
HOPE UPSTREAM
FOR ZERO SUICIDE COMMUNITIES
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SUPPLEMENT, SUPPORT OR ENHANCE REVIEW

A REVIEW OF THE AOTEAROA NEW ZEALAND SUICIDE PREVENTION SECTOR

Conducted by Hope Upstream Charitable Trust

OCTOBER 2023

ADVISORY WARNING:
CONTENT INCLUDED IN THIS REPORT RELATES TO SUICIDE

This report refers to suicide. Although the content included in this report looks positively at future services and support, where suicides are rare events, you may find continual references to people experiencing mental ill-health, self-harm and suicidal thoughts and actions triggering.

If reading this report causes you distress, you may find it helpful to speak with someone.

The following resources may be helpful:

- Call or text 1737 for support from a trained counsellor any time
- Call Lifeline at 0800543354 or text them at 435
- Call Tautoko 0508 828 865

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I. INTRODUCTION

New Zealand continues to experience persistently high rates of suicide, disproportionately impacting Māori (approximately 30% of suicides vs 16% of the population) and youth (14.9 per 100,000 compared to OECD average of 6.5 per 100,000). This report summarises insights from extensive stakeholder interviews on how to strengthen the country's approach to suicide prevention. Key themes include the need for greater national coordination, investment in timely data systems, increased funding for community-based services, support for the workforce capability and/or capacity, and enabling locally-designed solutions.

To achieve substantial reductions in suicide attempts and deaths by suicide, New Zealand must empower a centralised suicide prevention office, foster multi-agency collaboration, scale community interventions grounded in cultural understandings of wellbeing, promote trauma-informed compassionate care, expand service capacity, and normalise open discussions around suicide. By implementing evidence-based solutions tailored to diverse needs, prioritising those most affected, New Zealand can overcome the fragmented status quo to realise a future where far fewer lives are lost to suicide.

Hope Upstream Charitable Trust has a vision for zero suicide communities. To realise this vision, we intend to research, evaluate and develop suicide prevention initiatives for Aotearoa New Zealand.

Our core charitable actions/activities are as follows:

- collating and mapping international initiatives and research on the topic of suicide prevention, as well as commissioning research and preparing white papers on this topic;
- developing and evaluating new suicide prevention methods and initiatives using human-centred design methodology;
- providing education to those at risk as well as support networks by running seminars, workshops and conferences to promote suicide prevention; and
- promoting and advocating for changes to legislation, regulations and practices to deliver better services and programmes which can support those affected by, or at risk of, suicide.

AIM

This report presents findings from interviews with 30 stakeholders across the suicide prevention sector[1], conducted by Hope Upstream from August to September 2023. The review aimed to understand key perspectives on improving New Zealand's suicide prevention efforts and identify opportunities to supplement, support or enhance current work. Participants included service providers, community leaders, those working in the sector with lived experience, and experts across health, social services and culture.

Participants we asked the following five open ended questions:

1. What are the key outcomes of your service or organisation?
2. What is some feedback you receive on your service or organisation? (both positive and negative)
3. What are the challenges in providing your service or running your organisation?
4. What would be one thing that would make your life easier as a service provider/organisation, other than more money?
5. Any other comments or thoughts on what would help suicide prevention in Aotearoa New Zealand?

The report summarises the core themes, insights and opportunities to supplement, support or enhance current work from these collaborative discussions. It provides a solutions-focused platform to guide Hope Upstream's planning and coordination for the charity's New Zealand's suicide prevention strategy over the coming years.

[1] 35% of respondents were Service Providers; 20% of respondents were Community Leaders; 25% of respondents were Lived Experience Providers and 20% of respondents were Health and Social Service Experts

EXECUTIVE SUMMARY

Firstly, a massive thank you needs to be given to the tireless commitment from the people supporting suicide prevention around the country. The people working in suicide prevention are very dedicated and passionate about the cause. There is a real strong desire to help others. This shows in the impact and positive outcomes of community led suicide prevention initiatives.

This Supplement, Support or Enhance review ultimately became a progress report against the recommendations in the Government Inquiry into mental health and addiction in 2019. As you will read in this report, some of the recommendations from that inquiry have been actioned and are producing positive outcomes. Conversely the actioning of other recommendations (or lack thereof) falls disappointingly short of the intended outcomes. This participant feedback is detailed in the key themes from participant interviews.

LACK OF NATIONAL COORDINATION

Participants voiced a real need for coordination and alignment of suicide prevention at a national level. Furthermore, the need for initiatives to be properly resourced, to achieve the intended outcomes. We highlight one participants quote on the lack of this resourcing:

"It's like the organisation hires a cardiologist and then they say to them, look, we're glad we got you on board. We don't have a theatre and we don't have any clinic space for you, but we do have a cardiologist on staff now, so this is great."

Suicide prevention requires a holistic public health approach across health promotion, prevention, intervention and postvention. It's not just a mental health issue.

LACK OF CLEAR PATHWAYS

Participants highlighted how a lack of clear and robust pathways are detrimental to people trying to seek help, but also for mental health and suicide prevention staff trying to navigate where best to refer or provide support within a region.

DATA AND INFORMATION SHARING CHALLENGES

Participants cited data and information sharing as fundamental to be able to do their jobs and deliver positive outcomes. Many cited the lack of robust data sharing agreements and technology as being the hurdles to fulfilling potential.

NEED FOR COMMUNITY-FOCUSED APPROACHES

One of the real positives to be illustrated in our participant interviews was the benefit of community-led suicide prevention initiatives. Resourcing and empowering communities to address their own suicide risks and challenges are shown to lead to positive outcomes.

FUNDING AND RESOURCE CONSTRAINTS

Funding, budgets and resource constraints are well known within mental health and suicide prevention. For example, participants cite our poor standing in OECD rankings when it comes to mental health inpatient beds.

IMPORTANCE OF COMPASSIONATE CARE AND PEER SUPPORT

Participants discussed the importance of human connection and peer support and the need for trauma informed care.

WORKFORCE CHALLENGES

The ageing workforce and compassion fatigue, again, is well known within mental health and suicide prevention. Participants continue to cite the challenges around this.

VALUE OF LIVED EXPERIENCE PERSPECTIVE

Participants cited how crucial lived experience perspectives are. This is a common theme within suicide prevention.

THE ROLE OF TECHNOLOGY

Technology does have a role to play within suicide prevention, especially for communities that are reluctant to engage with support. However, there still needs to be a human element in support. The role of technology can be detailed as "Technology enabled support"

IMPORTANCE OF SAFE MESSAGING

Participants discussed the importance of safe messaging and language on suicide. Three groups were identified in how they deliver the message with varying degrees of safety, ethicality or straight avoidance.

These participant interviews, supported by further research, provided opportunities to supplement, support or enhance suicide prevention in New Zealand.

DEVELOP AND PROMOTE ROBUST PATHWAYS

Promoting clear and robust pathways for not only those seeking help, but those within the mental health and suicide prevention sector looking to refer patients, is fundamental for suicide prevention in New Zealand. This opportunity falls on the SPO to fulfil their founding objectives.

ENHANCE NATIONAL LEADERSHIP AND STRATEGY ALIGNMENT

Participant interviews were clear, the Suicide Prevention Office (SPO) needs to be properly resourced to fulfil the founding principles. This is an opportunity for the Government and Ministry of Health to address.

