Mental Health Foundation OF NEW ZEALAND
mauri tū, mauri ora

Submission: Public consultation on the draft Suicide Prevention Action Plan 2025-2029

By the Mental Health Foundation of New Zealand

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Ministry of Health | Manatū Hauora

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Tuia te rangi e tū nei
Tuia te papa e takoto nei
Tuia i te here tangata
Tihei mauri ora.

He hōnore, he korōria ki te atua ki te runga rawa
He whakaaro maha ki a rātou kua haere ki te wāhi ngaro
Rau rangatira mā, ānei ngā whakaaro me ngā kōrero nā Te Hauora Hinengaro.

Thank you for the opportunity to comment on the draft Suicide Prevention Action Plan 2025-2029 (the Plan).

The Mental Health Foundation of New Zealand (MHF) is a charity working towards creating a society free from discrimination, where all people enjoy positive mental health and wellbeing.

An important part of the MHF's work is contributing to suicide prevention and postvention. We develop information and resources to support people who are worried about their own suicide risk or the suicide risk of someone else and provide advice and information to help people support themselves and each other after a suicide death. We provide guidance to the media regarding both their obligations under law and best practice when reporting on suicide. Additionally, the MHF convenes the Suicide Bereavement Service Advisory Group, composed of people with lived experience of suicidality and suicide loss who are working in the suicide space in Aotearoa. The Group supports MHF resource development and provides external consultation on a range of suicide prevention and postvention projects at a national level.

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General comments

The MHF would firstly like to acknowledge the voices of those with lived experience, tāngata whaiora, whānau and communities who contributed their invaluable expertise to the development of the Plan. These contributions are drawn from the real, shared pain and an enduring willingness to support the creation of a safer, more supportive, and more equitable suicide prevention and postvention system in Aotearoa New Zealand. This is a taonga that cannot be taken for granted.

Equity and Te Tiriti o Waitangi

The Plan does not have a sufficient focus on equity, te ao Māori, mātauranga Māori and Te Tiriti o Waitangi. This is in stark contrast to *Every Life Matters – He Tapu Te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029* and the first Action Plan, both of which centred equity issues. This contributes to the sense that the Plan is disconnected from a broader, cohesive, long-term system improvement package. Māori are positioned in the Plan as a statistic and an inherent problem to be fixed (e.g., Māori are referred to as "higher needs") rather than acknowledged as being disproportionately impacted by negative wellbeing outcomes due to a multiplicity of external social determinants. The Plan also fails to recognise or elevate the wealth of evidence-based solutions that Māori communities have developed for achieving positive wellbeing outcomes.

There are mentions of Māori success within the existing initiatives listed, but no action is dedicated to amplifying these initiatives in the future. We note that *Every Life Matters* opens with the following commitment: "While [this] is a strategy for all people in Aotearoa New Zealand, it recognises that honouring the special relationship with Māori under Te Tiriti o Waitangi is key to achieving the vision of the strategy and pae ora (healthy futures) and equity for Māori." *Every Life Matters* also cites *Tūramarama ki te Ora: National Māori Strategy for Addressing Suicide 2017-2022* as an important document relied upon in its development and makes explicit commitment to supporting the achievement of the vision and solutions outlined in *Tūramarama ki te Ora*. This is a critical gap within the Plan.

Additionally, it is concerning that some of the recommendations from the report *He Arotake – Te Aka Whai Ora suicide prevention and postvention review* have not been reflected through the Plan. These include increasing investment in kaupapa Māori suicide prevention, simplifying the suicide prevention system and

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strengthening system leadership, and developing a national suicide prevention and postvention workforce development plan.

The MHF has long supported a separate Māori suicide prevention action plan to specifically address equity gaps, and we still consider this to be the ideal solution. However, if this is not feasible, we recommend that a general population plan has a significantly increased focus on equity, Māori, and Te Tiriti o Waitangi, with a parallel funding stream to accompany the commitments. In their stocktake of progress made against the 2019-2024 Action Plan, DPMC's Implementation Unit noted that initiatives need to be implemented in a way that recognises the needs of Māori and reflects te ao Māori.[i] This is not currently reflected in the 2025-2029 Plan.

