A Strategy to Prevent Suicide in New Zealand 2017

Submission to the Ministry of Health

PSA
For a better working life
New Zealand Public Service Association
Te Pūkenga Here Tikanga Mahi

A Strategy to Prevent Suicide in New Zealand 2017: Draft for public consultation

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22 June 2017

Background

The New Zealand Public Service Association Te Pūkenga Here Tikanga Mahi (the PSA) is the largest trade union in New Zealand with over 63,000 members. We are a democratic organisation representing members in the public service, the wider state sector (the district health boards, crown research institutes and other crown entities), state-owned enterprises, local government, tertiary education institutions and non-governmental organisations working in the health, social services and community sectors.

The PSA has been advocating for strong, innovative and effective public and community services since our establishment in 1913. People join the PSA to negotiate their terms of employment collectively, to have a voice within their workplace and to have an independent public voice on the quality of public and community services and how they're delivered.

PSA members have a strong commitment to protecting the democratic integrity of our public institutions and our legislative framework - both at a local and a national level.

We are committed to the principles of the Treaty of Waitangi.

Introduction

1. The PSA is the main union representing mental health workers. Many members across our DHB, Community, and Public Service sectors work in jobs that include some aspects of suicide prevention, identification, treatment, service design and postvention support. They have a unique insight into how a suicide prevention strategy can work in practice. Across our membership, we have members who have been affected by suicide as have their family/whānau, friend groups and colleagues.

2. This submission has been informed by feedback from members working in mental health, as well as by members in the PSA's Māori representative structure Te Rūnanga, the PSA Youth Network (PSAY) and Out@PSA. All comments from members recorded in this submission are anonymous.

General comment

3. Thank you for the opportunity to provide feedback on the draft Strategy to Prevent Suicide in New Zealand. The following paragraphs outline some of the common themes from members' feedback.

4. While there are many positive aspects to the strategy that members, in general our members felt that the strategy is too broad, with insufficient detail. This could make it difficult to operationalise, and thus ineffective.

5. Members also felt that the strategy has insufficient emphasis on the workplace, which as one member noted: "can be both a protective and a risk factor". Workplaces should be a central focus of the strategy, as places where people can easily access support, but also as places that can contribute to suicidal behaviour. Some of the workplace-related risks to mental wellbeing outlined by members included stress, high pressure and overwork, and workplace bullying. The strategy could benefit from more detailed proposals related to improving workplace cultures, attitudes and practices (see paragraphs 31-35 for more discussion on the workplace). The PSA would welcome the opportunity to work with the Ministry of Health in the future development of plans to enhance workplace policies and practices in this area.

6. Members highlighted the need to have well-resourced universal social and health services in place as a priority. They commented that the effectiveness of the strategy would be undermined without significant investment in health services to ensure the availability and accessibility of services. Many members are concerned about the ability of core services to meet demand, and the crisis in the mental health system in particular: "*The crisis in the mental health system is well documented but ignored by the government. Until such time we have a government that acknowledges this nothing will change."*

7. PSA members also commented on the importance of ensuring access to community support services. They noted the degradation of services that has occurred due to underfunding of community services. Members are concerned that the government needs to fund services properly and ensure they are accessible to all who need them. It is also important that non-clinical pathways are open to people, as some may feel reluctant about seeking help if services are associated with the mental health sector. Members highlighted difficulties accessing professional counselling :

> *"The key issue I have come up against for myself is the difficulty of getting access to early intervention counselling. It is a really important service to catch issues early. It takes quite a lot of courage to ask for counselling, and if the service is not readily available, people will be put off. Often one or two professional sessions can help put issues in perspective and avoid people going down the road to suicide. I understand that counselling is not the panacea for suicide prevention. However, the lack of access at early stages is an enormous gap in our mental health system".*

8. Another common theme was that the strategy doesn't adequately address the socio-economic factors that often contribute to suicidal behaviour. While we understand the limitations of this strategy in being able to affect economic change, members were very mindful that unless social

and economic deprivation, marginalisation and inequalities are addressed, the strategy will have limited effect:

> *Perhaps a reference to Abraham Maslow may be helpful here in as much that unless the basic safety, security and support needs are met – then we will continue to have people in distress to the point where they consider ending their own lives.*

Detailed comment

Part One: "What we know about suicidal behaviour"

9. Our members thought that the strategy is generally accurate in describing the causes of suicidal behaviour, although some omissions were identified. These included:
    - "Rejection by support systems, friends, family/whanau, and co-workers".
    - The stresses and pressures of the workplace. One member commented that "work can be both a protective and a risk factor… I overwork myself, and the organisations I have worked for have taken advantage of this, sending me into a downward spiral that is hard to come back from."
    - Bullying – in workplaces, educational facilities and elsewhere.
    - "places of worship", which could be added to the "Community" section.