INVEST IN DATA SYSTEMS AND INFORMATION SHARING

The need for Real Time Suicide Surveillance to enable data informed suicide prevention and intervention is clear. Robust data and information sharing agreements are fundamental for this work. Whilst this opportunity falls on the SPO and wider suicide prevention sector, Hope Upstream stands ready and available to support, given our experience in the United Kingdom.

ADDRESS FUNDING AND WORKFORCE CAPABILITY GAPS

Whilst funding and resourcing is a common theme in mental health and suicide prevention, participants suggested, backed by research, that more could be done to address these workforce challenges. Utilising staff rotations and receiving in-person feedback from treated patients may be a way to combat this. The Ministry of Health, SPO, Te Whatu Ora and Te Aka Whai Ora are best placed to respond to this opportunity.

SUPPORT COMMUNITY-LED AND CULTURALLY GROUNDED RESPONSES

There are some amazing community-led suicide prevention initiatives leading to positive outcomes around the country. More needs to be done to support these initiatives and provide opportunities and support to develop and implement more targeted initiatives. The Ministry of Health, SPO, Te Whatu Ora and Te Aka Whai Ora are best placed to respond to this opportunity.

PROMOTE TRAUMA-INFORMED AND COMPASSIONATE PRACTICES

Childhood trauma and experiences are a well-known suicide risk. Promoting trauma-aware practices across the sector is a key opportunity for every stakeholder in the sector. This starts with the SPO setting best practice guidelines.

EXPAND BEST-PRACTICE “CARING CONTACTS” AND PEER SUPPORT CONNECTIONS POST-DISCHARGE TO ENHANCE CONTINUITY OF CARE.

Providing connection and care for post-discharge alongside receiving professional support is a real opportunity to contribute to suicide prevention. Hope Upstream will be considering how best to support and address this opportunity.

NATIONAL AGREEMENT ON THE SAFE MESSAGING FOR SUICIDE PREVENTION

There is value in adopting the #chat safe guidelines, in addition to running outreach training projects with social media influencers in New Zealand. This opportunity could be responded to by the SPO and wider suicide prevention community.

GUIDELINES FOR TECHNOLOGY USE IN PREVENTION AND INTERVENTION

International research provided guidelines for technology use in prevention and intervention. There is an opportunity to adopt these as a sector, starting with the SPO.

KEY THEMES

II. KEY THEMES FROM STAKEHOLDER INTERVIEWS

LACK OF NATIONAL COORDINATION AND LEADERSHIP

45%

OF PARTICIPANTS MENTIONED THE NEED FOR GREATER COORDINATION AND NATIONAL OVERSIGHT.

This highlights the lack of coordination between support organisations and government agencies and the lack of leadership and oversight at a national level.

Furthermore, participants discussed how the founding objectives of the National Suicide Prevention Office (SPO) have not been met, citing disappointment that the office has not be properly resourced to fulfil its potential and lifesaving obligations.

The founding principles:

1. The SPO should sit initially under the Ministry of Health. However, within 2 years the SPO should become independent of the Ministry of Health.
2. The office needs to be appropriately staffed and resourced
3. The establishment of advisory groups made up of experts, stakeholders and those with relevant lived experience to advise the SPO
4. The development of a website and virtual hub with quality resources and guidance, including clear pathways to local support and quality training and education

LACK OF COORDINATION/ALIGNMENT IN SECTOR

There is a clear need for greater coordination and strategic alignment in New Zealand's suicide prevention sector. Organisations are working somewhat in silos and there is duplication of efforts in some areas and gaps in others. There appears to be a lack of clarity around roles and responsibilities in relation to suicide prevention staff and organisations across different regions, inconsistent job descriptions for suicide prevention staff, and a general lack of coordination between different organisations and government agencies involved in suicide prevention. Suicide Prevention Coordinators are employed by different organisations and agencies depending on where reside geographically and the capabilities and funding of that region.

It was noted by several participants, the need for national standards around qualifications for working in suicide prevention. Many thought this could be the role of the SPO.

Participants suggested a centralised approach for suicide prevention staff contracting through either Te Whatu Ora, or Te Aka Whai Ora, or even the SPO could address this.

NEED FOR INTEGRATED, COLLABORATIVE APPROACHES

15%

OF PARTICIPANTS MENTIONED THE NEED FOR INTEGRATED, COLLABORATIVE APPROACHES.

"There's a need for integration between suicide prevention local groups and other services. This would ensure that individuals are referred to the right services and supported throughout the process."

On issues with coordination, one participant discussed how mental health services frequently discharge suicidal individuals from the emergency department without follow-up or notifying GPs, leading to dangerous gaps. Better coordination between health entities could ensure continuity of care.

There was a consistent emphasis on taking an integrated, collaborative approach through multi-agency working groups across health services, government agencies, NGOs, community groups etc. However, challenges exist in actually operationalising this integration. The need for robust data sharing and a memorandum of understanding (MOU) between suicide prevention service organisations was discussed by most participants. Once agreements are in place, proper consideration should be given to the appropriate systems and processes.

In regions where there are multi-agency suicide prevention groups, some participants mentioned the lack of effectiveness of the group due to turnover of staff and lack of resources. Some thought more guidance could be provided at a national level on how the regional groups multi-agency should function.

There's a clear need for better integration between different parts of the system. Whether it's between education, prevention workers, service providers, or postvention teams. Improved communication, collaboration and the use of technology can help identify early warning signs and provide timely interventions.

LACK OF CLEAR PATHWAYS

20%

OF PARTICIPANTS MENTIONED THE NEED FOR CLEAR PATHWAYS FOR INDIVIDUALS SEEKING HELP, EMPHASISING THE IMPORTANCE OF SEAMLESS TRANSITIONS AND GUIDANCE FOR THOSE IN DISTRESS.

A service provider participant explained there is no centralised database to easily identify local partners and services when trying to connect someone in need. This lack of shared data results in duplicated efforts and people falling through the cracks.

"There's a lack of clear pathways for people to access the right services, especially for those in acute distress. This often leads to individuals bouncing between services without receiving the appropriate care."

"It's essential to have the right 'drafting gates' to direct individuals to the appropriate services."

"Different areas of the country have different processes, and if the transition between services doesn't go well, the service user loses out. If the referral doesn't go to the right crisis team, it's a significant problem."

"There are electronic pathways to guide clinicians based on the acuteness of the situation. However, there's a challenge in staying updated with local community initiatives and support."

Lack of access by not being considered serious enough, was also a theme in the Government Inquiry into mental health and addiction in 2019.

"A challenge in facilitating pathways is that individuals often get the run-around from mental health services. The service delivery model of community mental health teams doesn't meet the demands of a 24/7 environment."