Overall, there is generally a poor equity focus on groups who experience higher rates of suicide and suicidality. Population group statistics highlighted are not reflected through the proposed actions. However, we acknowledge some mention is made of maternal, youth, elderly, rural communities, and the prison population.

Additionally, the inconsistent use of data in the Plan makes it difficult to compare suicide rates between population groups. For instance, Māori suicide statistics are not reported as rates of suspected and confirmed suicide deaths per 100,000, as is done for the general population. Given that coronial data adheres to this format, we recommend presenting the data in a way that enables clearer comparisons across ethnic demographics.

Whole-of-government leadership

The MHF agrees the lack of national leadership is a significant gap in the current system. National leadership is a crucial enabler that needs to be properly resourced, both financially and with appropriate expertise, to undertake critical functions associated with suicide prevention, such as monitoring progress of the Plan, evaluating outcomes, fostering an effective whole-of-government approach to suicide prevention and postvention, and building the necessary data and evidence infrastructure to support it.[ii]

The dissolution of the Suicide Prevention Office (SPO) has been a disappointing decision. The SPO offered hope that a crucial gap in coordinated, national-level oversight would finally be addressed – *He Ara Oranga* envisioned the SPO could "serve as a repository of suicide information, support local implementation of

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programmes and coordinate cross-agency activities." Unfortunately, the SPO was never adequately resourced, and its placement both within a central health agency and within the Clinical, Community and Mental Health directorate undoubtedly hindered its ability to exercise independent oversight and effectively influence cross-government and non-health driven prevention efforts.

We agree with the assessment that there is a need for national leadership and that we want to get to a place of strong national leadership. However, there are no dedicated actions to support this. Relying solely on a few dedicated FTE within the Ministry of Health | Manatū Hauora (the Ministry) to carry this responsibility is not sufficient and does not provide the necessary degree of separation required to take a macro-level view of system change. We recommend establishing national leadership mechanisms that are independent, have cross-government reach, are adequately resourced, and have a whole-population focus to spearhead and maintain progress. We also recommend developing a more appropriate measure for a leadership-related outcome – "increased awareness and collaboration" is not the same as leadership.

Tone and language clarity

Overall, we consider the Plan is missing the appropriate level of compassion owed to an issue of such gravity, and that there is an overt emphasis on statistics without an accompanying acknowledgement that these numbers represent real people – the whānau and communities who continue to shoulder the burdens of grief and/or lived experience of suicidality.

The Plan is not framed in a strengths-based way. For example, improvement in mental wellbeing is noted as a long-term outcome, but the measures used are deficits-focused – less psychological distress is not the same as increased wellbeing. While measuring a decrease in population-level distress is part of the picture, we recommend also focussing on outcomes and corresponding measures that seek to concretely assess positive changes. For example, outcomes could be more aligned with the Mental Health and Wellbeing Commission's *He Ara Oranga Wellbeing Outcomes Framework*.

We recommend addressing inconsistencies and clarifying the language used in the Plan. For example, area three focusses on "prevention and early intervention" and it would be useful to be clearer about whether this refers to primary prevention and/or

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population-level prevention, and whether 'early' refers to early in life, or early in the journey towards harm/away from wellness.

Disconnection with *Every Life Matters* and the 2019-2024 Action Plan

The MHF considers the Plan is largely disconnected to both *Every Life Matters* and the 2019-2024 Action Plan. It is important that the foundations established under the Strategy are honoured, maintained, and improved upon through the Plan. We recommend maintaining the strong guiding values originally developed.[1]

Every Life Matters identifies that "the Suicide Prevention Office will collect information and report on progress around implementing Every Life Matters" – however, no detailed progress reports have been made publicly available. There is currently limited evidence of assessment of past actions in the Plan. We recommend that lessons learned from the progress made under the first Plan be meaningfully reflected upon and utilised to make evidence-based decisions about what to continue, expand, or remove in the new Plan.

Disconnection between insights, evidence and actions

We strongly support the summary of the eight community insights outlined and the gaps identified in the Plan. However, it is not clear how these are being reflected throughout the proposed actions, outcomes, and their corresponding measures. Insights that have no corresponding action include, for example, government agencies addressing societal factors associated with suicide, a comprehensive continuum of care, strengthening kaupapa Māori approaches, growing the suicide prevention and postvention workforce capacity, and addressing the persistent gaps in developing quality local evidence (including funding for research).