10. Some members felt that the causal analysis was too broad, and tended towards over-simplification:

> *There is no simple explanation for the cause of suicidal behaviour, it arises in relation to a myriad of direct and contextual factors. In some cases it can be as a direct result of mental illness – such as in response to command hallucinations and somebody who has a psychosis; in other cases suicidal behaviour can result from a person's internal distress and pain and the lack of effective coping strategies at the time.*

11. In general, we found the proposed framework for preventing suicidal behaviour – that incorporates universal, targeted and indicated activities – to be useful. We support a targeted and indicated approach but think it necessary to emphasise the importance of comprehensive, accessible and quality universal services for all who need them. These universal services provide the important safety net upon which the success of the strategy rests, and will be the first line of assistance for vulnerable people, their friends and whānau. One member commented that:

> *"Yes I agree with the three types of approaches, as long as these are:*
>
> - *pro-active and outreaching, making a real effort to actively work with the relevant groups, not just waiting for people to come to the agencies;*
> - *supported by universally accessible services. That is, although specific services might be delivered through the 'targeted' or 'indicated' approach, there should be a long-term commitment to sufficient funding and resources to ensure that anyone who needs support can quickly and easily be identified (or self-identify) and gain access to the relevant services. The services offered through each approach need to be widespread (in every part of NZ, not just major centres) and*

universally accessible. People should not have to be at crisis point to access services, nor should they be denied access if they aren't part of (or haven't openly identified as) the most high risk groups."

12. Another member commented

"*A mixture of universal and targeted measures may be effective but it will be very hard to determine which measures, if any, may have a causal relationship to any decrease in suicidal behaviour. At a policy level to indicate a range of different issues which may influence suicidal behaviour does not give any degree of certainty in relation to which government departments or other organisations need to take responsibility for taking direct action to address the general areas which have been identified and this is something that the consultation document lacks – that is a degree of detail".*

Part Two: "Our approach to preventing suicidal behaviour"

Vision and purpose statements

13. Comments on the vision and purpose statements included:

"I like that it is holistic rather than just looking on an individual level. This recognises the impact of society, community, families on wellbeing and suicidal behaviour.

I like that the focus is to reduce suicidal behaviour, not just suicides. Also I like the focus on groups that are disproportionately affected by suicide".

"The purpose should be the elimination of suicide in NZ"

"They are outward looking. My concern is those in deep distress struggle to view the world with an outward and future perspective, their pain is inward focussed and immediate".

"The vision is silent of the fact that life is something to be valued. Surely, if we are wanting to reduce suicidal behaviour, then we should be clearly stating in no uncertain terms that human life on an individual basis is something that should be valued – and that the government (as representative of the wider community) needs to make that statement loud and clear!"

"Suitable vision, realistic purpose."

"*The vision statement is straight to the point and inclusive of all people within New Zealand. Although few words, the vision is big. Realistically though, it is somewhat unattainable. The purpose is well thought, and touches on how they aim to reduce suicide in New Zealand*".

The three "pathways" (p.8,9)

14. The three "pathways" was an area where members thought the strategy should make more mention the importance of workplaces in people's lives. We recommend that workplaces be included in each of the pathways, for example: "strengthen/support whānau, families, friends and workplaces."

15. We are pleased that the strategy acknowledges the importance of economic factors in contributing to positive wellbeing throughout people's lives. However, the strategy is too vague on how economic wellbeing can be enhanced. It needs to incude stronger statements that detail the tangible social and economic policies likely to promote wellbeing. One member noted:

> *"The 'Building positive wellbeing throughout people's lives' pathway is presented using very general statements. If the strategy is adopted, there needs to be material changes made to raise the standard of living of many people in Aotearoa New Zealand. This includes universally accessible free health care (including mental health care), housing security and financial security.*
>
> *There also needs to be a focus on education around mental health including suicide. I have frequently come across extremely damaging attitudes towards mental health (e.g. that no-one should have depression in NZ because we haven't had any wars recently, that suicide is cowardly, that people with anxiety just need to calm down) and towards wellbeing in general (e.g. that people whose health is impacted by poverty, systemic racism, housing insecurity, financial stress, etc have just made the wrong choices).*
>
> *It is often a struggle for people to improve their wellbeing in our neoliberal society, with governments and citizens who aggressively refuse to acknowledge systemic inequality and instead focus on putting all the blame for life circumstances and health status on individual. Strategies such as this one need to recognise the impact that societal and systemic issues have on people's lives. Their high-level broad policy statements also need to be followed up by real action and more funding. I realise that this can be difficult to capture in a strategic document, but maybe some stronger wording around the impact of a person's/whānau's/community's broader health & security on mental health and suicidal behaviour."*