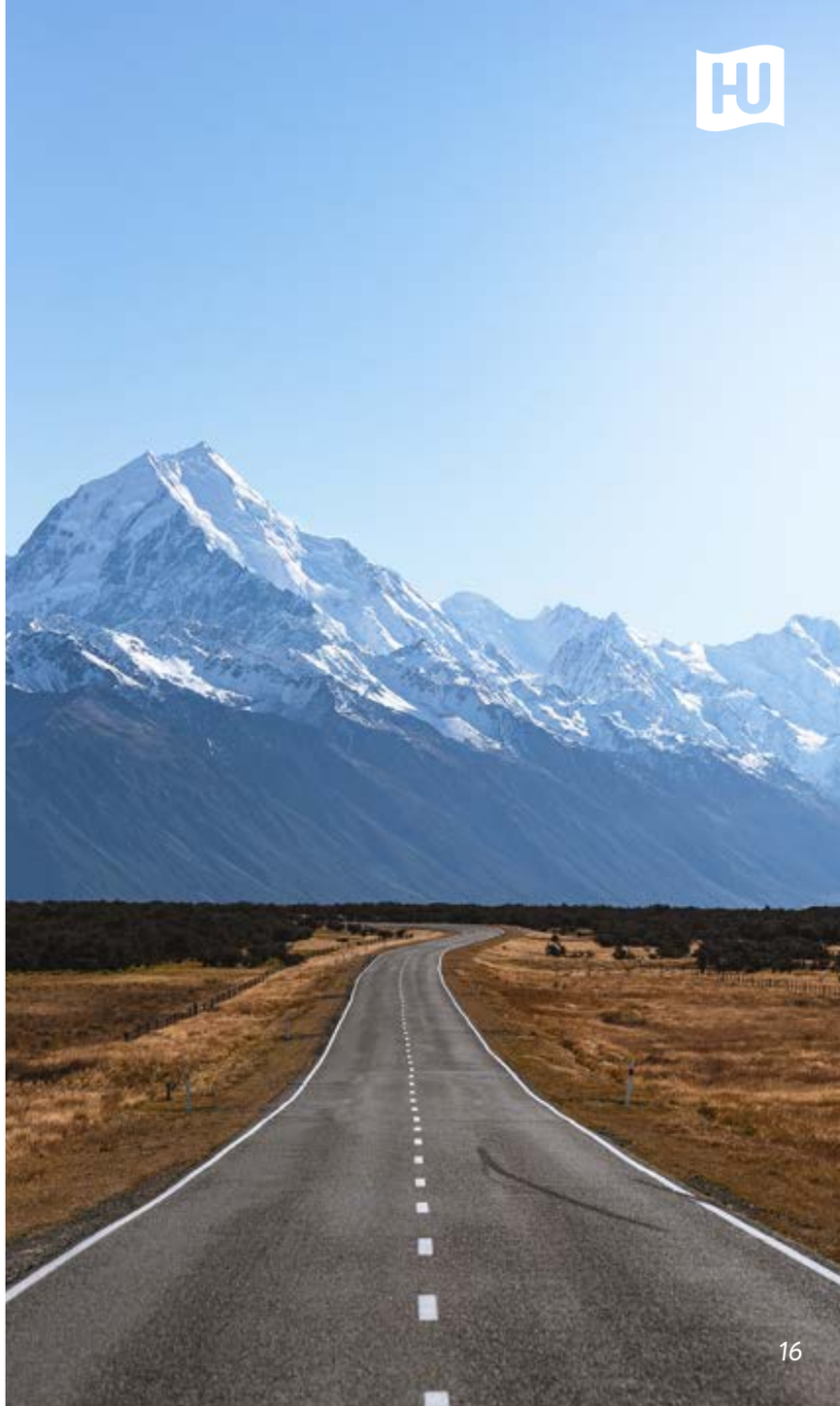
From these insights, it's evident that there's a recurring theme of a lack of clear and consistent pathways for individuals seeking mental health support. This lack of clarity often results in individuals not receiving the appropriate care or being passed between services. There's a need for better integration between services, clearer referral processes, and more accessible information on available support.

Individuals in acute psychological distress often end up bouncing between multiple services without receiving coordinated, appropriate care. They get "the run-around" as they are passed on from provider to provider, with no single point of accountability for continuity of care.

Participants cited the following contributing factors:

- Variability in processes across different regions of the country. This causes confusion when people move between areas.
- Gaps in awareness of local community support initiatives amongst frontline staff and clinicians.
- Lack of integrated IT systems and information exchange between mental health services, primary care, NGOs, and community organisations.
- Mental health services not designed to meet demands of a 24/7 environment.
- Overloaded mental health services that resort to discharging patients without proper follow-up.

The impacts of this fragmentation are serious delays in individuals getting the required care, increased risks during transition periods, and people falling through cracks in the system.



30%

OF PARTICIPANTS NOTED THE NEED FOR THE SHARING OF REAL-TIME SUICIDE DATA.

"They weren't allowed to access the confidential clinical records of the person or the family in their particular role, but they had to go and do postvention with his family. So they didn't know what they were walking into. They didn't know whether the situation was safe. They didn't know whether there were siblings, and often they were unsure how safe the siblings were and what to do about them"

DATA AND INFORMATION SHARING CHALLENGES

The lack of access to confidential clinical records can significantly impact the ability of individuals providing postvention support to effectively support families after a suicide. Without access to these records, support providers may not have crucial information about the person who died by suicide or their family, such as their mental health history, previous suicide attempts, or any ongoing treatment or support they were receiving.

This lack of information can make it challenging for support providers to understand the context and specific needs of the family, which can hinder their ability to provide appropriate tailored support. They may not be aware of potential risks or safety issues within the family, such as the presence of siblings who may also be at risk or any history of violence or self-harm.
This can put support providers in potentially unsafe situations when they are working with families.

A similar theme was illustrated in the Government Inquiry into mental health and addiction in 2019, whereby the lack of data collection and sharing was noted, in addition to a lack of quality and detailed statistics.

Furthermore, multi-agency data sharing informs prevention and intervention strategies and can result in identifying high risk areas and clusters. One participant discussed how they had been campaigning for a national MOU in postvention sharing information for four years. Several participants stated how Real-time Suicide Surveillance would help solve these challenges.

Overall, the lack of access to confidential clinical records can limit the effectiveness of individuals providing postvention support, as it hinders their ability to understand the specific needs of the family, assess potential risks, and provide appropriate and tailored support. Suicide prevention staff have an informed approach to prevention and intervention strategies, when data is readily available.

BUDGET AND RESOURCE CONSTRAINTS

20%

OF PARTICIPANTS MENTIONED LIMITED FUNDING AND RESOURCES, WITH ORGANISATIONS FACING CHALLENGES IN MEETING DEMAND DUE TO LIMITED BUDGETS.

"One of the biggest gaps is that the only money we have is our wage. So, if we're looking to run suicide preventions initiatives in the community, we have to beg and scrounge for money. Our prevention budget wouldn't feed your parking meter for a day. It's like the organisation hires a cardiologist and then they say to them, look, we're glad you got you on board. We don't have a theatre and we don't have any clinic space for you, but we do have a cardiologist on staff now, so this is great. And that's our situation."

In terms of available beds for mental health inpatient,
"We are also one of the worst resourced countries in the OECD, we have 31 beds per 100,000. The OECD averages 69. We don't have a lot of community beds, which would usually make up for that."

This participant observation has been validated by a 2016 study, where New Zealand was ranked 32nd out of 36 member countries in the Organisation for Economic Cooperation and Development (OECD) for numbers of hospital-based psychiatric beds[2]

This was also observed in the Government Inquiry into mental health and addiction in 2019.

