Draft Suicide Prevention Strategy

A collaborative, public submission.

Background

On the 2nd June 2017, Changing Minds held a forum called 'Speaking the Unspeakable' to discuss the new Suicide Prevention Strategy.

To watch the panel discussion part of the day, you can tune in here - https://www.facebook.com/changingminds.nz/videos/1883629205010658/

'Kaumatua George Hill (Ngāti Whātua) and Changing Minds welcomed the general public to a safe space to hear professional perspectives, ask questions and share concerns and opinions around the new suicide prevention strategy.'

People attending the forum live, identified themselves from all walks of life including those with Lived Experience of suicidality, mental "illness" and Addictions, whanau and friends bereaved by suicide, mental health service providers, (DHB representatives and Non-Government Organisations), politicians and local businesses.

The forum was very well attended by nearly 100 people present and over 5000 views of the live video feed. The morning kicked off with a 7-strong panel of experts in the field (see below). Robust discussions were held in the afternoon with four break-out workshops of each of the four most popular 'Actions' from the 10 actions the strategy listed, giving the public, consumers and families an opportunity to ask important questions, raise issues around suicide prevention that were important to them or suggest actions they thought should be covered in the strategy but weren't.

There was also safe spaces where participants could access peer support on the day as well as an opportunity to anonymously contribute digital narrative to the korero.

The following discussion points, articles and resources have been collated by Changing Minds, for those seeking information on The Suicide Prevention Strategy Forum. They come from the day, and from discussions held leading up to and post the event.

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For more information, or if you have something to add to this pack please contact us at admin@changingminds.org.nz

Panel Members/ Guests

- Host – Taimi Allan, CEO – Changing Minds (Speech contained in this pack)
- Mike King – Key to Life Trust and Comedian
- Dr David Codyre - Psychiatrist, Mental Health Lead, East Tamaki Healthcare
- Kayte Goodward - Livingworks ASIST and safeTALK Trainer
- Manu Fotu - Waitemata District Health Board Suicide Prevention Strategy
- Lucy McSweeney - Youth Mental Health curriculum in Education
- Shaun Robinson - CEO of Mental Health Foundation (Powerpoint slides contained in this pack)
- Leigh Murray - District Health Board- Family Advisor

Discussion

- Attendees were asked to submit their questions to the panel BEFORE the event so that we could direct questions to the most appropriate panelist for preparation and safety.
- Panelists spoke on all areas surrounding suicide and its effects, what they would like to see, the challenges they face in working in this space and personal reflection.
- After lunch, Participants reflected that all the proposed action categories mentioned in the draft strategy were important, and all needed work, particularly in defining what exact actions and by whom. (e.g. does the responsibility for this action lie with government, services, community, emergency, family or individuals)
- Given the time available, and that that the strategy's feedback process asked us to prioritise 4 of the 10 action categories, we concentrated on selecting 4 to work on specifics, and also captured generalisations about the strategy.
- Attendees were given 4 green dots. They were asked to place their green dots on the 4 most prevalent strategy activities out of the 10 we had posted up around the room.
- The top four with the most dots were the activities we worked on in separate workshops around the room. Attendees were asked to join the group that they felt they could contribute to the most.
- Around 60% of the mornings attendees stayed for the afternoon workshop session.
- There was a good balance of the amount of people in each workshop group with the bigger numbers being in actions (6) & (7).

<u>Strategy Activities chosen out of the 10</u>

- (1) Support positive wellbeing throughout peoples lives

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- (2, 3 & 4 combined) Build social awareness of and well-informed social attitudes to suicidal behaviour. Encourage responsible conversations about suicidal behaviour and preventing suicidal behaviour. Increase mental health literacy and suicide prevention literacy. These three sections had equal votes and the general consensus was that because these three dealt predominantly with attitudes and conversations, that this was a stigma and discrimination action and could be grouped as one Action Category.

- (6) Strengthen systems to support people who are in distress

- (7) Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors

Feedback from the Forum

Points to note/ Generalisations about the strategy as a whole:

- Several questions were centred around what was significantly different about this strategy document in comparison to earlier strategies, there seemed to be no link to previous learnings, nor comments on what we had learned so far from previous actions or programmes (good and bad) in this space.
- There was a "nod" to the WHO guidelines in the documents preamble but then the guidelines themselves (funding to determine outcome measures, social determinants, restriction to means, early intervention etc) were notably absent.
- The strategy is lacking clear leadership and lines of accountability.
- The strategy is too general, and not ambitious or inspiring.
- The feedback from every one of our break out workshops was that Police should STOP being the 'access point' for people in distress.
- A lot of suicidal and self-harming thoughts and actions are never reported to health providers (self-stigma, fear of discrimination/impact)
- Focusing on tech interventions (alone/ in isolation) loses the vital aspect of face to face connections.
- There were many comments about how the language used in the strategy needs to change. People agreed that it could use more verbs. More action words. Each action point should be completed with the word "by" to give specific actions and examples. It was also pointed out that the word "timely" access was only used once in the document (section 6, Page 18) and yet is an integral term in preventing death.
- People commented that some specific things were missing from the strategy, e.g. Rangitahi, Older Persons, LBGT, Whanau, strategies for dealing with impulsivity and isolation etc.
- People commented that they each needed to see themselves in the document – e.g. they did not want it to me a document that sat on the shelf, but a working guide that they could use as individuals, communities or at work to know what to do, what actions to take responsibility for)
- Many indicated that they wanted the "who" named in the responsibilities for action in prevention, intervention and post vention – e.g. government (Health, Education, MSD, Justice etc) , DHB, services/NGO's, Private Sector, Iwi, Community, Media, Emergency Services, whanau, individuals

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etc.

- There were many comments on the contracting relationships this space, for example NGO's are contracted to work with government on a particular area and therefore there is only communication around that particular contracts deliverables. Participants felt there was a real need to open up the conversation/relationship to talk about all of the areas they work in and get perspectives with and from each NGO including space and financial resource to increase innovation, increase and reward collaboration and provide unity in both focus and perspective.
- Stigma and discrimination came up as a hot topic even in the groups were not focussed on this as a strategy topic. Participants agreed that more needs to be done (Through NDI/ LMLM or other) to reduce the stigma and discrimination around suicidal thoughts and behaviour including a targeted "suicide" campaign to normalise and de-isolate the "thought" and concentrate on help-seeking, as opposed to only mental "illness" (although this is also important). It was believed by many that self-stigma leads to death. (i.e. the shame, fear of discrimination or judgement prevents help seeking and is a major contributing cause to suicidal behaviour)
- Investment in suicide prevention actions saves both economic and social costs, the general thought was that a significant financial proportion of what is "costs" New Zealand each year should be invested into researching, measuring and enacting best practice in this space. (e.g if we lose 600 lives to suicide each year and has an economic cost of 494k per death, 100 million (around 200+ lives should be re-invested in saving lives)
- More could be done, and much could be learnt in the post-vention space to support the bereaved to give their thoughts around what they think retrospectively might have prevented their loved ones death had the right support/education/interventions been available. Collect Data.
- The document needs to have particular strategies to restrict access to means, as this is cited by the WHO as having the most impact in the prevention space.
- Most (not all) agreed that the government needed to revisit a target (e.g. zero suicide) as whilst we may not reach it, it sets a benchmark (like the road toll) to take an epidemiological approach to reduction across the whole of society.
- Those who had studied the prevention strategy's feedback form believed that it felt biased toward simply supporting the document as opposed to finding the gaps, or improving the document.
- We have consulted on the strategy now in this document, and we would like an opportunity to consult on the action plan that falls out of this.

The four individual Action Points Prioritised:

1. Support positive wellbeing throughout people's lives

Start doing:

- A general focus on early youth education is a must. Curriculum standards must contain life-skills such as teaching about relationships, emotional regulation, coping skills and tools, growing food, nutrition (specific to mental health and brain development) and financial literacy would mean resilience in early stressful situations and times in life.

- Making these accessible to all so that community members recognise when youth or peers might be in a vulnerable position and understand how to approach the situation from a safe and responsible perspective. Include nutrition for positive mental health, SMART goal education, increasing metacognition education and making compassion and gratitude practice compulsory in schools.
- Free community training and public messaging about them.
- Immediately enact funded “alternatives” to pharmacological interventions via packages of care for choice (as in the disability space)
- Enact “every door is the right door” through destigmatising the process of asking for and accepting help as soon as help is needed, not just when things get bad. Allow anyone (regardless of whether they have a diagnosis or are known by MH Services) access to free/affordable talking therapy (not just medication/crisis intervention). Criteria for help needs to be defined by the person themselves, not the system. E.g. *“If I say I am feeling suicidal and need help, I should get it, not have to be put on a waiting list, told “I’m not sick enough” or have to make a serious attempt on my life to be taken seriously”*

Do more of:

- Evaluate all existing programs and assess impact measurements.
- Create a ‘Map’ of programs, services, groups and therapies including price (if applicable) and referral process and make it highly accessible to the public through increased marketing and social media direct streams to target groups. Increasing funding for those programs that show positive impact.
- Longer term funding in essential to get scope of measurements. Helping people to build on what they are already doing and how that contributes to building protective factors and reducing risk factors. Connection needs to be a big part of the conversation.
- Check as standard procedure for physical causes and links to psychological distress including social determinants, autoimmune and inflammatory markers, hormonal imbalances, sleep patterns and nutrient deficiencies.
- More consumer voice representatives in all regions, “nothing about us without us”.