A comprehensive suicide prevention programme typically employs a combination of universal, selective and indicated interventions.[iii] We are concerned the Plan has not struck the right balance. The need to address the broader social determinants that contribute to or detract from wellbeing is identified in the Plan as a system gap, yet the overall cross-government actions do not adequately address this, which

[1] Mahi tahi – Working together, Hautūtanga Māori – Māori leadership, Poipoi wairua – Trauma-informed, Mauri ora – healthy individuals, Whānau ora – whānau, family and community-centred, Wai ora – healthy environments, Rangatiratanga – people powered, and Whakamana tāngata – treating people with dignity (p.2, *Every Life Matters*).

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further perpetuates the incorrect idea that suicide prevention is only the responsibility of the health system. Evidence suggests that enhancing economic and welfare support in periods of recession, reducing domestic violence and abuse, supporting opportunities for social support, and reducing alcohol consumption, particularly binge drinking, may be effective for reducing suicide.[iv]

Overall, it is unclear why certain actions were selected, particularly those that seem inconsistent with recent evidence and best practice advice. It is also concerning that potential actions for inclusion that would align with the evidence base are not included, such as reducing access to suicide means and addressing structural determinants. We will explore this further in response to the consultation questions.

Measurement, monitoring, and evaluation

The MHF welcomes the introduction of quarterly updates to the Minister for Mental Health (although this could be future proofed by referring to the Minister with responsibility for mental health) and annual updates to Cabinet regarding progress, and the nod to transparency in making the latter publicly available. Overall, we appreciate the inclusion of clear timelines and that responsible agencies are named against actions.

Several proposed actions are vague, using terms like "support exploration," "enhance," or "improve effectiveness," which will make it difficult to measure tangible progress. Similarly, many of the outcome measures lack specificity, calling for changes like "increased awareness and collaboration" and "improved cohesiveness." As a result, even marginal improvements against these metrics could be considered successes regardless of their actual impact, and progress may be measured in ways that do not reflect meaningful change. We encourage the Ministry to establish clearer benchmarks that demonstrate real progress made against the status quo.

We are concerned about the lack of any planned future evaluation of actions under the Plan and we recommend making an explicit commitment to this.

Do you agree with the proposed actions for health and cross-government agencies? How could these actions be improved?

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We have only provided comment on actions where we have specific feedback, rather than canvassing all the proposed actions.

Focus area 1: Improve access to suicide prevention and postvention supports

Establish a suicide prevention community fund focused on populations with higher needs (e.g., maternal, youth and rural communities)

The MHF is supportive of this action. We recommend changing the language used ("higher needs") to phrasing that does not put the onus on these groups as the problem, for example, "populations disproportionately impacted by/experience higher rates of suicide and suicidality." We also recommend making clear all the priority populations this fund will support.

Establish and evaluate six crisis recovery cafés/hubs/services

The MHF supports this action. Evidence shows crisis cafés can serve as a promising alternative to traditional mental health crisis responses and has demonstrated benefits such as reduced hospital admissions[v] and enhanced user engagement with primary support services. Service users report valuing the non-clinical environment and the social connections fostered by this model.[vi] We understand more research is needed to determine their effectiveness conclusively, and robust evaluation through the roll out will be instrumental in supporting this. Key considerations include providing role clarity, training and supervision for peer support workers, addressing the potential over-reliance on peer support for complex cases that may require multidisciplinary care, and ensuring mechanisms for continuity of care post-crisis.

Additionally, these services are not always accessible to everyone (especially non-urban populations) and may not necessarily be the first port of call for those in crisis. We recommend balancing this action with further commitments to strengthening and expanding the peer support model in Emergency Departments, improving Emergency Department infrastructure (such as creating space for a therapeutic environment), and enhancing workforce capability and capacity.