One New Zealand organisation has described operating 'on the smell of an oily rag', relying on donations and fundraising, as they lacked resources for even basic client management systems to coordinate their peer support services and suicide prevention programs. Access to core operational funding could enable them to consolidate and enhance their services.

Youthline relies on significant fundraising each year to cover the $1.6m needed to run their service. Despite proven demand, they have no guaranteed long-term funding source to ensure they can meet the need.

Many participants discussed funding and resourcing challenges, with limited budgets impacting their ability to meet demand for services. There also seems to be a view that more funding is needed for frontline mental health services.

Limited funding and resources are major challenges, impacting the ability of organisations to meet demand and provide adequate services. Investment is needed to strengthen mental health services and support community-based suicide prevention initiatives.

[2] Allison S, Bastiampillai T, Castle D, et al. The He Ara Oranga Report: What's wrong with 'Big Psychiatry' in New Zealand? Aust N Z J Psychiatry. 2019 Aug;53(8):724-726. doi: 10.1177/0004867419848840.

COMMUNITY FUNDING INITIATIVES

Participants cited several community funding initiatives throughout the country. Funding is provided by either the Ministry of Health backed organisations or provided by the local community funding organisations. Fierce competition for the funding was discussed, with a tendency for funds to be awarded to more well known initiatives. Conversely, it was noted that initiatives needed to be well thought through and planned.

Examples given of community funding initiatives:

- Tiaki Tākata fund in the Southern Lakes region which provides small grants to community groups for mental wellbeing activities.
- Le Va Pasifika Suicide Prevention Fund is aimed at preparing more Pasifika families and communities to respond effectively to prevent suicide within communities.
- Te Rau Ora and the Centre of Māori Suicide Prevention provide The Māori Community Suicide Prevention & Postvention Fund. The purpose of the Fund is to build the capacity of Whānau Māori, Hapū, and Iwi to prevent suicide within communities and respond effectively if, and when, a suicide occurs.

WORKFORCE CHALLENGES

"It's not just about money anymore, it's actually staff. We have got this big hole which is getting bigger by the year, and so if the government said, "Here is $180,000,000", it wouldn't help."

The suicide prevention and postvention workforce faces unique challenges. There is high staff turnover. They are often affected by compassion fatigue, burnout and trauma, given the nature of their work. There's a pressing need to enhance the work environment and establish support systems for these professionals to ensure their well-being and, in turn, the quality of care they provide. There is also a need to invest in and support the long term capacity of the sector through a range of initiatives.

THE MENTAL HEALTH WORKFORCE IS AGEING RAPIDLY[3]

50% IS OVER THE AGE OF 50

20% IS OVER THE AGE OF 60

[3] Foulds JA, Beaglehole B, Mulder RT. Time for action, not words: the urgent rebuilding of New Zealand's mental health workforce. N Z Med J. 2023 May 26;136(1576):8-10. PMID: 37230085.

15%

OF PARTICIPANTS MENTIONED THE NEED FOR COMMUNITY FOCUSED APPROACHES.

NEED FOR COMMUNITY-FOCUSED APPROACHES

One participant discussed a person who would frequently call the police threatening suicide when they were struggling. Rather than brush the caller off, they would walk down to their house, restrict the means they planned to use to harm themself, talk through what was going on, and provide support in an ongoing way. This compassionate community-based response was more impactful than institutional mental health services.

Participants highlighted the value of community-focused, grassroots suicide prevention efforts, including proactive outreach, rather than expecting at-risk individuals to come to services. Having strong local relationships and networks is seen as crucial.

Community-focused, grassroots approaches seem to work best for suicide prevention, given New Zealand's diversity across regions. Proactive outreach, forming local relationships and tailoring solutions is key rather than expecting at-risk individuals to come to services. By affording community groups more opportunities and support through initiatives like their community fund, they aim to mobilise leadership from within to deliver locally-driven prevention.

COMMUNITY KNOWLEDGE AND TRUST

Long-serving staff have built up very good knowledge and connections within their communities over time. New Zealand has some excellent grassroots, community-driven suicide prevention initiatives.

"We have a good grasp of what our data collection is here locally. And we usually know quite a lot about particular families because also where I live we're like in a semi-rural but definitely isolated community."

Another participant shared how his background as a police officer helps him connect with at-risk individuals in his community. Rather than waiting for people to come to him, he proactively visits their homes to check in, takes them to coffee shops to talk through their issues, and leverages his local relationships built over many years to provide a human, peer-like form of support.

"Our communities move at the speed of trust."

Participants discussed how the build-up of goodwill and trust needs to be harnessed and turned into a structure that limits service outcome and engagement decline when there is staff turnover.

CULTURALLY TARGETED PROGRAMS

One participant shared a Samoan proverb:
'E fofo e le Alamea le Alamea'

It has been said among Samoan traditional fishermen that if you get stung by the spines of the Alamea (crown-of-thorns) you should turn it over & have its spongy like feet touch the area where you have been stung to let the Alamea heal its own doing.

The view for using this proverb is that; solutions for issues & challenges affecting a community can be found within that same community.

Furthermore, a Māori provider talked about the difference of being told about a solution and sharing knowledge. Whakahihi means to be vain, conceited, arrogant and smug. Local iwi/hapū look to avoid their people being viewed as Whakahihi by questioning (and providing approval to do so) when someone within the iwi/hapū wishes to share knowledge or experiences outside of the local group. They also require a full debrief on what was shared and how it was received.

Conversely, when you are invited to Wānanga, there is no Whakahihi as you're invited in to share your knowledge and experiences.

25%

OF PARTICIPANTS MENTIONED THE IMPORTANCE OF COMMUNITY-LED AND CULTURALLY-INFORMED PREVENTION, ESPECIALLY MĀORI AND PASIFIKA COMMUNITIES.

Participants shared how they have developed culturally grounded suicide prevention initiatives for Māori communities in their region. This includes a Rangatahi-led initiative that promotes cultural identity and belonging. They emphasise that solutions must come from within communities.

Participants discussed how different communities are at different stages in their understanding of suicide. Some parts of Māori and Pacifika are still in the awareness and understanding phase of suicide prevention. Efforts are being made to enhance community education and workforce training around suicide prevention.

One service provider discussed running a workshop for a Māori community that had recently experienced suicide loss. Initially, some elders on the marae and local pastors expressed stigmatising attitudes about suicide being a sin or forbidden on tribal land. However, by the end of the interactive workshop exploring myths and facts about suicide, there was a marked shift. The elders and pastors apologised to the grieving family and committed to being more compassionate and informed when dealing with suicide in the future.

10%

OF PARTICIPANTS DISCUSSED THE IMPORTANCE OF HUMAN CONNECTION AND PEER SUPPORT.

ROLE OF PEER SUPPORT AND HUMAN CONNECTION

It was raised that something as simple as having peer workers provide support while someone is waiting to be seen in ED has made a huge difference. They also noted that most people who attempt suicide don't have strong natural support networks, and services should focus on helping rebuild connections.

A recurring theme is the role of connections and the impact of loss. Many individuals who contemplate or die by suicide often experience a form of loss, whether it's a loss of connection, a loved one, or something else. A participant discussed from their experience through Victim Support that people made a suicide attempt within 24-48 hours of a relationship breakdown. Another participant discussed from their experience how people made a suicide attempt following two forms of loss, i.e. a job, relationship, money etc.