Stop:

- Reduce pharmaceuticals, particularly prescribing to kids.
- Medication as a go-to, try nutrition first as a general rule for GP’s
- Using medication, police and hospitalisation as the standard crisis response

Develop:

- Keep developing the programs that are currently working, increase funding to those that are showing a real impact, by evaluating and auditing independently and committing to those orgs that have positive measurements of impact.
- Supporting those NGO’s that are doing great work by public reinforcement.

2. Build social awareness of and well-informed social attitudes to suicidal behaviour,

3. Encourage responsible conversations about suicidal behaviour and preventing suicidal behaviour,

4. Increase mental health literacy and suicide prevention literacy.

As a group, we felt these three activities could be grouped together. Also, we felt works such as "encourage and support" were not strong enough for actions around stigma and discrimination, for example instead of "encouraging or supporting" the media to report sensibly, we should be "leading, guiding, explaining how to, give guidance around, developing best practice around" or even "Mandating, expecting, regulating, teaching and demanding " non-discriminatory reporting.

Start doing:

- When we talk about metal health we should refer to it as positive "super power" that needs to be number one on our health check list calendar,
- enabling people to feel empowered by having good mental health, just as it is a pride to have good physical health.
- We should be constantly checking what language we are using to target different demographics eg Youth. When discovering and deciding on language we should always consider stigma and use words that instead empower all individuals. Language should be educational and we should include language in all mental health education.
- We believe that mental health and mental distress should be a conversation that isn't hard to have. It should be talked about all the time and having a bad day or having negative repetitive self-chatter should be talked about as something we all experience. Normalised.
- Depicting suicide as an ACTION rather than a feeling will help with a positive perspective and anyone having suicidal thoughts. Acknowledging feelings reduces stigma.
- Providing guidelines (or better yet, laws) for media reporting that prevents them from sensationalising the violence-mental illness connection and makes them balance articles with stories that challenge that myth/link.

Stop:

- There needs to be much less fear based language and actions and we should be educating youth around what and why certain language is negative. Reduction in labelling is seen as important to reducing stigma and discrimination, and this should be adhered to from every corner of our society.
- Prevent certain industries/services/employers (Police, Adoption Agencies, Winz, Airlines, Mining and Drilling etc) from discriminating against people for their history of mental illness. By all means, make them prove they are able to do the job and that they manage their "condition" well with examples, but reward disclosure by valuing the learning and resilience that comes from these experiences.
- "pussy-footing" around the word "suicide". Acknowledge that having the thought is a normal, human experience and that it is a signal to reach out for help. If we hide the fact that most people at one time or another have these thoughts, people will feel alone and more likely to act on these thoughts.

Do more of:

- The use of humour (especially social media) is an opportunity to use creative methods as a vehicle for promoting positive messages. We have seen this working and would like to encourage more of this. We feel we can reach the issue of discrimination and self-discrimination.
- Evidence based training and support for communities around what language increases and decreases stigma and discrimination.

Develop:

- We have an increasing Pacifica/Asian/Oriental population. We are seeing a rise in the need for more cultural engagement and respect of all cultures when speaking about mental health and or mental distress. Opening with 'Safe' spaces and encouraging compassion and empathy when working with these communities.
- We have an increasing older population, include "a life worth living" programmes for older communities that encourage community connection and mixed ages (e.g. situate more child-care centres in with or alongside rest-homes, offer free or cheap accommodation for students to live in older-people communities such as rest homes and retirement villages in return for a "rental" of helping the older people daily)
- Network of people across the country who are willing to speak openly about their lived experiences, respond to the media and be seen as challenges to the "stereotype" of mental "illness". Find more people to speak out than the "usual suspects" personalities.
- Financial grants for projects in the communities that tackle stigma and discrimination using evidence-based language and techniques, train and support these projects so that they make a positive difference.

7. Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors

Start doing:

- By looking at stress in the workplace, we are able to gauge what industry requirements are for employers and employees. We would like to see a remit of the health and safety act that responds to mental health and considers the guidelines and policy.
- Have an integrated and specialised crisis team as part of the Police service or give crisis training to the Police force so that they will recognise mental distress and be more successful in their outcomes.
- Have more information at GP's clinics of the NGO's and services available for them and their family members. Make this more a point of conversation with receptionists and GP's so that the conversation becomes normalised in these spaces.
- All other government departments that have heightened stress levels such as Housing to be trained in recognising and positively managing mental distress and combatting discrimination.
- A for Maori by Maori workforce training in mental distress awareness. Cultural considerations and engagement roles in large organisations. And Pakeha workforce education. All sectors to have lived experience representatives so that any decisions or policies written have lived experience advisory. With more of a focus on stigma and discrimination as a general worldview across all sectors.