Focus area 2: Grow a capable and confident suicide prevention and postvention workforce

Increase access to suicide awareness training for communities, families and whānau

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The MHF recommends this action is implemented in line with recent and best-practice evidence. For example, evidence suggests awareness training appears to be effective and cost effective within school settings and is considered an emerging area of promise (acknowledging also the effectiveness of a whole-of-school approach to wellbeing and suicide prevention).[vii] However, these findings may not be readily generalisable to both the general population and priority populations, especially when factors such as differing cultural worldviews are considered. Furthermore, studies show that while small improvements in behaviour can be observed following mental health awareness training (in which suicidality is often covered), effects are generally small-to-moderate post-training and at future follow-up intervals.[viii]

The Ministry may wish to consider an additional action to also support increased access to suicide *prevention* training, which aims to not only provide the knowledge and skills to recognise suicide risk but also effective strategies to intervene appropriately.

Develop induction materials, best practice support, and enhanced guidance for the workforce

While the MHF is generally supportive of any improvements in these areas, the planned actions show a lack of focus on dedicated training and education. The MHF has heard from those in the suicide prevention and postvention sector that the existing mental health workforce considers they receive inadequate training to develop suicide-specific expertise. Additionally, there are insufficient training and upskilling opportunities for people contributing to suicide prevention who are outside the mental health workforce, such as teachers. To enhance the quality of intervention delivery, all professions involved in suicide prevention require minimum standards for curriculum development in both undergraduate and post-qualification training, along with core competencies to support practice. These standards should be complemented by induction materials and best practice guidelines as part of a broader package to support the workforce effectively. This will require significant investment and sustainable funding.

Focus area 3: Strengthen the focus on prevention and early intervention

Launch a new wellbeing promotion campaign including targeted resources for youth

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The MHF supports this action, however we recommend supporting and enhancing existing initiatives within the sector, rather than framing them as new. The MHF already offers a suite of mental wellbeing promotion resources and campaigns, including those specifically aimed at young people. Other organisations such as Te Rau Ora and Youthline have targeted resources and supports for youth. By focusing on enhancing current activities, the government can maximise the impact of investment and better support the communities in need. As such, we recommend reframing this action as "Increase investment in wellbeing promotion, including targeted resources for youth."

Develop and publish updated media guidelines and supplementary resources for different types of media

The MHF strongly supports of this action, recognising evidence supports responsible media reporting guidelines as an effective universal intervention to prevent suicide deaths.[ix] Updated guidelines are required to keep pace with the changing media landscape – they must also include specific information relevant to social media, screen, and theatre. The current guidelines are not fit-for-purpose and need greater specificity about scenarios where media coverage may increase harm. Better support for media is also required to increase adherence to the guidelines. We note that, as with most best practice guidelines, responsible reporting practices appear most likely to be adopted following a model of consultation, collaboration, media ownership, and sustained training.[x] The MHF delivers the suicide media response service and given our history and expertise in this area, we would seek to contribute to the development of the new guidelines.

Develop and implement a national alcohol screening and brief intervention programme that includes suicide prevention aspects

Evidence shows that alcohol use is a substantive risk factor for death by suicide.[xi] In Aotearoa, more than 26 percent of suicides involved heavy alcohol consumption between 2007 and 2020 (compared to the global estimate of 19%), and population groups that already have disproportionately higher suicide rates, including younger

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New Zealanders and Māori, have a higher proportion of suicide deaths involving alcohol than the general population.[2]

While we support this action in principle, it lacks information about where and how this initiative will be implemented, and we suggest it does not adequately address the contribution of alcohol use as a major risk factor. Alcohol screening and brief interventions are just one component of a broader package of interventions needed to effectively prevent alcohol-related harm and its connection to suicide and suicidality at a population level. Reducing access to suicide means (including limiting access to alcohol) is a crucial, evidence-based approach to suicide prevention, and has been highlighted as a key component in effective multilevel strategies.[xii] This underscores the need to prioritise measures that restrict the sale and supply of alcohol, such as increasing unit prices, reducing sales hours, limiting marketing and promotion, and limiting the number of retailers. Research shows alcohol-related harm increases with greater availability and decreases when restrictions are in place.[xiii] These measures are particularly effective in reducing harmful alcohol use among men and young people.[xiv]

Create safer environments in inpatient mental health and addiction and correctional facilities through progressing work to remediate and minimise ligature points

The MHF supports this action, especially considering the evidence behind the effectiveness of means restriction. We note that research shows a potential for reduction in deaths where ligatures are the means in institutional settings such as hospitals, prisons and police custody using design for safety principles.[xv] However, a systematic review on changes implemented after patient suicides in mental health services concluded that adverse event reviews of suicide deaths tend to repeat recommendations such as removal of ligature points, which are almost always already incorporated into existing policies and procedures. Much less focus has been directed towards implementing broader, more meaningful changes such as better overall facility safety design and addressing leadership and organisational attitudes to mental distress-related risk.[xvi] We recommend taking a more holistic approach in line with best practice advice.