Situational distress and crisis, in the absence of long-term mental health challenges, was a theme in the Government Inquiry into mental health and addiction in 2019.

Interventions that focus on rebuilding connections can be particularly effective. Caring contacts is an example of this. Multiple participants discussed the importance of follow-ups or caring contacts for people post-discharge from services EDs, inpatient units, or mental health care.

Digital tools alone are currently seen as insufficient, there still needs to be human intervention or support.

TRAUMA-INFORMED AND COMPASSIONATE APPROACHES

A participant talked about how most of the people who die by suicide in their region have experienced adverse childhood events and trauma. They noted that when people with trauma histories experience new crisis, their first instinct is often that the world is hopeless because they lack trust and healthy coping skills. They argue clinicians need better trauma training.

Issues like adverse childhood experiences and trauma are linked to suicide risk, illustrating the need for more trauma-informed and compassionate approaches in suicide prevention.

5% -

THE LINK BETWEEN TRAUMA AND SUICIDE RISK WAS MENTIONED, EMPHASISING THE NEED FOR TRAUMA-INFORMED CARE.

VALUE OF LIVED EXPERIENCE PERSPECTIVE

Lived experience perspectives are critical. Initiatives should meaningfully engage attempt survivors, family/whanau impacted by suicide etc. The value of involving peer support and people with lived experience is increasingly recognised.

A participant discussed openly drawing on her own lived experience of suicide loss to inform her prevention work. She models how personal experiences can be channelled into helping others, when done in a safe and ethical way.

This highlights the importance of learning from those with lived wisdom.

Other participants noted how lived experience can bring empathy and understanding to support people in mental distress or who have been bereaved by suicide.

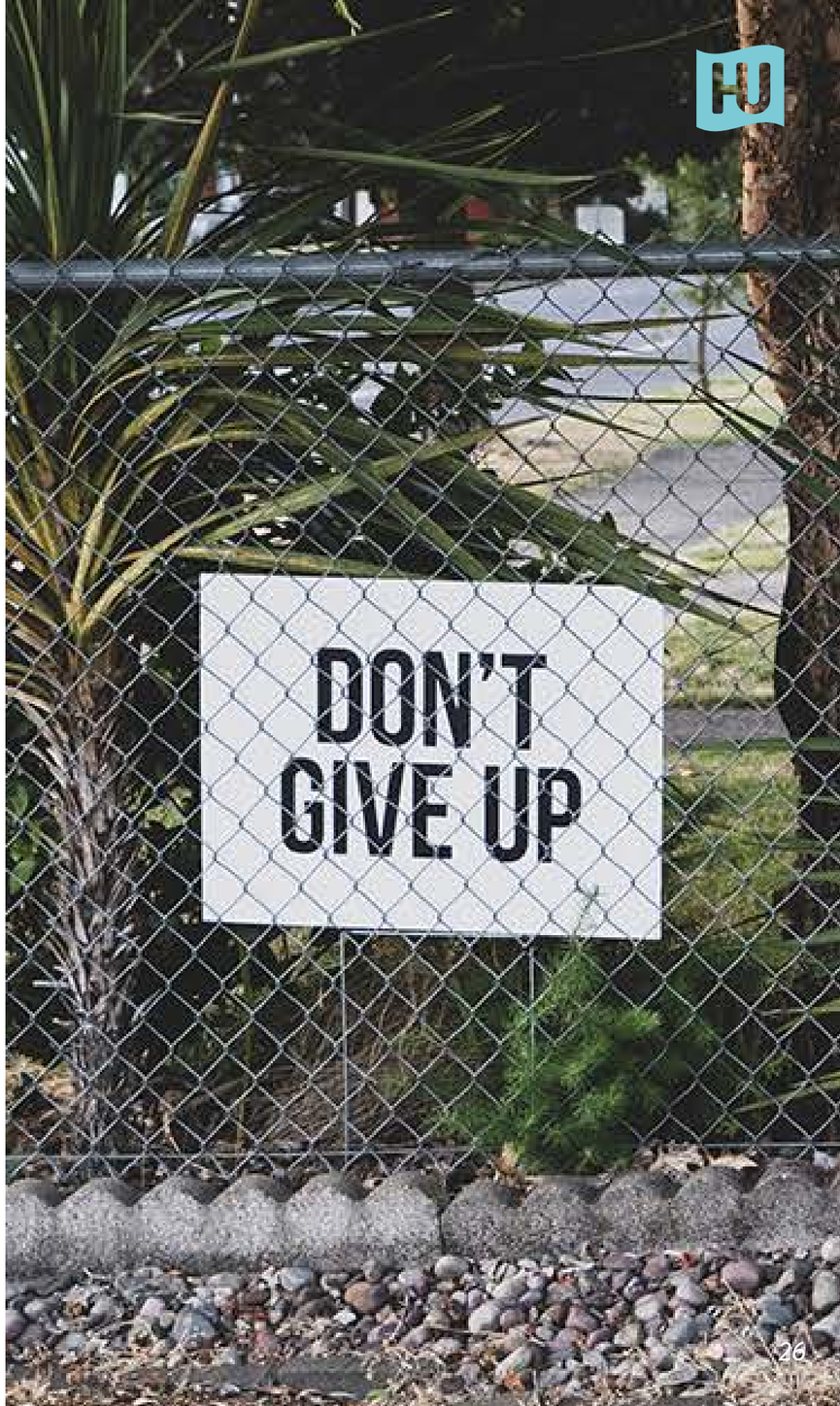
THE ROLE OF TECHNOLOGY

While technology has a role to play, human connection and peer support are crucial elements in suicide prevention. Providing follow-up caring contacts after interactions with health services can provide much-needed support.

On the need for human connection, one story involved a young man with autism who was suicidal and latched onto someone who showed him kindness, becoming dependent on them as his sole support system. This illustrates how for socially isolated individuals, human connection is a lifeline. But it also shows the need to set boundaries and link suicidal people to broader support networks.

Conversely, there were stories of male construction and forestry workers wanting to receive support, connection or contact at a distance.
"They don't want to do anything in person."

These stories suggest technology could be a potential solution to delivering support in some cases, whilst in other cases technology could play a supporting role to a 'human-lead' approach. However, research suggests that this view may be due to masculine problem solving/coping norms of wanting to solve the problem themselves and lack of education and lived experience of seeking help.[4]



[4] Gallagher, J. M. (2021). 'That fantasy that you can deal with everything yourself and move mountains', an examination of men's beliefs and media representations about mental health services: a thesis presented in partial fulfilment of the requirements for the degree of Doctor of Clinical Psychology at Massey University, Wellington, New Zealand (Doctoral dissertation, Massey University

THE IMPORTANCE OF SAFE MESSAGING

Several participants discussed the importance of safe messaging and language on suicide, and not being "numb" to suicide accounts, given trauma-affected workforce.

There's a delicate balance to strike in discussing suicide. While it's essential to talk about it, there's a risk of doing more harm than good. Past suicide prevention programs have inadvertently caused harm. It's crucial to learn from these mistakes and ensure that future initiatives are both safe and effective.