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Do more of:

- By informing all sectors of a 'People over Process' approach and working with authenticity we set a precedent and expectation that discrimination and Stigma is not part of our culture. That it is EVERYONEs role to work with cultural consideration for Maori and Pacifica. With continuous training in mental health within organisation not just a one off workshop once over 5 yrs.

Stop:

- Currently the Police working as a crisis service is not working or resulting in positive outcomes.

Development:

- Mental Health training 101 should be strength based training and not diagnosis focussed, with the approach that people's innate ability for resiliency and problem solving is important to being mentally healthy.
- All training programs to have persons with lived experience consultation within development, evaluation and improvement stages as well as absolutely facilitated by to combat stigma at the same time through the power of contact.
- Promote more positive lived experience stories through-out New Zealand. Include youth korero around suicide.
- Develop a youth focused suicide prevention strategy, separate to the overall strategy.

6. Strengthen systems to support people who are in distress:

- People felt there was no system to strengthen – so this needs to be changed to 'Develop systems to support people who are in distress'.

Start

- Increasing capacity and capability of the workforce i.e
  - Increasing engagement skills
  - Upskilling primary care so suicide prevention work is in the primary sector, rather than tertiary sector
  - Recognising the different workforce needed in primary care
  - Enable primary care services to better recognise distress and provide better services i.e talking therapies
- Flexible access to support services i.e public holidays, increasing geographic locations
- Giving out useful messages if people are asking for support i.e "not suggesting have a hot bath"
- Reviewing evidence from other counties who have reduced incidents of suicide and translate 'best practice' to fit the NZ context
- Separate the suicide hot line/increase capacity in the system to better support

- Incorporate the needs of family/whanau, and recognise it is a family in distress [not just an individual]. Huge level of disconnect between what people expect [when supporting/accessing help for a family member] and when it hits you in the face.
- Being accountable – no one wants accountability. That's why we need a target
- Funding psychosocial support/access to services to support these needs.
- Creating services that are responsive to the 'spirituality' component of holistic health care.
    - Ensuring spirituality is in the strategy, addressing the meaning and hope. Finding a way out of the cycle [of distress] for people
- From a Pasifika space, eliminating the reasons for people experiencing distress [causes of the cause/addressing psychosocial needs)
- Connecting NGO and Primary sector to work together

Stop

- Using police as a 'access point' for people who are distressed

Do More

- Resource more community groups to deliver in this space. Better equip communities
    - Run more groups in the community
- Increase community capacity i.e. family/whanau capability to support
- More MH resources in suicide prevention in primary care sector
- In schools and primary care [education/support]

Develop

- Better navigation of services, and ensure they are connected. Developing a roadmap of 'where to go' for individuals and their whanau online and on posters at every GP in the country.
- Join up help so that it is connected-
    - ED
    - GP
    - Telehealth
    - Secondary/ Private and NGO
- Systems that are user/whanau defined. People don't 'want' services [stigma being the barrier], so if they are asking for help we need to have a system that is responsive
- A community model to support family/whanau to open up their homes to a vulnerable person (ensuring care for younger children). (works successfully in Germany)
- Develop systems that involve family/whanau including:
- informed consent. Robust discussion (without consensus reached) regarding a proposal of 'the risk should outweigh privacy if the person is living with a family member'
- Encouraging staff to involve (and not blame) family

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Resources

1. The Draft Strategy for public consultation: http://www.health.govt.nz/publication/strategy-prevent-suicide-new-zealand-draft-public-consultation
2. Suicide prevention strategy, action plans, and reporting: http://www.oag.govt.nz/2016/suicide-information/part2.htm
3. #ItMatters: http://www.itmatters.org.nz/
4. MSD Youth suicide prevention strategy evaluation: http://www.msd.govt.nz/about-msd-and-our-work/publications-resources/planning-strategy/youth-suicide-prevention-strategy/
5. MoH Working to prevent suicide: http://www.health.govt.nz/our-work/mental-health-and-addictions/working-prevent-suicide
6. NZ Suicide Prevention Strategy 2006 – 2016: https://www.health.govt.nz/system/files/documents/publications/suicide-prevention-strategy-2006-2016.pdf
7. New Zealand Suicide Prevention Action Plan 2008–2012 http://www.health.govt.nz/publication/new-zealand-suicide-prevention-action-plan-2008-2012
8. New Zealand Suicide Prevention Action Plan 2013–2016 http://www.health.govt.nz/publication/new-zealand-suicide-prevention-action-plan-2013-2016
9. Helplines from MHF: https://www.mentalhealth.org.nz/home/our-work/category/34/suicide-prevention
10. ‘Skylight’ statistics: http://skylight.org.nz/suicide+research%2C+statistics%2C+prevention+strategy
11. ‘Zeal’ Youth Suicide Prevention: http://zeal.nz/livefortomorrow?gclid=Cj0KEQjwmv7JBRDXkMWW4_Tf8ZoBEiQA11B2fvssUXqTHk-N4qIRs6uw2Smg6gieVzeMhTfv5IGDzxcaAije8P8HAQ
12. Stats NZ data: http://www.stats.govt.nz/browse_for_stats/snapshots-of-nz/nz-social-indicators/Home/Health/suicide.aspx
13. Data story - An overview of suicide statistics (pdf, 544 KB) http://www.health.govt.nz/system/files/documents/pages/data-story-overview-suicide-prevention-strategy-april2017.pdf

