psychiatrists, 2010; Schaffer & Sinyor, 2016; WHO 2014), as well as the learnings that can be drawn from the previous Strategy (MoH, 2006). However, it is not apparent that any of this material has been integrated into this Strategy, although it does receive a cursory mention in the section 'About this draft strategy' (p.1). If an associated document citing the evidence for the Pathway and Actions has been compiled it would be useful to have access to this so those reviewing and commenting on the draft Strategy understand the reasoning behind the specific elements that have been included.

1.4 Many of the comments about Vision, Pathways and Action are entirely laudable and appropriate, but not in a Strategy document about suicide prevention. It is our view that the points made belong in a more general health or mental health strategy document as they are not specific enough to form the centrepiece of this document. We believe that while society-wide initiatives are important there is a risk they become so diluted that the likelihood of reducing deaths by suicide is low. For example, the Strategy mentions actions associated with improving health literacy, but there is evidence that improving health literacy in the community and through educational programmes in schools makes little difference to suicide rates (Kutcher, Wei, & Behzadi, 2016). This is an example of an action that would be nice to do and makes sense in terms of general health, and even mental health where base-rates are higher, but does not make any sense for suicide prevention.

1.5 We know that many people who successfully complete suicide are, or have recently been, in contact with a health practitioner, usually their general practitioner (e.g., Luoma, Martin, & Pearson, 2002), although this is less often the case for young people (Gulliver, Griffiths, & Christensen, 2010). Because of this it appears that the primary issue is not for members of the public to become more 'health literate' (although that would certainly be a good thing), but for health services to become more accessible and 'suicide literate', and have access to the resources to be able to assist in timely and meaningful ways.

1.6 The challenge is to establish a strategic plan that supports research/actions that identify those most at-risk and provide effective support to them and their networks. The most recent (2015/6) provisional suicide data for New Zealand across the age range reveals an increased rate of 12.33 per 100,000 (Ministry of Justice, 2016), a total of 564 deaths. Understanding the implications of focusing on a problem with a small base-rate, and by avoiding generalities and focusing on evidence-based specific knowledge, it should be possible to secure positive gains for those who are at greater risk of suicide, and stop unnecessary deaths. To this end it would be useful, we think, to challenge our community by proposing a specific reduction target for the forthcoming years, for example, a 10% reduction by 2020, as suggested by the World Health Organisation (WHO, 2013).

1.7 In the section 'What we know about suicidal behaviour' (p.3), there is a statement that some groups within our population are at greater risk of suicide, and the groups that are identified are based on ethnicity and age. However, the reality is that the most significant group is men, especially Māori men (MoH, 2016; WHO, 2014). If the rate of completed suicides in New Zealand is to be reduced then strategies and actions need to be formulated which are designed to engage primarily with men, of all ages and ethnicities.

2.0 Specific Feedback

2.1 Causes of suicide

The risk factors listed on page four make intuitive common-sense, but they are not specifically evidence-based, or primary indicators. That is, it is unclear why some factors have been included (e.g., being shamed, and having a court case coming up), when more obvious direct risk factors have been excluded (e.g., clinical depression, previous attempt, family history, high impulsivity; see Bostwick & Pankratz, 2001; Cavanagh, Carson, Sharped, & Lawrie, 2003; Foster, 2011; Nock, Hwang, Sampson, & Kessler, 2010).

On page five there is a bullet-point list of areas within which initiatives can be located to help prevent suicide. This list covers *everything* and because of this is unhelpful. We need to know where the government is going to place its emphasis, where the focus is going to be.

2.2 Vision

The Vision Statement states correctly that this strategy should be forward looking and enabling people to "hold on to life".

2.3 Pathways

Three pathways are identified; (a) building positive wellbeing for all, (b) supporting people who are in distress, (c) post-vention. Pathway (a) and (b) are very general. More specific alternatives would be:

- Better understanding and identification of suicide risk factors relevant to NZ and those people who are confronted by them, and through this working with vulnerable and at-risk individuals to build personal resilience and support.
- For all those struggling with suicidal ideas, and those at-risk, provision of a range of evidence-based, accessible supports and interventions to enable them to address the causes of their difficulties and build a sustainable future.
- Build effective 'communities of concern' around at-risk individuals and groups, making access to support easier and affordable, making support more informed and effective, and reducing the stigma associated with suicidal thinking and help-seeking.

2.4 How the framework can guide prevention planning

This section (p.8-9) has three sub-sections that link to the Pathways. There is a significant literature on resilience as an individual characteristic, but also as a feature of families, groups, and communities which could be drawn on here, but which seems to be missing (Brent, 2016; Frey & Cerel, 2015; Walsh, 2015).

The health sector, including the field of suicide prevention, encourages innovation. While this is laudable it is not acceptable to innovate without evaluation, just because an idea is new does not mean that it is good. The final bullet-point on page nine refers to building systems that share information and build knowledge. This is generally missing from the Strategy, but is (in our opinion) a critical component of developing an efficacious and sustainable response to the challenge of suicide. New initiatives need to be established only after evaluating the evidence on which they are founded, and must have a robust evaluation system built-in (refer to Suicide Prevention Australia, 2015a, b).