Three groups within the New Zealand suicide prevention landscape were discussed by participants through the interviews.

1. Media and social media personalities who are promoting suicide prevention awareness, (which all participants agreed is great). However, some of which were doing it in an unsafe way and potentially causing harm.
2. A small group of "experts" who believe suicide should not be discussed in any way, shape or form, as by doing so will cause harm.
3. The remainder of the suicide prevention community, including academics, mental health professional and lived experience trying to save lives, deliver their messages of hope, all the while navigating between groups one and two.

III. OPPORTUNITIES

OPPORTUNITY 1:
ENHANCE NATIONAL LEADERSHIP AND STRATEGY ALIGNMENT

The creation of the national Suicide Prevention Office in 2019, as part of the Government's response to its mental health inquiry, was welcomed by the suicide prevention sector. However, participants uniformly note it has failed to fulfil its intended role. Without dedicated leadership, alignment of priorities, quality standards, and oversight, New Zealand's suicide prevention efforts will remain fragmented and siloed. We recommend empowering and properly resourcing a centralised office to coordinate nationwide efforts, align data systems, set benchmarks, and support communities in a strategic manner (whilst enabling and supporting community led, designed and delivered initiatives to be undertaken as per Opportunity 5). This cannot be achieved with the SPO's current capacity. A fully operational office would greatly enhance New Zealand's ability to target its suicide prevention resources effectively. Disappointingly, this was a recommendation in the Government Inquiry into mental health and addiction in 2019.

OPPORTUNITY 2:
DEVELOP AND PROMOTE ROBUST PATHWAYS

There is a clear need to establish more streamlined and consistent pathways across New Zealand. This requires greater collaboration and information sharing between various mental health players to improve coordination and continuity of care. Integrated IT systems, timely data sharing, and centralised knowledge of community supports would aid more seamless referrals. As would implementing standardised discharge and follow-up protocols across regions. Stronger national leadership, strategic direction and coordination (ie, Opportunity 1) would likely better promote and develop more effective and efficient pathways.

The founding principles of the SPO, suggest they are best placed for developing and promoting clear pathways. However, there is a need to reduce the stigma around suicide and mental health struggles, promote help-seeking among men, and increase suicide prevention literacy at the community level. Perhaps more resources could be provided to existing community-led organisations to facilitate the local need.

OPPORTUNITY 3:
DEVELOP REAL-TIME DATA SHARING PLATFORMS AND AGREEMENTS TO ENABLE COORDINATED CRISIS RESPONSE

The lack of timely data hampers active suicide prevention and clustered response efforts when contagion risks emerge. Duplicative information gathering wastes precious intervention time. We recommend developing secure real-time data sharing platforms and formalising data sharing protocols between coroners, health providers, and community partners. This will allow coordinated crisis response, informed by accurate, up-to-date data to activate support around impacted individuals and communities as early as possible.

Consideration should be given to which organisations and service providers should be given access to real-time data. There is potential to categorise these by the priority and level of detail the organisation receives, i.e. bereaved data is only provided to emergency services, the Coroner and bereavement support (if the bereaved approves).

International research shows that real-time suicide mortality data facilitates rapid data-driven decision-making in suicide prevention[5]. Furthermore, Hope Upstream brings a wealth of experience in the development and implementation of Real Time Suicide Surveillance in the United Kingdom and stands ready and available to support New Zealand efforts in that regard.

[5] Benson R , Rigby J , Brunsdon C , et al . Real-time suicide surveillance: comparison of international surveillance systems and recommended best practice. Arch Suicide Res 2022:1–27. doi:10.1080/13811118.2022.2131489

OPPORTUNITY 4:
INCREASE FUNDING FOR FRONTLINE MENTAL HEALTH AND ADDICTION SERVICES TO IMPROVE ACCESS AND CAPACITY

Many participants highlighted insufficient resourcing of primary mental healthcare as a major gap, resulting in inadequate responses to those at moderate risk who fall below the high threshold for specialist care. With at-risk individuals unable to access timely support, preventable suicides occur.

We recommend increased funding to expand community-based mental health and addiction services, allowing more proactive outreach and moderate risk support. This must include services tailored to high-risk groups like Māori and young men. Bolstering frontline capacity to assess, refer and follow-up those at risk is an urgent priority. There may be a range of levers available to central government to support sufficient capacity within the sector. For example, immigration settings (short and long term), support and funding for increased capacity and attractiveness of tertiary training (medium to long term), measures to promote retention of existing staff such as pay and conditions (short to long term), and other alternative and novel ways of attracting talent into mental health, for example through apprenticeships and on-the-ground in house training programmes through delivery partners.

It might be that mental health and suicide prevention staff are on a periodic rotation with other areas of health and the suicide prevention ecosystem to help them maintain energy and engagement.[6]

Additionally, receiving in person feedback from patients who have recovered from treatment has proven to increase resilience and help nurses to continue giving.[7]

Figures show that 10 percent of all 111 calls are from people experiencing mental distress, and that police were simply too busy to respond to all of these callouts. To alleviate some pressure, it was announced on Wednesday the 30th of August 2023 that police, ambulance and mental health co-response teams will be rolled out nationwide. An integrated, collaborative approach is consistently emphasised as necessary across health services, government, NGOs, community groups etc., but challenges exist in actualising this integration.

[6] Klimecki, O., & Singer, T. (2012). Empathic distress fatigue rather than compassion fatigue? Integrating findings from empathy research in psychology and social neuroscience. In B. Oakley, A. Knafo, G. Madhavan, & D. S. Wilson (Eds.), Pathological altruism (pp. 368–383). Oxford University Press.

[7] Bellé, N. (2013). Experimental Evidence on the Relationship between Public Service Motivation and Job Performance. Public Administration Review, 73(1), 143–153. http://www.jstor.org/stable/23355447

OPPORTUNITY 5:
SUPPORT COMMUNITY-LED AND CULTURALLY GROUNDED SUICIDE PREVENTION INITIATIVES

Participants emphasise that solutions must come from within communities to be effective and sustainable. Top-down, one-size-fits-all models invariably fail due to New Zealand's cultural and regional diversity. We recommend policies and funding enabling community-led co-design of suicide prevention, drawing on local insights. At the same time, these community-led, designed and delivered initiatives can still be consistent with any overarching national strategy and objectives, being part of an overall integrated approach, and applying consistent pathways and technologies, as per Opportunities 1-3. Initiatives grounded in Māori cultural concepts of wellbeing promotion show particular promise for reversing the high Māori suicide rates. Supporting grassroots efforts is critical.

The Government Inquiry into mental health and addiction in 2019 noted that community led solutions work well because "there are little to no systemic constraints, taking away from the core purpose and focused too heavily on processes."

Furthermore, there is major potential to promote suicide prevention literacy and help-seeking behaviours by integrating education into diverse community settings outside the health sector.

Partnerships with local institutions like sports clubs, churches, schools and workplaces could enable positive messaging to reach a wider range of at-risk groups.