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14. Data story - An overview of suicide statistics (ppt, 698 KB) http://www.health.govt.nz/system/files/documents/pages/data-story-overview-suicide-prevention-strategy-april2017.pptx
15. Suicide Facts: Deaths and intentional self-harm hospitalisations 2013 http://www.health.govt.nz/publication/suicide-facts-deaths-and-intentional-self-harm-hospitalisations-2013
16. Suicide Facts: 2014 data. http://www.health.govt.nz/publication/suicide-facts-2014-data
17. Ngā Rāhui Hau Kura (Suicide Mortality Review Committee Feasibility Study 2014–15) - Health Quality and Safety Commission NZ http://www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/2471/
18. Themes from Community Suicide Prevention Workshops 2017 (Word, 43 KB) http://www.health.govt.nz/system/files/documents/pages/themes-community-suicide-prevention-workshops-apr17.docx
19. Themes from Suicide Prevention Clinicians and Academics Consultation Workshops 2017 (Word, 28 KB) http://www.health.govt.nz/system/files/documents/pages/themes-suicide-pevention-clinicians-academics-consultation-workshops-apr17.docx
20. Suggested Actions for Suicide Prevention 2017 (Word, 180 KB) http://www.health.govt.nz/system/files/documents/pages/suggested-actions-suicide-prevention-apr17.docx
21. Stocktake of suicide prevention activities across government agencies (Word, 34 KB) http://www.health.govt.nz/system/files/documents/pages/stocktake-resources-across-agencies-suicide-prevention-apr17.docx
22. The Cost of Suicide to Society (Word, 197 KB) - September 2016 http://www.health.govt.nz/system/files/documents/pages/cost-suicide-in-nz-apr17.docx
23. The Cost of Suicide to Society - December 2005 http://www.health.govt.nz/publication/cost-suicide-society
24. Collecting and using information about suicide - Page 7 paragraph 1.5 - Controller and Auditor-General NZ http://www.oag.govt.nz/2016/suicide-information
25. Estimating the benefits of investment in ongoing suicide mortality review – a cost benefit analysis - Health Quality and Safety Commission NZ http://www.hqsc.govt.nz/our-programmes/mrc/sumrc/publications-and-resources/publication/2855
26. A rapid review of the Suicide Prevention Literature (Word, 788 KB) http://www.health.govt.nz/system/files/documents/pages/rapid-review-suicide-prevention-literature-dec16.docx
27. Preventing suicide: A global imperative - World Health Organization http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/
28. Suicide prevention strategies revisited: 10-year systematic review - US National Library of Medicine https://www.ncbi.nlm.nih.gov/pubmed/27289303
29. Suicide prevention outcome framework (PDF, 1.4 MB) - May 2015 http://www.health.govt.nz/system/files/documents/pages/spof_final_may_2015_hal.pdf
30. Suicide prevention outcome framework (PDF, 1.8 MB) - November 2016 http://www.health.govt.nz/system/files/documents/pages/spof_final.pdf

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31. Approval to consult on A draft suicide prevention strategy (Word, 725 KB) http://www.health.govt.nz/system/files/documents/pages/suicide-prevention-redacted-cab-paper-apr17.docx