16. Other comments included that:

> "*The vision is silent of the fact that life is something to be valued. Surely, if we are wanting to reduce suicidal behaviour, then we should be clearly stating in no uncertain terms that human life on an individual basis is something that should be valued – and that the government (as representative of the wider community) needs to make that statement loud and clear!"*
>
> *"Yes. It is important to support people not only during a crisis but in their everyday life, and to support the people around them as well."*
>
> *"Yes although priority must be on the recognising and appropriately supporting people in distress pathway".*
>
> *"The Pathways state laudable goals but lack detail about how these goals/pathways are going to be operationalised, and as they say the devil is in the detail! What this document needs is a lot more detail about how these pathways are going to be operationalised and*

who is going to take responsibility for making sure this happens, and also how all this activity is going to be resourced.

Part Three: Turning the shared vision into action

17. On the areas and activities that are the highest priority for government agencies, our members made the following comments:
    - "Education – places of learning. Health – access to medical resources and counselling."
    - "Ensure that there is sufficient and ongoing funding and resourcing for support agencies/organisations (including DHBs and NGOs) to carry out their work. The last few years have seen frequent funding cuts and freezes meaning that support agencies/organisations have closed down and/or had to cancel vital services. Examples include Relationships Aotearoa, the ongoing threats to Lifeline's funding, and the closure of several DHB acute services units."
    - "Provide more funding so that people accessing healthcare through DHBs can be seen quickly rather than face a wait of months or even years. Bring back the ring-fencing of mental health funding. Measure the speed of access – that is, measure if people can or cannot access all the services they need within an ideal timeframe. If they can't this needs to be fed back to government to show that more funding is needed."
    - "Ensure that support services (including mental health and other health services) remain free for users or, if there is an existing cost, are actively transitioned towards being free for users."
    - "Actively support, fund, and work constructively with agencies/organisations that provide appropriate support for tāngata Māori and Māori communities (using the definition in the draft strategy which includes culturally appropriate support), that are Māori-led, that work within Māori communities, and/or that honour Te Tiriti o Waitangi."
    - Actively support, fund, and work constructively with agencies/organisations that provide appropriate support for other groups that have higher levels of suicidal behaviour.
    - Advocate for funding and resourcing in other healthcare areas which have a significant impact on the wellbeing of certain groups. For example, actively increasing funding and resourcing for gender-affirming healthcare (including surgery). The existing waitlist is horrifically long and this is likely to have a significant negative impact on the wellbeing of transgender New Zealanders.
    - Education and information for employers.
    - Educating individuals and their support people about their rights with employment and mental health issues,
    - Easy access to support networks for those experiencing suicidal behaviours.
    - Providing engaging information to the families, friends and the community to ways they can support a person in need – whether it be to contact someone, or have action plans in place for those with known behaviours.
    - "Promoting the understanding that suicide being described as a selfish act is extremely unhelpful. Often we seriously feel as though we are doing everyone a favour. At other

times, the pain, suffering and distress are so intense that we just want it to stop. It seems the only way out of it."

- One member quoted her mother at length I think it is important for families to get support and education because to be honest I struggle coping knowing that you have suicidal thoughts even now when you are receiving treatment. I am worried, concerned, scared, sad, etc. And I felt useless because there is nothing I can do to stop you having those thoughts. Everyday I live in fear that I am going to get that phone call saying that you've made another attempt or that you have done it. I have dreams about it to, I just never told you before" Our member thought this this demonstrated the need for families to have access to the support they need. Regardless of whether the person is in another country, the family in New Zealand should be able to have access to the support they need."
- "From a union perspective, it's important to highlight that the workforce (both paid and voluntary) are struggling and issues such as compassion fatigue need to be recognised and appropriate strategies put in place to enable professional and voluntary caregivers including family/whanau to effectively perform their relative functions to support people who are in distress."