In the final paragraph on page 9, there should also be specific mention of the role of the media in suicide prevention, given the literature on suicide contagion from media reporting of suicide and the resource and guidelines documents for media (Tully & Elsaka, 2004; MoH, 1999, 2011). New Zealand has had the most extreme censorship laws against the reporting of suicide of any country (Hollings, 2013). Although these laws were very slightly relaxed in 2016, these restrictions have contributed to a more general anxiety about talking openly about suicide. The rather narrow focus on the risks of suicide contagion has inadvertently helped to close down conversations about suicide in a range of other contexts (Fullagar, Gilchrist, & Sullivan, 2007). In research with youth, the sense that suicide is a 'taboo' subject in society can prevent young people from seeking help (Bourke, 2003; Gilchrist & Sullivan, 2006). To counteract this effect of previous policies it would be helpful to take a stronger stand on the value of talking openly about suicide. This can be done while still acknowledging importance of not glamorising the subject and emphasising alternative ways of coping with difficult situations.

2.5 Turning the shared vision into action

This section starts well. On page 11 there is a clear statement that government agencies propose to start working with those at greatest risk including Māori, mental health service users, Pacific peoples and young people. As noted above, men are also a high-risk population especially Māori men. Secondly, there is a problem identifying those admitted to hospital for intentional self-harm because a vast majority of those who self-harm do not seek medical advice. Also, this approach prioritises medical risk, which is often not the primary indicator of who is likely to suicide, where psychological, emotional and social factors are often important (for example, Berman, 2017; Ward-Ciesielski, Schumacher, & Bagge, 2016; Whitlock et al., 2013).

Research has shown that particularly for young people that they are reluctant to approach traditional mental health services (Curtis, 2010). Attempts to design more informal and destigmatised youth support services in the community is likely to result in more effective services to prevent suicide (McGorry, Bates, & Birchwood, 2013).

2.6 Potential Areas for Action

The Overview of Potential Areas for Action is unclear, and this needs to be revised before details of actions can be proposed.

2.7 Action area 1, Building Wellbeing

This appears to focus on prevention, and the development of community resilience with respect to suicide risk and suicidal behaviour. There are five items listed in this section. It is our view that this could be reduced to two.

1. In collaboration with other government departments, agencies, and community organisation, work to support the growth of resilient and mentally health individuals, families, and communities.
2. Encourage responsible conversations (incl. education, media coverage) about suicide and suicide prevention, that build positive social awareness and knowledge (suicide prevention literacy).

2.8 Action Area 2, Support those at risk

This is about recognizing and supporting those at-risk of suicide and those engaging in suicidal thinking and behaviours. There are two items listed in this section, we would suggest this could be expanded as this is where the most gains are likely to be made in preventing suicide.

3. Support the development of accessible and effective suicide prevention services.
4. Build and support a suicide prevention and response workforce that provides for a range of evidence-based responses to be readily available to those considering or at-risk of suicide.
5. Support the development of systems to collect and share evidence about what works so that beneficial services can be implemented, and resources can be directed to the most efficacious supports.
6. Build collaborations between those working to prevent suicide.

2.9 Action Area 3, Post-vention

This area is focused on the impact of a completed suicide, or significant suicidal behaviour, on individuals, family/whanau, and the community.

7. Work to mitigate and manage the negative impact of suicide and suicidal behaviour on those most affected by it; family/whanau, friends, as well as the wider community.

Within each of these areas it will be necessary to consult widely to identify approaches and programmes that have proven efficacy in preventing suicide, and minimising the negative effects of this behaviour.

3.0 Closing Comment

3.1 The recent UNICEF Innocenti report (2017) confirms that New Zealand has the highest child suicide rates amongst wealthy nations (15.6 per 100,000 for 15-19 year olds). It is clear we need to review our collective strategy to ensure more effective outcomes.

3.2 The New Zealand Psychological Society believes that the draft Strategy document needs to go further in setting a clear agenda for all of New Zealand to work at reducing suicide. Our concern that time, effort and resources will be wasted on initiatives that are a less likely to have a meaningful impact on New Zealand's suicide rate.

3.3 Coopersmith et al (2017) have reported that during the period of the last New Zealand suicide strategy the majority of its national suicide research budget was spent on epidemiological research, although we already seem to know the proximal and distal risk factors for suicide. We need more resourcing and action at the grass roots, when people are in real crisis, working with the people who are at greatest risk. One explanation for the lower suicide rate in Australia is that it spends less on epidemiological research and more on action research with high risk groups (Suicide Prevention Australia (2015a/b).

3.4 The review of government strategy in this area is critical in setting out what the country needs to do to address suicide. This is a golden opportunity to provide real leadership which is decisive and what will make a measurable difference in keeping New Zealanders alive.

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