Associated Media Articles / Follow up news etc

1. Stuff; Suicide Prevention Strategy, the responsibility of all of us: http://www.stuff.co.nz/national/health/92586882/suicide-prevention-strategy-the-responsibility-of-all-of-us
2. The Guardian; Royals launch campaign to get Britons talking about mental health: https://www.theguardian.com/society/2017/mar/29/royals-launch-mental-health-campaign-videos-get-britons-talking
3. Be the change NZ: http://www.bethechangenz.org/?gclid=Cj0KEQjwmv7JBRDXkMWW4_Tf8ZoBEiQA11B2fv6Mv7_oBUYwebZ5pMeVM0Jl2opY4MHVU5stwkFEoswaAgCH8P8HAQ
4. Stuff; Mental Health advocates support Mike Kings stance on suicide prevention: http://www.stuff.co.nz/national/92609311/mental-health-advocates-support-mike-kings-stance-on-suicide-prevention
5. The Spin Off; Mike Kings letter of resignation: https://thespinoff.co.nz/society/15-05-2017/a-masterclass-in-butt-covering-mike-kings-letter-quitting-suicide-prevention-panel/
6. Radio NZ; A meaningless plan: http://www.radionz.co.nz/news/national/330858/suicide-prevention-plan-a-meaningless-statement
7. Radio NZ; 13 Reasons Why, resonating with young people: http://www.radionz.co.nz/news/national/329044/teen-suicide-series-%27resonating-with-young-people%27
8. ADLS connecting lawyers; Suicide in NZ, a reflection: http://www.adls.org.nz/for-the-profession/news-and-opinion/2017/5/5/suicide-in-new-zealand-%E2%80%93-a-reflection/

Panelists Speeches/ presentations

"Speaking the unspeakable" Safe Discussions around Suicide Prevention.

Taimi Allan, CEO, Changing Minds - Introduction

Tena Koutou, tena koutou, Tena koutou, katoa.

Kō Lofty te maunga , Kō Murray te awa, Nō Australia ahau

Kō Ngati Manene te iwi, Kō tangata iti whiora te hapu

Nō Titirangi taku whare,

Kō Rod rāua, kō Sue ōku mātua

Kō Stewart taku tane, Kō Taimi Allan taku ingoa

Kō Flynn rāua kō Jamilah aku tamariki

Nō Reira,

Tena Koutou, tena koutou

Tena koutou Tatou Katoa

Thank you Matua George for that beautiful karakia, and reminding us of what is important here today, he tangata, he tangata, he tangata.

I'd like to begin by acknowledging those who we have lost to suicide, it is for them that we are here today

I'd like to acknowledge the Lived experience in the room of those who have survived suicide and are brave enough to share the courage and bravery it took to recover.

I'd like to acknowledge families, whanau, friends and colleagues that are grieving, and those in the room still in pain.

I acknowledge all the work that is going on in this space, with dedicated and passionate people who are not in it for the money, but because they genuinely care – many of these people are here today, both on our panel and in the audience. I want to thank you for the important mahi you do, and by increasing the mana of people who experience suicidal thoughts and their families.

I want to also acknowledge the media who do their best to raise awareness of the problems in mental health and addiction although they don't have the bigger picture, and I want to put a challenge out to everyone in the room to help the media with that bigger picture by equally sharing those stories of help and recovery, so that when stories are released, they do not enforce the notion that all is hopeless, and if I reach out for help it won't be there. Help is there, and while it's far perfect, there are thousands of us committed to making change, even in trying circumstances.

And lastly, I need to acknowledge that everyone in the room has a story (or more than one) to tell, and that those stories are real, valuable learning opportunities for a system and culture that needs to get better at this, but I also want to recognise that for many in this room today, they are not ready to hear those stories for their own safety, and that even the word "suicide" is a difficult to hear. So, I respectfully ask you today to hold onto those stories. Be kind and compassionate to each-other, speak to help and consider how your words may affect others. After lunch, when we enter the workshop session there will be two safe places to share those stories.

In the meantime, I want to point out and thank our Peer Support Workers from Mind and Body who have generously gifted their time to us today to sit with you if at any time you feel you'd like some support or need to share your story. They are the ones wearing the "hearts" on their sleeves. We have booked a private room upstairs where you can go to talk confidentially. Just catch someone's eye as you leave the room and someone will follow you.

(quick touch on housekeeping – bathrooms and alarms, morning tea and lunch)

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Why are we here? The government has released a Draft Suicide Prevention Plan which is fair to say, most of us here think it still needs some work. Today is an opportunity to hear from our panel who live and breathe their own personal experience in the suicide prevention space.

We are not Ministry of Health representatives, nor did we write the plan, so we cannot answer questions directed at the plan itself, but we can take this as an opportunity – to feed-forward to the Ministry our concerns, priorities, learnings and knowledge of what works, and what does not, what's needed and what needs to stop. Our panel will give you some very different perspectives on this today.

We want to see ourselves in this plan, we want the actions to be something we can all relate to, and use as a guide in our own personal and community efforts to change our horrifying statistics. And to see ourselves in it, we have to put ourselves in it.

After lunch I want you to really consider the actions as real things we can do to make a difference, so we can tell the government how to speak about suicide safely, how to survive those moments in time where we've lost our strength to reach out, and how to help others through those moments.

We want to tell the government about how to address the self-stigma we feel around reaching out, or burdening others – how the consequences of real discrimination and judgement are often more frightening than death itself.