Activities targeted at identified high-risk population groups

18. While most of our members agreed with the targeting of activities at high-risk groups, members also argued for a nuanced approach to identifying targets. Some comments included that:

> *It's important to understand why people become suicidal, and from the people who have been suicidal but did not suicide we need to understand the reasons why they did not in their life. While direct targeted activities in identified groups who have a higher rate of suicidal behaviour is a necessary factor given resource constraints, there also needs to be recognition of the benefit of continued ongoing research in the area of suicide and suicidal behaviour.*

> "*As a mental health service user with hospital admissions for suicide attempts and self-harming behaviours, (along with falling in to the young people category). I absolutely agree that the targeted activities should focus on the above listed groups. The list is comprehensive and identifies those at the highest risk of suicidal behaviours within New Zealand. Of course, attention should also be paid to other groups such as LGBTI and disabled people and those who have suffered significant trauma. I also wonder if the age of young people should be lowered. I began stereotypically self-harming when I was 12. However, throughout primary school there has also been instances of me intentionally hurting myself. So for a number of people, it does go far younger than 15 years old."*

Do you think there is enough focus on the specific needs of men, LGBTI and the Rainbow community, and disabled people (p.11)?

19. A number of members thought that the strategy pays insufficient attention to the needs of LGBTIQ people. Members felt strongly that there is ample evidence that this group of people have significant need for targeted support and help. For instance, the Youth'12 study, published

by the Faculty of Medical and Health Studies at the University of Auckland, found that "approximately 40% of transgender students had significant depressive symptoms and nearly half had self-harmed in the previous 12 months. One in five transgender students had committed suicide in the last year."[1]

20. The following comments typified members' feedback on the needs of people who identify as LGBTIQ:

"There needs to be a more specific commitment to the actions that will be taken with regards to these communities/groups. This probably needs more time, knowledge, experience and data than is being put into this strategy (as acknowledged, each group will likely have different needs and different messaging). But there should be a commitment to create policies or action plans for these groups within an agreed timeframe. Policy-makers should work closely with people who have lived experience in the relevant groups, not assume to write policy for those groups. This is particularly true for any policies or plans regarding support for disabled people, LGBTI and the Rainbow community.

The strategy should also address intersectional issues. For example, the risks experienced by and support that should be provided to people who belong to two or more groups with higher rates of suicidal behaviour. The draft strategy does not mention targeting support activities towards people who intersect target groups, despite the probability that these people will be living with an even higher risk level.

There also needs to be a commitment towards amending other legislation and regulations (and providing supporting educational and informational messaging) that impacts these groups. For example: updating regulation regarding gender neutral and accessible toilet facilities (using best practice, not the outdated and barely adequate standards that are currently in place) and promoting inclusionary facilities as normal and expected; committing to providing necessary and respectful healthcare access to trans people in Aotearoa New Zealand (instead of requiring people to navigate extensive 'gate-keeping' by doctors and psychologists in order to access treatment)".

"LGBTIQ people (especially those aged 15-24) should be on the list of priority groups. I note the footnote in the discussion doc saying there is insufficient data in the national dataset about suicide rates based on sexual orientation and gender identity, but there is lots of evidence already out there that LGBT teens and young adults have one of the highest rates of suicide of any group, significantly higher than average.

So I think that it's not good enough to just refuse to prioritise one of the most at-risk groups just because the method of data collection used by MOH doesn't cover them in an easily measurable, standardisable way. I note action area 10 involves collecting more info relating to LGBTI and rainbow community, but I think even in the absence of that info there is

[1] Faculty of Medical and Health Science (undated), "Youth'12: Fact Sheet about Transgender Young People", retrieved 21 June 2017 from https://www.fmhs.auckland.ac.nz/assets/fmhs/faculty/ahrg/docs/Youth12-transgender-young-people-fact-sheet.pdf

probably enough existing evidence to make them a priority. Not having sufficient data is not an excuse not to do anything, especially when the (possibly limited) data indicates a significant problem".

"Misses LGTB people 15-24 entirely as a named population group. We know that Trans youth face higher risk factors than the general population:
Youth12 Study result"

"The LGBTI and Rainbow Community should also be a focus as people who are at high risk. We need to make it easier for this group to share their issues and have their sexual orientation statistics measured whilst protecting their identity."

21. Other members thought that strategy needs to focus more on the specific needs of men, including the specific needs of men in rural communities. One member wrote that: "There definitely needs to be a focus on men as the most at risk. Build on the fabulous work of John Kirwan and Mike King to bring this out in the open and show there is a way forward." Another member thought that service design and delivery for men needs to be informed by an understanding of how men seek help. In their experience men are less likely than women to step outside their comfort zone to seek help, hence support services need to come to them.

22. Another member thought the strategy got it right: "I think there is enough coverage. The draft strategy in its entirety is non-specific to gender, sexual orientation, etc."