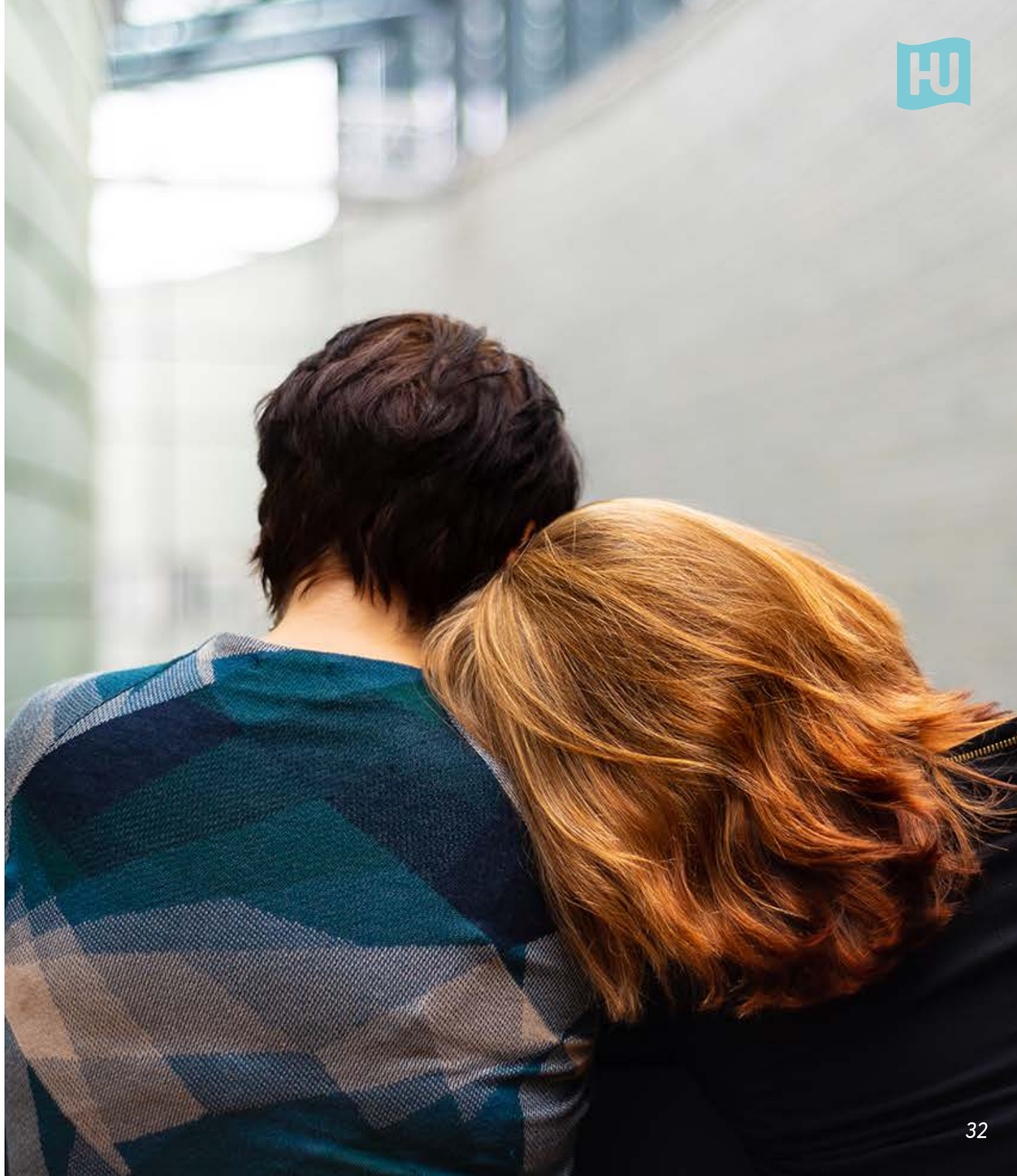
For example, several participants discussed outreach opportunities through rugby clubs or other sports teams, which are social hubs especially for youth and men. Providing coaching staff and volunteers with basic training in having supportive conversations, recognising signs of distress, and referral pathways could make a significant difference. One participant does suicide prevention work through a rugby league program, using tournaments where youth players, coaches and family gather as opportunities to share mental health resources.

Others highlighted churches and religious communities as partners for education, given their extensive reach and moral authority. However, sensitivity is required as some faith-based messaging creates stigma around suicide. One story involved a marae community workshop resulting in elders apologising for past stigmatising attitudes and vowing more compassion going forward - evidence of transformational learning.

Several participants also emphasised the need to start early by incorporating youth suicide prevention into school health curriculums. Training teachers to recognise warning signs, run class discussions safely, and link students to support is vital. A suicide prevention coordinator discussed implementing teen mental health first aid training in schools to this end.

Finally, workplaces are prime targets for promoting prevention literacy, as adults spend significant time at work. Consultations mentioned suicide prevention partnerships with sectors like construction, forestry, and corrections where occupational stresses are high. Supportive messaging in workplace break rooms or on payslips could reinforce help-seeking norms.

Overall, community organisations with wide reach and influence over cultural attitudes could expand the frontiers of suicide prevention exponentially if engaged. By meeting people where they are, tailored educational partnerships in sports, faith, schools, and work settings help normalise open conversations, reduce stigma, spread referral pathways and ultimately save lives.



OPPORTUNITY 6:
PROMOTE TRAUMA-INFORMED AND COMPASSIONATE CARE PRINCIPLES THROUGHOUT THE HEALTH AND SOCIAL SERVICE SECTOR

Many participants highlight adverse childhood experiences and trauma histories as a frequent factor in suicide risk. We recommend initiatives to build capability by promoting trauma-aware practices across all government services engaging vulnerable individuals, requiring trauma training and compassionate service delivery principles. This includes avoiding re-traumatisation, building trust and safety, and creating human connection. Trauma-informed care can enhance suicide prevention outcomes when implemented consistently and leveraged with lived experience in co-designing solutions.

OPPORTUNITY 7:
EXPAND BEST-PRACTICE "CARING CONTACTS" AND PEER SUPPORT CONNECTIONS POST-DISCHARGE TO ENHANCE CONTINUITY OF CARE

A major vulnerability for suicide risk is the period following discharge from inpatient mental health facilities or emergency care. Participants emphasise care transitions are perilous as people can fall through the cracks.

Moreover, suicide can be classified as a "bad day problem" due to a relationship breakdown or loss of connection which poses a different challenge for addressing suicide risk.

We recommend initiatives enabling proactive human outreach to all discharged individuals via regular "caring contacts" (texts, visits etc.) to check in, reconnect people to community support, and ease the transition home. Contacts should come from trained peers or whānau with lived experience, who can relate deeply. Ideal caring contacts are personalised, reflecting what gives the individual purpose and hope. For example, linking them to a sports team, cultural group or loved ones. The goal is sustaining human connection beyond clinical services.

Evaluation of caring contacts shows there is evidence of a protective effect for suicide attempts[8]. Other countries have demonstrated such models are scalable and sustainable. New Zealand should learn from these successes to enhance continuity between clinical treatment and community reintegration. Backing innovative peer-based transition programs is an evidence-based suicide prevention priority warranting immediate investment.