[2] Among 4,658 suicides in those aged 15 years or over between July 2007 and December 2020, 26.6% (1,238) involved heavy alcohol consumption (Crossin et al., 2022).

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Promote wellbeing and strengthen supports provided by schools to students experiencing distress or self-harm and after a suicide

We support this action but encourage the Ministry to consider the evidence suggesting suicide prevention interventions should be integrated into a whole-of-school approach that emphasises the importance of supporting wellbeing and emotional development. This approach is essential for creating a sustained impact, rather than delivering interventions solely as individualised responses for students who are approaching, experiencing, or recently recovering from crisis.[xvii]

Focus area 4: Improve the effectiveness of suicide prevention and our understanding of suicide

Support exploration of testing of a real-time suicide data tool to provide timelier and improved suicide data

The MHF supports this action. We have heard from experts that a real-time suicide data tool will help to identify and map risk (such as detecting novel methods and monitoring contagion), support response efforts, and support postvention. However, in addition, substantial improvements are required to establish formal information-sharing mechanisms between relevant government agencies, as current practices rely heavily upon informal, good-will-driven exchanges of information. Implementing a national agreement or memorandums of understanding between specific organisations could enhance accountability and strengthen interagency collaboration.

Improve the effectiveness of online coronial recommendations recaps

The community feedback suggesting "the coronial process for investigating suspected suicide deaths also needs to be improved to make the process less drawn out, less transactional and easier to navigate" is not reflected in this action. The MHF has heard from experts that seeking feedback to improve the (administrative) review process for individual cases of suicide death, but not actively implementing change as a result of these insights, is counterproductive. We strongly urge the Ministry to commit to implementing the suite of recommendations from the report *Shining a Light on Whānau Experiences of Coroners' Investigations of Suspected Self-Inflicted Deaths*, which would also support a more whānau-centred and compassionate response to those bereaved by suicide.

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What other actions do you think could be included for government agencies to consider?

Grow the suicide prevention and postvention workforce

The Plan notes that communities recommended "there is a need to grow and develop the suicide prevention and postvention workforce." However, there is no explicit action committing to growing workforce capacity (despite this being the intended impact of focus area two). We acknowledge the *Health New Zealand | Te Whatu Ora Mental Health & Addiction Workforce Plan 2024–2027* has been recently released, which commits to increasing training places annually across multiple disciplines, including the consumer, peer support and lived experience (CPSLE) workforce, and addressing blockages in the existing training pipelines. This is welcome progress, but the suicide prevention and postvention workforce is not covered in this plan. This is concerning, as this workforce requires a unique skillset and training, including in culturally appropriate, trauma-informed care provision.

Review continuum of care and coordination of services

The Plan notes there is a need for a comprehensive continuum of care. We support this view and continue to advocate for wrap-around, joined-up supports and services that meet people where they are. We recommend the Ministry include an action to review and map the system and range of current responses available and propose ways it can support an improved continuum of care.

In particular, the previous Action Plan committed to "reviewing the systems and range of current responses available for people who have been discharged from an emergency department or inpatient services following a suicide attempt." We recommend ensuring continuity of care by developing safety plans and establishing reliable mechanisms for follow-up with people who have been discharged after experiencing suicidal crises or attempts.

Develop a national suicide prevention and postvention research plan

He Ara Oranga recommended we "include a strategic research agenda to systematically build our knowledge of the factors that contribute to suicide for different populations, strategies that are effective in reducing suicidal behaviours, including through appropriate reporting about suicide in the media, and the most

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effective ways to support people bereaved by suicide." A real-time suicide data tool is helpful, but this does not address the significant and persistent research gaps.

