Suicide Prevention and Mental Health – the path ahead

Briefing paper from the New Zealand Maori Council and our recommendations on moving forward

Matthew Tukaki
Executive Director, Chair of the Tamaki District Māori Council, Member of the National Executive of the Māori Council, Chair of Suicide Prevention Australia, former Chair of the National Coalition for Suicide Prevention, Chair of the National Maori Authority

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Overview

This paper is a short form document and is based on the broader internal report to Maori Council's Executive and District Chairs. The document contains the baseline recommendations being made to the Government and comes after exhaustive assessment and analysis of the Mental Health and Addictions Inquiry report and recommendations, documents obtained under the Official Information Act and submissions made directly to Maori Council.

Introduction and summary: Matthew Tukaki

Suicide and mental health remain as one of the biggest challenges to confront Maori and whanau. The data tells a story of Maori being amongst the highest per head of population rate of suicide in western countries and we remain the single largest consumer of the mental health system. Over many decades the numbers have worsened for our people and the harsh reality is the programs that are currently in place are not working effectively enough to prevent the deaths of many of our people. For every suicide it is estimated that twenty would have tried and it is generally accepted that suicide related deaths are not always connected to a mental health condition; nor do some have a history of presenting for help or assistance. When it comes to non-mental health related pre-cursors, we see the presence of economic deprivation, disconnection from culture and community, disconnection from whanau and loved ones, the failure of relationships and more. Successive governments have failed to address the systemic and societal challenges that we, as a people, face and to some degree that has left communities to try and respond. In doing so there is no shortage of Maori and Iwi based organisations out there trying to respond in a way that receives little or no funding or material support. Compounded with the increasing nature of administrative bureaucracy, the challenge of navigating through the plethora of services organisations many initiatives fail to grow to scale – and yet the demand increases. In fact, if what we were doing was the right way of doing things then we would not be a in conversation.

Things would be working as they should be and more of our people would be living long and healthy loves. But the truth is the system has failed us. In 2009 the Australian Senate called on an Inquiry into suicide in Australia. It was a hard-hitting assessment of what was going on and why the system had failed so many people. The Inquiry panel included a former New Zealand Vietnam Way Nurse, Senator Judith Adams. The inquiry was very much like the recent one held in New Zealand and outlined a series of recommendations that did not shy away from reform. In 2011 I joined the Board of Suicide Prevention Australia and took charge of the recommendations as our path to a reduction in the rates of suicide. The journey continued when I became both Chair of the National Coalition for Suicide Prevention and the Chair of Suicide Prevention Australia. While Australia still has a long way to go the business of reform has begun; reform of the system, reform of the workforce, reform of the way programs are developed and evaluated, the model of investment and that investment into innovation. This was matched by reform of the way data is collected and assessed, merging trends are dealt with and how planning to meet workforce demand is met. At the State and Territory level came coronial and mental health act reform and a dedicated focus on innovations such as zero suicide within the general hospital system.

In New Zealand the Mental Health and Addictions Inquiry failed to meet the general question of reform and the model of change that needed to be implemented over a short, medium- and longer-term time scale. In fact, the model of inquiry focused primarily on the things that we already knew:

(a) hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction and what needs to change
(b) report on how New Zealand is preventing mental health and addiction problems and responding to the needs of people with those problems
(c) recommend specific changes to improve New Zealand's approach to mental health, with a particular focus on equity of access, community confidence in the mental health system and better outcomes, particularly for Māori and other groups with disproportionately poorer outcomes.

As the report states:

Mental health and addiction problems touch the lives of many people in New Zealand. Each year around one in five of us experience mental illness or significant mental distress. Increasing numbers of children and young people are showing signs of mental distress and intentionally self-harming. In addition to the human costs, the annual cost of the burden of serious mental illness, including addiction, in New Zealand is an estimated $12 billion or 5% of gross domestic product.

Any one of us can be affected: over 50–80% of New Zealanders will experience mental distress or addiction challenges or both in their lifetime. But some people are more at risk. A range of social determinants are risk factors for poor mental health: poverty, lack of affordable housing, unemployment and low-paid work, abuse and neglect, family violence and other trauma, loneliness and social isolation (especially in the elderly and rural populations) and, for Māori, deprivation and cultural alienation.

New Zealand has persistently high suicide rates. Annual suicide rates reported by the Office of the Chief Coroner have increased over the last four years, with the 2017/18 suicide rate the highest since 1999. Every year, 20,000 people attempt to take their own life. In 2015, 525 people died by suicide. Our suicide rate for young people is among the worst in the OECD. The greatest loss of life through suicide occurs among people older than 24, particularly males aged 25–44. Every suicide creates significant, far-reaching impacts on the person's friends, family and whānau, and the wider community.

Addiction to alcohol and other drugs is causing widespread harm in New Zealand communities. A heavy drinking culture harms health and wellbeing. Harmful use of alcohol and other drugs is significantly implicated in crime – around 60% of community-based offenders have an identified alcohol or other drug problem and 87% of prisoners have experienced an alcohol or other drug problem over their lifetime. Well over half of youth suicides involve alcohol or illicit drug exposure. Over 70% of people who attend addiction services have co-existing mental health conditions, and over 50% of mental health service users are estimated to have co-existing substance abuse problems.