And most of all we want to give real strategies to address the pain, for the person, their families, our communities and our society.

The strategy asks us to prioritise 4 of the 10 suggested actions, and we will do that after lunch, but we know that in asking us to prioritise, they are really asking us to tell them what to fund. So I am going to quickly touch on that.

Suicide costs New Zealand 2 billion dollars a year, this is the combination of economic costs like hospital, ambulance, police, victim support and the coroner and social costs like psychological distress, impaired physical and mental health, pain, suffering and loss of employment. In other works, the value of a statistical life is 3.85 million per fatality.

Mental health services are currently funded at around 1.4 billion across the country, we are spending less on our total system than suicide alone costs us, and as Mike will talk to, suicide is not just a mental health issue.

We know however from looking across the world that real investment in suicide prevention saves both money, and lives. Scotland's "Choose Life" programme invested the economic cost of 5 people's lives and saw a 17% reduction in suicides, and in Florida where they fine-tuned the target even further, they invested 18 million in suicide education and 11 million in peer support for college students. The economic savings from the lives they saved in that programme? $112 million.

We know that the saving of lives is worth far more than the economic cost, and so that is why profits from today are going in to the "it matters" campaign to tell our politicians, regardless of who you vote for that robust policy and funding for mental health and addictions needs to be a priority this election. So, if you haven't already added your name to it matters and shared it, please do that today.

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Lastly, I want to leave you with a story.

Don Richie was a retired insurance salesman who lived at the Rocks, on Sydney's harbour – a beautiful place which also happens to be Australia's top suicide spot.

When he saw someone standing on the top of the cliffs he could see from his window, he would go out to them and ask them into his home for a cup of tea and a chat.
That simple act officially saved over 160 lives.

Don wasn't a mental health professional, he was just someone who had the compassion to care about others and the courage to do something about it.

Let's walk through today with compassion and courage.

I will now hand over to our first speaker, Mike King.

Leigh Murray, Family Advisor, WDHB – Waitemata District Health Board

- As a family advisor I bring systemic family, whānau perspective to DHB senior mental health management & facilitate staff access to training, education & resources on working with whānau. Contact with whānau is generally via surveys, focus groups & forums. I am currently a member of the ADHB/WDHB Suicide Prevention advisory committee.
- Lots of people feel suicidal at some time in their lives, so it is relatively common to support a whānau member or friend who is having suicidal thoughts. This is something I have had to do fairly regularly over the years and I want to say I have never found it easy. Inside there are still the butterflies of anxiety & fear knowing that someone I care about wants to end their life.
- As a whānau member I have learn't to supportively ask the question "Have you thought about suicide?" and know how to respond when the answer is yes.
- I am passionate about excellent written resources like 'Are you worried someone is thinking of suicide?' getting out to friends and whānau. Also the latest booklet from the MH Foundation 'Having suicidal Thoughts & Finding a Way Back' getting out to people who need it. This booklet will save lives.
- Have found the Thomas Joiner model of suicide risk helpful. It acknowledges the place of thwarted belonginess & perceived burdensomeness as increasing risk for suicide. Where someone is alienated from others & not an integral part of a family or valued group and where someone's existence is perceived as a burden on family & friends. I want to remind whanau about the importance of language. A label often ascribed to us is word carer/caregiver. Easy for person we are looking after to see themselves as a burden with no room for mutuality or reciprocity when we use labels like that. Hope we can move to a place of mutually respectful relationships where we are there for each other when support is needed.
- Fear about what might happen can make us doubt our ability to provide support as whanau and friends & even back away. I want to say please don't underestimate the power that you do have to make a difference. Difficult things do happen in life and while everything may not always be

ok. It is a powerful thing to say 'You do not have to face this alone. Together we will get through this. Let's go and talk to someone."

- I also want to acknowledge those who end up ending their life even when they are receiving a lot of professional support. When people are paid to support you they can get another job and be out of your life the next day. Getting close to people and then never seeing them again can be traumatic and trigger feelings of abandonment. I can't overestimate the importance of natural supports to promote wellbeing and purpose for us all.

Public Commentary on the day of the event

The thing I want to know…

Could the M.O.H. fund a campaign to encourage men to speak up and de-stigmatise mental health? Such as the Queensland campaign "Soften the fuck up".

Will the M.O.H. acknowledge the social distinction alcohol causes and demand that the government taxes alcohol to reduce consumption? The funds could then be directed into social services to support people in distress.

Would the M.O.H. fund a campaign (media & online) that covers these five things that people can say to someone who is distress: - Are you OK? -What happened? -Are you talking to someone? -I care. -If you want to go and talk to someone, I will come with you.