Part Four: Potential areas for action

Do you think that the ten areas for action listed on p.12 cover everything that is necessary? Is anything missing?

23. Suggestions for additional action points include that:

The actions under 'Building positive wellbeing throughout people's lives' should include:

- *Instituting a living wage, so that people, whanau, and communities experience less financial stress and have more time and energy to build their wellbeing. This should be supported by better workplace conditions, including sick leave being used to support/manage mental health.*
- *Moving to a healthcare system that is free for users (no co-payments). This will allow people to access healthcare when they need it, not just when they can afford it.*
- *Acknowledging that our existing healthcare systems often discriminate against people who are also in groups that experience higher rates of suicidal behaviour. For example, appropriate and respectful healthcare can be very difficult to access for people who are transgender, disabled (especially people with chronic illnesses or chronic pain), etc. And actively working to reduce these levels of discrimination across healthcare systems, as well as providing targeted support for suicide prevention.*
- *Housing reform, including tenure security, rent control, and healthy & safe housing stock.*

24. One member noted the necessity of actions that support economic, social, physical and mental wellbeing if the strategy is to succeed: "These actions are vital. Targeted suicide prevention services are unlikely to be effective if people are not getting the support they need in other parts of their lives – for example their financial, workplace and housing security, and their everyday healthcare."

25. One member thought that the strategy needs to include social and electronic media and entertainment as areas for action.

Action Area 5: Support and partner with communities to develop and carry out activities that help to prevent suicide prevention.

26. To the questions "Do you think the proposed activities are priorities? And will they be effective? members submitted the following:

    "*Possibly, if they are supported by having appropriate services available for communities to work with (for example, healthcare and education services), which are properly funded and resourced so that they can stay in the community. All communities need the stability of knowing that their support services will continue to be available and are not constantly under threat of losing funding and/or closing. If communities have the support, funding, and services that they need and want then they can build a much greater capacity to help prevent suicidal behaviour."*

    "The potential areas for action are in themselves acceptable. It's the how to implement activities that is the problem. Developing social and economic policies that reduce inequalities would help. Sufficient funding in health, education and housing. Robust and proper collaboration/consultation across sectors."

    "The actions are fine but appear to be written with the assumption that the resources to meet the need are already in place. The crisis in the mental health system is well documented but ignored by the government. Until such time we have a government that acknowledges this nothing will change."

27. However, members thought that the following things were missing:

    "A commitment to financially supporting these communities and ensuring that they are properly resourced to lead and carry out the proposed activities."

    "Need to work with survivors. Their stories are invaluable to the success of this strategy".

    "Educational establishments (schools/universities) – having wellbeing programmes."

    "Encouraging the workplace community as well may be of use."

    "Not sure if the focus on suicide per se is enough. Where is the analysis of the social factors contributing, eg "unemployment, AOD issues, homelessness, violence etc"

Action area 7: Build and support the capability of the workforces in the education, health and police sectors and in the wider justice and social sectors? (p.19)

28. Members thought that the workforces in these sectors are over-worked and under-resourced and that addressing these issues is essential. Members stressed the need to strengthen the capacity and capability of the workforce and the importance of collaboration. Examples of members' comments included that:

> "*This can only happen with increased funding and resources. Health, education, social services and justice are all areas which are stretched with an overworked workforce"*
>
> *"It's quite aspirational. Capability is an issue, but capacity is probably equally important."*
>
> *"[This section] should also include instituting a living wage and better working conditions for all workers. This includes the frontline and healthcare workers.*
>
> *Training is really important, but workplaces need to be sufficiently resourced that staff can do all the training they need without service levels dropping. For example, teachers often do not get any additional resourcing to assist when they take time to do training. Instead it adds to their workloads and stress levels, which is likely to lower their capacity to support students.*
>
> *Training needs to include anti-oppression training. Having experienced frontline staff (including police and healthcare staff) who used ableist language ("He's loopy", etc) and oppressive attitudes (WINZ staff harassing disabled clients and accusing them of lying about their disability), it is blatantly obvious that this needs to change. All workforces in the education, health and police sectors and in the wider justice and social sectors (ESPECIALLY front-line staff), should receive anti-oppression training. This usually addresses oppressions including racism, classism, patriarchy, ableism, heterosexism and cissexism. In the Aotearoa NZ context this should also include Te Tiriti o Waitangi training".*
>
> *"There is still more to do in this area. We need to emphasise the issue in all workplaces. As a Health and Safety Officer responsible for inducting new staff as far as mental health is concerned I inform staff about the EAP (Employee Assistance Programme) and my employer has recently employed a half-time mental health practitioner".*
>
> *"There still seems to be an attitude of fear and stigma in relation to dealing with suicidal ideation and behaviour. Current restrictions on media reporting don't seem to help. I've seen this in practice with practice nurses who don't seem at all confident in dealing with suicide ideation".*
>
> *"At times when I have been in the emergency department for non-self-harm related problems, I have often been hounded by the nursing staff about the injuries I have, and why I do it. In this case, they could certainly use education measures as outlined in the strategy.*