In other words it failed to meet the specific challenge of reform and establishing a system that was not just about mental health and addictions – but more broadly the approach needed when it came to non-mental health and addictions challenges facing our people.

In the latter stages of the Inquiry the expectation was set that the voices of Maori had been heard – and yet the absence of specific data in the final report is concerning. Once the Inquiry has ceased the New Zealand Maori Council asked for the report and its recommendations to be released without delay. It

was not. This caused Council to immediately ask for copies of all the submissions related to Maori and ultimately the report called "Maori Voices". Over the course of the ensuing months the report was finally released but it would be some time before the Maori specific report was released. This caused much angst and pain in the community. It caused people to lose faith.

In early 2019 Council took possessions of a range of documents and submissions related to the Inquiry and its focus on Maori. This then informed the recommendations contained in this report and our intended approach when it came to mapping a course forward.

In doing so we need to be very clear; Maori should oversee the affairs of Maori; Maori organisations and service providers should be providing services to Maori people and we should not shy away from reform.

What is the New Zealand Maori Council recommending?

Hapori Tahi – One Community: investing in a single national strategy for Maori

1. A ten-year roadmap towards a reduction in the rates of suicide underpinned by the above eight points / this would include program development, reform and change, design and delivery, health promotion and so on. It would be the roadmap to change – this would include targeted policies for:

- Maori men / middle years
- Rangatahi Maori
- Youth
- Women in their latter years
- Middle aged white males between 35 – 55
- Rural and regional communities
- Workplace
- Employment / Unemployed

A National Mental Health Commission and legislative reform

2. The establishment of the Mental Health Commission to oversee the co-ordination of the Governments response to the recommendations of the mental health and addictions inquiry. In addition, the role of the Commissioner will be preparing drafting for the changes need to the Mental Health Act including the separation of the role and duties of the Director of Mental Health to create a higher degree of independence, governance and oversight. There would be two Commissioners, one Maori (to continue the community engagement and development piece).

A Single National Commissioning Agency

3. A single national commissioning agency to coordinate funding and evaluation of services being delivered in both suicide prevention and mental health – this could be attached to the Mental Health Commission

A National Hub for Suicide Prevention and Mental Health Program Evaluation

4. Establish a national hub for suicide prevention and mental health program evaluation. This would create a greater degree of consistency when it comes to how programs are being evaluated and assessed; the model would follow the Australian "Hub" model and including the ability for programs to be mentored if they didn't quite make the first round. This would provide Government agencies and departments, health authorities and so on to introduce the programs with more confidence.

A National Suicide Prevention and Mental Health Research Fund

5. Establish a National Suicide Prevention and Mental Health research fund – investing in research will enable us to interpret the data in a much more coordinated way, identify innovations occurring in programs and service delivery as well as further design and deliver programs for purpose for either demographic or geographic groupings

A National Co-Design Team

6. Establish a national co-design team within the Ministry of Health to work with Maori and highly impacted groups when it comes to service delivery models

The Introduction of a Zero Suicide Approach in the Hospital System

7. Introduce trials sites in Auckland, Christchurch, Northland, the Bay of Plenty and Gisborne for "zero suicide" in hospitals and health systems – this could use the same evidence-based framework underway in the States of Queensland and Western Australia as well as several sites in the United States.

The Development of Additional Health Promotion Campaigns in Te Reo and English

8. Shift specific focus for national health promotion campaigns related to both suicide prevention and mental health amongst target groups such as youth, Maori (rangatahi and middle years), women in their latter years and middle-aged white males.

Further building and investing in teacher training skills and school resources

9. Build and develop teacher and school specific resources for suicide prevention and mental health in line with the eSafety framework, bullying and cyber bullying etc.

A National Workforce Plan

10. Develop a national workforce plan for both allied and non-allied staff; the building of a mental health workforce to meet demand and specific workforce development and capacity building for high impact groups such as Maori.

Investing in Addiction Rehabilitation

11. Investing in the building of five new rehabilitation centers (three north and two south-island) to be directly funded by Government or through an increase in the alcohol and cigarette levies / taxes targeting people with high rates of addiction to move them back into well being

Investing in Youth Space Centres

12. Investing in the establishment of "youth space" centers across the country similar to the "head space" programs targeting young people with mental health challenges / outreach and well-being

Investing in the Mens Shed Networks

13. Investing in a new national program to further build the mens shed networks targeting males between the ages of 45 and 75

Investing in Work Place Care Programs

14. Investing in the development of a workplace strategy providing roving counselling services and pastoral care services directly in the work place. A program that would be required for all Government Departments and opt in with financial support for business and industry

Bringing Down the Silos

15. Establish an interagency taskforce headed by the Mental Health Commissioner to better co-ordinate programs, services and funding across the public sector

Where to from here?

The New Zealand Maori Council intends on publishing this document and making it available to members and Maori more broadly. It will also serve as a document to lobby on behalf of Maori to Government and the Crown when it comes to ensuring the interests of our people are heard and acted upon.

This is a short form document.