I would like to know if: The committee that developed this strategy have read "Sorrows of the Century" by John Weaver about interpreting suicide in NZ 1900-2000 as it clearly identifies key social and cultural issues which often lead to suicide.

The thing I want to say…

I feel that disabled people are not represented. We have a hell lot of lived experience that is educational towards prevention, given the suicidal rates are huge within the disabled community. I believe every community can benefit from the disabled prospective.

I am most concerned about the people who fall between the cracks (people who are unemployed, self-employed, underemployed, who don't belong to communities, who possibly don't have networks of schools, people who don't have partnerships, people who aren't in any tertiary/primary education)

All the suicide prevention effort goes towards communities and whanau but most people who are truly isolated don't belong to the community. We professionalised and academicized basic human kindness or care for each other.

Target strategies specifically for creatives and artists as they have with farmers. Investigate the contributing factors to artists suicide e.g. undervaluing artists.

Spotify is killing musicians.

Butterfly dairies - very powerful resource, at engagenz.co.nz

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One thing that bugs me…

From the blind prospective, we are invisible within the mainstream society as opposed to death (who are very visible and heard).

People ask questions like "why" when they are very valid reasons, if individuals were asked.

A sense of isolation and distance from epicentre. Island mentality. Tall poppy syndrome - idea that there is scarcity, only a few people can be at the top. Distrust of experts. An idea that you have to do everything yourself. Being too independent. Passive aggression. Binge drinking culture. Trivializing addiction.

Having people who moved to NZ shared their experience why they love this country.

We do need to talk about addictions.

It would be healthy to think of each suicide as murder to ascertain motives.

I need to tell me story…

I did try to commit suicide when I was in my late 40's and recovering from some years of side effects from brain overload of pharmaceuticals and still with these side effects draining me. Later I could prove I had the incorrect medication and eventually one was given me that allowed me to think clearly. Another story. While under the side effects, it eventuated for me that I began to feel in a state of feeling not to eat or drink. I felt this way and lay on my bed for two or three days without eating or drinking or leaving the bed. I know now, because I was not eating fresh vitamins and minerals into my brain, it became very hard for me to break away from the initial thought pattern that then occurred of a sudden, to end my life. In fact, my mind stuck in a groove thinking only this, for some hours, and not able to think anything else. I cannot remember if it was after 3 or 4 or 5 hours that I could only think one thing; to end this life: so much it felt as if building up to it. I got up out of bed and went downstairs to the garage to find a thin rope I had stored there. And I tried more than once to achieve an end of things. I put it down to not seeing a way to shift my mind out of the initial pattern and thought which became reinforced with each new effort to think otherwise. I became stuck in this groove. With no apparent way out. Two friends visited after the suicide attempt and while I opened the door to them, I then went straight back to the bed. I did not then get off the bed but perked up. They must have rung the Mental Health service. Another friend climbed in the window over a two story drop from the stairs outside and gave me a pack of sandwiches which I tipped out of the window in the kitchen into my compost bin below. A day or two later I was picked up by a crisis team to be taken to a mental health unit where I was put on a drip, of liquid nutrition, because the nurse thought I was going to die. Due to severe malnutrition and absolute dehydration I had been seeing images while at home not eating and drinking, that I thought were testing me and were not I thought helpful to me. They were fear inducing. Due to this experience of the effects of not eating and drinking normally, I feel to advocate the following: That information on the importance of the intake of pure water for drinking several times a day is necessary for healthy brain function, hydration, electrolyte balance of the brain, and for lubricating the myelin sheath of nerves to conduct adequately the nerve impulses. That information on the importance of fresh vitamins and minerals and essential fatty acids is significant for healthy brain function and thought processing and

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control of thoughts. That drinking and nutrition education is essential in suicide prevention education in schools, with supporting families, within the service of public primary health care by doctors; and NGO and health board mental health services. That narcotic drug and alcohol intake distort our nutritional balance and this fact may also lead to suicidal tendencies; and correct nutrition is essential for reinstatement of correct nutritional balance for brain repair, and consequent better thought control and insight into recovery. That fully trained orthomolecular nutritionists specialising in mental health be trained or brought out from overseas to diagnose imbalances and deficiencies of vitamins and minerals for adequate brain function and give dietary counselling and supplements; and that these nutritionists work in team with doctors in primary health care and mental health services, and in early prevention before the tipping point occurs for anyone with suicidal tendencies of thought and anxiety and emotional despair or depression, obsession or fear or hallucination which may all be accentuated by malnutrition in the form of imbalance or deficiency of water and healthy foods. Both fear and anxiety, and also trauma can lead to a depletion or imbalance nutritionally. And a depletion or imbalance can be a cause that facilitates fear and anxiety and consequent trauma! A real double bind in effect!

END

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