The only way I was able to get them to leave me alone about it was to tell them that I was under the NCMHT. However, I have spoken with the NZ police call centre in the past while in severe distress after taking quite a significant overdose. The lady I was speaking with was able to keep me calm until help arrived. Each dealing with NZ Police has been exceptional and none of them came across judgemental in anyway. It is the general nursing staff I have come in to contact with that are. "

"Everyone needs to be educated in this area in every workplace. Mental Health should be openly discussed and normalised. Increase staff wellness initiatives and benefits.

"I think it's a good start. But I wonder where the support for workforces will come from? Mental Health staff?"

29. One member shared their experience of a suicide prevention initiative in Scotland:
30.

"I was involved in an initiative working alongside the local Police force to identify people who are at risk in the community sometimes prior to them being picked up by mental health services. It was really useful also as it let us be aware of patients already known to services, when they were becoming unwell and/or presented to police or were identified through anti-social behaviours, substance misuse or suicide attempts. That way we could provide timely interventions, support and prevent risk of suicide. I think that the police learned from us ways of managing people who were mentally unwell and supporting those that were in crisis. I did hear on the news that a lot of time is being spent by police helping those who are in need of mental health support so wonder if doing something similar is worth exploring?"

Action Area 10: Strengthen systems for collecting and sharing evidence and knowledge about suicidal behaviour and for tracking our progress (p.22)

31. To the questions, "What do you think about the proposed activities for collecting more information and research on suicidal behaviour among Māori, Pacific peoples, young people, LGBTI and Rainbow community? Is there anything more that could be done here?", members provided the following comments:
32.

"I support collecting more info on this, but I don't think the current lack of info is a good reason for leaving them out of the priority group. There is already other evidence that exists to show they should be a priority. In the meantime while a bigger evidence base is being developed they could still be working on interventions".

"The proposed activities appear to be quite thorough. I especially like the proposals of Māori leading research on preventing suicidal behaviour among Māori, and doing culturally appropriate research with a diverse range of ethnic groups. It is important that these considerations are also extended to other groups. For example, research focused on LGBTI/Rainbow communities or people with disabilities should be led by people in the relevant communities/groups and/or involve genuine collaboration with the groups. This also has to acknowledge that while umbrella terms such as Pacific, LGBTI, rainbow, and disabled

communities can be useful at a strategy level, these groups are actually very varied and cannot be treated as homogenous. Respect, care, and genuinely listening to the people involved need to be key tenets of anyone considering undertaking research. Researchers who do not have the same lived experience as the people from whom they are collecting information may not be in a position to actually understand that information, which is why research led by people within a community/group should always be considered first."

"The proposed activities seem appropriate, especially Māori leading research on preventing the behaviours among other Māori. This approach is culturally appropriate/sensitive and could be also translated to other ethnic groups etc. The suggestion of individual and family surveys/evaluations/reviews also gives a broader perspective of issues people throughout New Zealand are facing."

33. To the questions, "Are there any specific privacy issues associated with the collecting and sharing of data through the Integrated Data Infrastructure? Do you think this is a helpful way to identify target groups for priority intervention as suggested?", members provided the following comments:

"I am not familiar with the Integrated Data Infrastructure (IDI), but the information provided on the Statistics NZ website suggests that there are robust measures in place to maintain privacy. Using an existing system with tested security and privacy and dedicated staff sounds like a good, reasonably safe way to manage data that is or will be collected to support this strategy.

Using the IDI to identify target groups may be helpful if there is sufficient data available to make this identification with a statistically acceptable level of confidence. As the draft strategy has already identified that data does not exist for some groups, there will probably need to be a mix of using IDI data and using information about lived experiences from communities and groups. Also, it may be necessary to draw on overseas research about suicidal behaviour in different groups (as well as existing NZ research/data and information directly from communities/groups) in order to determine what data should be collected in Aotearoa NZ.

Additionally, the target groups should not be static. There should be a process to add more groups if new data indicates that a not-previously-identified group experience/are at risk of a higher rate of suicidal behaviour, and/or would benefit from being a target group".