Support workplaces to address suicide and associated stigma

Local evidence suggests workplaces are another promising universal intervention setting for suicide prevention and postvention. We recommend focusing on supporting organisations and their leadership to talk about suicidal distress to reduce stigma, misunderstanding, and invalidation, with a specific focus on sectors who have disproportionately high suicide rates. We note that multilevel interventions focused on first responders (e.g., military, police, firefighters, ambulance staff) are associated with reduced suicide rates in these groups. Healthcare workers also experience significant pressures and require specific, targeted interventions which focus on the organisational sources of their distress.[xviii]

The MHF has a long history of supporting workplaces to adopt activities that build mentally healthy workplace cultures, with a focus on developing industry-level wellbeing programmes in farming and construction, as well as generic workplace wellbeing resources. The MHF will soon publish two workplace guides: *Supporting your staff and organisation after a suspected suicide* and *Responding to a staff member's suicidality*.

Deliver dedicated frontline responses to suicide

The MHF is concerned about the lack of a dedicated frontline suicide response. We recognise the Government has committed to a phased transition plan to move away from a Police response to people experiencing mental and suicidal distress, aiming for a multi-agency, health-based approach. However, we note workforce shortages have been identified as a significant implementation risk that requires substantial investment to address.[xix] We recommend making an explicit commitment to any health-related actions that will support this transition towards a health-led response to suicide crises.

What do government agencies need to consider when implementing these actions to ensure what is delivered meets the needs of communities?

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Implementation must be well-resourced. We are concerned about the lack of corresponding investment to support delivery of the actions under the Plan and encourage the Ministry to make this information available as soon as is practicable. We agree with the statement in *He Ara Oranga* that "previous strategies have suffered from insufficient resourcing and a lack of attention to effective implementation. In addition to focusing on what needs to be achieved, a national cross-sectoral suicide prevention strategy must be accompanied by a concrete implementation plan that specifies the actions to be undertaken and the associated resources required to support effective implementation. Suicide prevention receives relatively little funding and dedicated resources, and expertise are lacking in central government. This lack of investment and focus does not support suicide prevention. We believe that a significantly increased strategic investment in suicide prevention is warranted."

More clarity is required of roles and responsibilities for actions. For example, it is unclear who is delivering the action "Launch a new wellbeing promotion campaign including targeted resources for youth." Identifying accountabilities will support better sector collaboration and reduce duplication of efforts.

In conclusion, the MHF appreciates the opportunity to provide feedback on the Plan. We encourage the Ministry to revisit the draft with a view to adopting a more strengths-based, equity-focused, cross-government approach that meaningfully addresses suicide prevention and postvention in Aotearoa New Zealand, incorporating the vital insights of those with lived experience. By enhancing clarity, ensuring continuity with the overarching Strategy and previous Action Plan, and establishing outcome measures that enable us to track tangible progress, we can work together to create a more effective and supportive system for everyone.

Mauri tū, mauri ora,

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Chief Executive

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About the Mental Health Foundation

The MHF's vision is for a society where all people flourish. We take a holistic approach to mental health and wellbeing, promoting what we know makes and keeps people mentally well and flourishing, including the reduction of prejudice and discrimination (particularly on the basis of mental health status).

The MHF is committed to ensuring that Te Tiriti o Waitangi and its Articles are honoured, enacted, upheld and incorporated into our work. We are proud that Tā Mason Durie is a Foundation patron.

We take a public health approach to our work, which includes working with communities and professionals to support safe and effective suicide prevention activities; advocating for social inclusion for people experiencing distress; and driving population-wide positive mental health and wellbeing initiatives.

Our positive mental health programmes include *Mental Health Awareness Week*, *Farmstrong* (for farmers and growers) and *Pink Shirt Day* (challenging bullying by developing positive school, workplace and community environments). Our campaigns reach tens of thousands of New Zealanders each week with information to support their wellbeing.

We value the expertise of tāngata whaiora/people with lived experience of mental distress and incorporate these perspectives into all the work we do.

Established in 1977, the MHF is a charitable trust, and our work is funded through donations, grants and contract income, including from government.