"It's definitely a helpful way, as collection and analysis of information will enable patterns to be defined, allowing specific targets to be identified, and ways to assist".

"Information collection is on track – i.e. technology is effective there. I think we lack analysis of all the info available though".

Workplace issues

34. Our members thought that the strategy needs a much greater emphasis on the importance of the workplace in relation to mental health and suicidal behaviour in particular and that it lacked tangible detail about actions. Improving workplace cultures, conditions and practices is a core area of expertise for unions, and we need to be fully engaged by government and community services in developing and implementing policies, practices and services related to suicide prevention. One member commented that: "There needs to be measures in place in all workplaces to ensure workers are kept safe. Currently this strategy seems to be focused around the individual, family and community, rather than measures that can be taken in and by the workplace".

35. Members described workplaces as being both a protective and a risk factor for suicidal behaviour. Employment in meaningful, decent work can contribute to mental wellbeing, however workplaces can also be sites of significant stress and unhappiness. Decent employment conditions are necessary to protect against common modern labour practices, which include: frequent "downsizing, layoffs, mergers, contingent employment, and increased work load."[2]

36. Policies and practices need to be in place in all workplaces to both minimise harm to workers' mental health and promote healthy, supportive and inclusive workplaces. These include measures to reduce work-related stress and overwork; eliminate bullying; and encourage, educate and train colleagues and managers to support their colleagues.

37. One member, with significant experience working in suicide postvention, sees workplaces as being critical to the delivery of support and services to vulnerable people who may feel uncomfortable seeking support through clinical pathways. The member commented that men in particular are less likely to actively seek support, but may be more receptive to passive support, delivered to them in places where they feel comfortable, such as workplaces.

38. Some of our members shared their positive and negative experiences of how workplace practices affected them during times of mental ill-health.

> *"A suggestion is workplaces providing a safe environment for people to talk about their mental health. I was diagnosed with mental health issues while working for my former employer, requiring hospitalisation. This was in 2015, and I ended up with four months unpaid away from work. Because I was unlikely to be off for more than six months, there was no financial assistance available to my family or I. This caused a lot of financial hardship on my family and I adding another element of stress to an already difficult situation. When returning to work, there was no one in the organisation that I felt comfortable speaking with about the issues I was having, leaving me feeling as though I had to combat it alone. When there were issues, the organisation was extremely difficult about it and used it to their advantage. Again in late 2016, I was hospitalised, ending with two months off work, again unpaid. Due to*

[2] Gabriel, Phyllis and Marjo-Riitta Liimatainen, "Mental Health in the Workplace: Introduction, Executive Summaries p.3, International Labour Office, retrieved 12 June 2017 from http://www.ilo.org/wcmsp5/groups/public/@ed_emp/@ifp_skills/documents/publication/wcms_108221.pdf

the discomfort and stigma, I failed to disclose mental health issues to my new employer, as such there have also been some issues. After disclosing the anxiety aspect to the employer and reaching an agreement with them, they are still not keeping up their end of what was agreed. This has once again left me feeling unsupported and resulted in many late night phone calls to the emergency psychiatric team in severe distress."

"In the early 2000s, I was able to access 6 free sessions with a qualified psychologist from my employers EAP programme . That was a tremendous help to me at the time.

When I had some further difficulties about 5-6 years later, the EAP provider had been switched and they were more of a careers advice service and could not offer counselling. From memory, they could make recommendations of services - but it seemed complicated and I decided that I didn't want to mess with that. As the issues at that time were less significant, I decided I would work it out on my own. But in other circumstances that may not have been a wise choice.

So for the work place, there needs to be a switch back to providing professional counsellors through the EAP programme. And managers need to be able to directly access professional counselling for their staff, with no questions asked - as and when required."

"Many workplaces need the capability to be able to address employees who are at risk of (or are) facing suicidal behaviour. My current employer has no regard for my needs, even after reaching verbal agreement. As such, education in all workplaces would be beneficial to the success of the strategy. Education is key to employers understanding the ramifications of not paying attention to or ignoring the needs of employees with mental health issues, especially suicide".

"Workers should be made to feel as though they can discuss these issues with their employer without fear of judgement or harsh ramifications. (…) I was diagnosed after I had been working for a firm for some time. Due to the actions of the previous employer, I did not disclose any underlying mental health issues to my new employer for fear of judgement and potentially being declined employment. When it started becoming an issue – anxiety in particular relating to specific clients they would not listen to what I was trying to say, even when I tried discussing the mental health aspect. Many late night phone calls to the […] EPS team, and letters from my mental health team were the only way to stop working with the triggering client. There needs to be measures in place to ensure future employees feel safe disclosing mental health issues, regardless of when diagnosis or issues arise."

39. Members had some practical suggestions for workplace-based policies and practices that could promote positive mental health. These included:

- Education on the rights and protections available to people suffering mental ill-health
- "Each pathway [of the strategy] should have aspects related to the workplace, the lack of support in many workplaces is astounding and should be addressed by the strategy. Programmes addressing bullying in the workplace will be effective, however there are more aspects than workplace bullying that may influence suicidal behaviours which should also be addressed".
- "Increase staff wellness initiatives and benefits. EAP, Mindfulness training, Yoga at work, golf/gym memberships etc."
- Training on bullying – "what it is, what does it look like, how to be attuned to the fact that it is happening in your workplace".
- Decent pay, including the introduction of the living wage. "If people have financial and employment security then they are more likely to be able to build their wellbeing and to support colleagues."
- The extension of sick leave provisions to cover mental health/illness/wellbeing.
- Dedicated independent counselling support for staff going through restructures/change processes. This could be done either by the workplace bringing someone in, or by allocating all affected staff extra sessions through EAP (currently staff can only access 3 sessions without additional permission, which can quickly get used up in stressful restructure situations).
- Additional training for small businesses.
- "Training for small businesses in recognising and reducing suicidal behaviour, and better supporting workers, as well as anti-oppression training as mentioned above, would be helpful".
- "Training for managers at all levels to better recognise and support workers experiencing things which have adverse impacts on wellbeing (including high stress, inadequate working conditions, personal difficulties, mental health crises, etc). "When someone is in a vulnerable space with their mental health, it can be very hard to bring that up with a manager if you don't think they'll understand. Fear of your situation being ignored, trivialised, or attacked are very real. This can be exacerbated by the widespread lack of managerial skills in Aotearoa NZ. (As a society, we tend to promote people into management roles without supporting them in learning and practising the skillset needed to be effective managers. This in turn means they are often unable and/or unwilling to support other staff.)."
- "Stronger profile for Occupational Health activity".
- "One point I would like to raise about suicide prevention is the issue of ' Bullying' in the workplace and everywhere for that matter. I think when a person is not included / does not feel included/ in a discussion, whether it is in a formal situation or with mates/friends, the outcome is that the person feels that they are worthless and nobody values their contribution. I think there needs to be a lot of training about what is bullying, what does it look like in its many different forms, and how to be attuned to the fact that it is happening in your workplace or education facility."
- "I have long felt that the school principals / teachers/ and other staffing members in schools do not know how to identify bullying / don't want to know about bullying, can't be bothered looking for signs of it in their school grounds or classes."

Part Five: Keeping track of progress

Outcomes and indicators

40. Our members had the following comments to make about the proposed outcomes and indicators:

> "*They seem to be quite comprehensive, but many are also very broad. We would need to see a commitment to further work that establishes what specific aspects of the outcomes and indicators are being measured. It is vital that what is measured is useful and meaningful data that has a real connection to the lives, wellbeing and experiences of people in Aotearoa NZ. We need to see a commitment to ask questions that the current government has shied away from, for example around the impacts of housing security and financial security (or the lack of these) on health and suicidal behaviour".*
>
> "Information to the rescue! Aspirational only. And weakly so".
> *"The list of the above seems relevant and is well rounded, encompassing many factors."*
>
> All appear to be useful indicators.

41. PSA members made the following comments about the use of targets to measure the reduction in suicide numbers:

> *Targets can be both positive and negative. Targets can make it seem simpler to measure the efficacy of strategies, and can provide 'hard data' to which resource allocation, funding etc. is often pegged. A risk with targets is that once a target is achieved, there is less focus on doing even better. Targets can allow a 'good enough' mentality to arise. Additionally, as mentioned in the draft strategy, a focus on only suicide rates does not take into account the fact that other measures might give us a better understanding of whether progress is being made.*
>
> *I would however definitely support a target of zero (following a vision zero approach which has been seen overseas in regards to road-related deaths and serious injuries). I think that the focus of the strategy on reducing suicidal behaviour has the potential to be much more effective and beneficial than a narrow focus on suicide numbers, but that it would be worth introducing a target of zero suicides as the goal towards which this strategy is working.*
>
> "I'm torn about if I am for or against the idea. While targets are generally seen as a good idea, if they aren't met the public are likely to jump to the conclusion that the strategy is ineffective. There is also the potential for people to fall through the cracks."
>
> *"The target should be Zero".*

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