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References

[i] https://www.dpmc.govt.nz/sites/default/files/2023-11/cpc-23-sub-0012-implementation-unit-work-programme-progress.pdf

[ii] McKenzie, S., Aspin, C., Bowden, C., Hoskin, A., Kairua, M., Best, T., Taylor, B., & Jenkin, G. (2024). *Calling for action on suicide prevention in Aotearoa*. Public Health Communication Centre Aotearoa. https://www.phcc.org.nz/briefing/calling-action-suicide-prevention-aotearoa

[iii] World Health Organization. (2018). *National suicide prevention strategies: progress, examples and indicators*. https://iris.who.int/handle/10665/279765

[iv] Haw, C., Hawton, K., Gunnell, D., & Platt, S. (2015). Economic recession and suicidal behaviour: Possible mechanisms and ameliorating factors. *The International journal of social psychiatry*, *61*(1), 73–81. https://doi.org/10.1177/0020764014536545

[v] Rojas-García, A., Dalton-Locke, C., Sheridan Rains, L., Dare, C., Ginestet, C., Foye, U., Kelly, K., Landau, S., Lynch, C., McCrone, P., Nairi, S., Newbigging, K., Nyikavaranda, P., Osborn, D., Persaud, K., Sevdalis, N., Stefan, M., Stuart, R., Simpson, A., Johnson, S., & Lloyd-Evans, B. (2023). Investigating the association between characteristics of local crisis care systems and service use in an English national survey. *BJPsych Open*, 9. https://doi.org/10.1192/bjo.2023.595

[vi] Murphy, L., Turner, J., & Doody, O. (2024). *An evaluation of the innovative peer-led, out-of-hours Galway Community Café mental health service*. University of Limerick, Health Service Executive Community Healthcare West, and Mental Health Ireland. https://galwaycommunitycafe.ie/wp-content/uploads/2024/06/Galway-Community-Cafe-Evaluation-Report.-June-10.-2024.-Final.pdf

Chmielowska, M., Mannocci, N., Tansel, A., & Zisman-Ilani, Y. (2022). Peer support and shared decision making in Open Dialogue: Opportunities and recommendations. *Frontiers in Psychology*, 13. https://doi.org/10.3389/fpsyg.2022.1059412

Shalaby, R., & Agyapong, V. (2020). Peer Support in Mental Health: Literature Review. *JMIR Mental Health*, 7. https://doi.org/10.2196/15572

Healthwatch Wandsworth. (2014). *Hampshire Safe Haven crisis café evaluation report*. Surrey and Borders Partnership Foundation NHS Trust. https://acem.org.au/getmedia/d955dbb0-86c6-4ca2-b25c-ac367b949bb8/Hampshire-Crisis-Cafe-Evaluation-ReportUK

[vii] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health. https://www.health.govt.nz/system/files/2024-07/report-evidence-synthesis-10jul24.pdf

[viii] Morgan, A. J., Ross, A., & Reavley, N. J. (2018). Systematic review and meta-analysis of Mental Health First Aid training: Effects on knowledge, stigma, and helping behaviour. *PloS one*, *13*(5), e0197102. https://doi.org/10.1371/journal.pone.0197102

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[ix] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[x] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xi] Isaacs, J. Y., Smith, M. M., Sherry, S. B., Seno, M., Moore, M. L., & Stewart, S. H. (2022). Alcohol use and death by suicide: A meta-analysis of 33 studies. *Suicide and Life-Threatening Behavior*, 52(4). https://doi.org/10.1111/sltb.12846

[xii] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xiii] Fitterer J. L., Nelson, T. A, & Stockwell, T. (2015). A review of existing studies reporting the negative effects of alcohol access and positive effects of alcohol control policies on interpersonal violence. *Front Public Health*, 3, 253.

[xiv] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xv] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xvi] Ramsey, C., Galway, K., & Davidson, G. (2022). Implementing changes after patient suicides in mental health services: A systematic review. *Health & social care in the community*, *30*(2), 415–431. https://doi.org/10.1111/hsc.13332

[xvii] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xviii] Fortune, S., Sharma, V., & Papalii, T. (2023). *Evidence synthesis of the research on Suicide Prevention and Postvention; Aotearoa New Zealand and International Perspectives*. Wellington: Ministry of Health.

[xix] https://www.health.govt.nz/information-releases/cabinet-material-people-in-mental-distress-presenting-via-111-transitioning-to-a-multi-agency

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