[8] Luxton, D. D., Smolenski, D. J., Reger, M. A., Relova, R. M. V., & Skopp, N. A. (2020). Caring e-mails for military and veteran suicide prevention: A randomized controlled trial. Suicide and Life-Threatening Behavior, 50(1), 300-314. https://doi.org/10.1111/sltb.12589

OPPORTUNITY 8:
GUIDELINES FOR TECHNOLOGY USE IN PREVENTION AND INTERVENTION

Using technology in suicide prevention and intervention can be an effective and scalable way to provide support to individuals at risk. Here are the evidence-based guidelines for incorporating technology into suicide prevention efforts.

1. Access to Crisis Helplines and Support Services:
Ensure that crisis helplines and support services are easily accessible through various communication channels, such as phone, text, chat, and email. [9]
2. Online Chat and Text-Based Support:
Offer text-based crisis support services where individuals can engage in real-time conversations with trained counsellors or volunteers.[10]
3. Social Media Monitoring and Intervention:
Implement social media monitoring tools to identify individuals at risk and intervene when concerning content is detected.[11]
4. Mobile Apps and Online Resources:
Develop and promote mobile apps and websites that provide information, coping strategies, and self-help tools for individuals in crisis.[12]
5. Artificial Intelligence and Predictive Analytics:
Utilise AI and machine learning to predict suicidal behaviours and proactively reach out to individuals at risk.[13]
6. Online Support Communities:
Encourage individuals at risk to participate in online support communities and peer-to-peer networks where they can share their experiences and receive empathy and guidance.[14]
7. Data Privacy and Ethical Considerations:
Prioritize data privacy and ensure that all technologies used in suicide prevention adhere to ethical guidelines.[15]
8. Continuous Evaluation and Improvement:
Regularly assess the effectiveness of technology-based interventions and adapt strategies based on research and user feedback.[16]
9. Collaboration with Mental Health Professionals:
Collaborate with mental health professionals and organisations to ensure that technology-based interventions align with established best practices.[17]
10. Training and Support for Crisis Responders:
Provide adequate training and support for individuals who deliver crisis intervention through technology to ensure they are well-prepared to assist those in need.[18]

Remembering that the use of technology in suicide prevention and intervention should always be complemented by traditional mental health services and a holistic approach to care. It is essential to continually adapt strategies based on the evolving landscape of technology and research.

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[9] Research Reference: Luxton, D. D., June, J. D., & Fairall, J. M. (2012). Social media and suicide: A public health perspective. American Journal of Public Health, 102(S1), S195-S200.
[10] Whitlock, J., Muehlenkamp, J., Eckenrode, J., Purington, A., Baral Abrams, G., Barreira, P., & Kress, V. (2013). Nonsuicidal self-injury as a gateway to suicide in young adults. Journal of Adolescent Health, 52(4), 486-492.
[11] Silva, C., Ribeiro, J. D., & Joiner, T. E. (2015). Mental health on social media: A content analysis of depression-related posts. Journal of Affective Disorders, 186, 188-194.
[12] Torous, J., Nicholas, J., Larsen, M. E., Firth, J., Christensen, H., & editors. (2019). Clinical review of user engagement with mental health smartphone apps: evidence, theory and improvements. Evidence-Based Mental Health, 22(4), 176-184.

OPPORTUNITY 9:
NATIONAL AGREEMENT ON THE SAFE MESSAGING FOR SUICIDE PREVENTION

Samaritans and the Mental Health Foundation of New Zealand are valuable resources for guidance on safe messaging and suicide prevention. Their guidelines are designed to help individuals, organisations, and the media responsibly address suicide-related content.

1. Use Caution with Language and Imagery
Use caution when discussing suicide on social media to avoid explicit details, graphic imagery, or sensational language. Encourage responsible reporting that avoids glamorizing or normalising suicidal behaviours.

2. Provide Helpful Resources
Share information about helplines, crisis services, and mental health resources in New Zealand. Ensure that these resources are easily accessible and up-to-date.

3. Promote Hope and Resilience:
Encourage messages that focus on hope, recovery, and coping strategies. Highlight stories of individuals who have overcome suicidal thoughts and found support.

4. Avoid Sharing Methods
Do not share specific methods or means of suicide on social media. Avoid providing details that could potentially be harmful to individuals at risk.

5. Be Respectful and Supportive
Approach discussions of suicide with empathy and respect. Respond to individuals in distress with kindness and offer support without judgement.

6. Correct Misinformation
If you encounter misleading or harmful information about suicide on social media, consider politely correcting it and providing accurate resources.

7. Encourage Help-Seeking
Encourage individuals in distress to seek professional help or reach out to a trusted person. Share information about how to connect with mental health services.

[13] O'Dea, B., Larsen, M. E., Batterham, P. J., Calear, A. L., & Christensen, H. (2017). A linguistic analysis of suicide-related Twitter posts. Crisis, 38(5), 319-329.
[14] Naslund, J. A., Aschbrenner, K. A., Marsch, L. A., & Bartels, S. J. (2016). The future of mental health care: Peer-to-peer support and social media. Epidemiology and Psychiatric Sciences, 25(2), 113-122.
[15] Mishara, B. L., & Weisstub, D. N. (2016). Ethical, legal, and practical issues in the control and regulation of suicide promotion and assistance over the internet. Crisis, 27(1), 7-13.
[16] Franklin, J. C., Ribeiro, J. D., Fox, K. R., Bentley, K. H., Kleiman, E. M., Huang, X., ... & Nock, M. K. (2017). Risk factors for suicidal thoughts and behaviors: A meta-analysis of 50 years of research. Psychological Bulletin, 143(2), 187.
[17] Zalsman, G., Hawton, K., Wasserman, D., van Heeringen, K., Arensman, E., Balazs, J., ... & Balint, L. (2016). Suicide prevention strategies revisited: 10-year systematic review. The Lancet Psychiatry, 3(7), 646-659.
[18] Mishara, B. L., Chagnon, F., Daigle, M., Balan, B., & Raymond, S. (2007). Comparing models of helper behavior to actual practice in online and telephone crisis intervention. Suicide and Life-Threatening Behavior, 37(1), 152-169.

8. Engage with Experts
Collaborate with mental health experts, organisations, and crisis helplines like Samaritans to ensure that your messaging aligns with best practices.

In Australia, resources have specifically been developed to provide social media guidance of suicide prevention and self harm targeted at young person and influencers - #chatsafe: A young person's guide to communicating safely online about self-harm and suicide. The guidance covers 8 sections:
General tips

1. Creating self-harm and suicide content
2. Consuming self-harm and suicide content
3. Livestreams of self-harm and suicide acts
4. Self-harm and suicide games, pacts, and hoaxes
5. Self-harm and suicide communities
6. Bereavement and communicating about someone who has died by suicide
7. Guidance for influencers

Taking this a step further, the Centre for Suicide Research and Prevention of the University of Hong Kong (CSRP), launched an innovative outreaching approach to connect the vulnerable youth via the power of social media. In the project, CSRP's suicide prevention professionals engaged with some influential YouTubers with positive public image and worked together to:

1. Initiate activities that aim to promote suicide prevention and help-seeking. These activities can be launched online or in the community.
2. Reach out to online youth with suicide risk and encourage them to seek help.
3. Refer high-risk cases to professionals for follow-up care and support.
4. Recruit and engage online users who are not at risk and willing to contribute to suicide prevention to join in our cause. In this way, we aim to continuously extend our partnership network.

All influencers and partners received suicide prevention training to empower them to properly address suicide issues and respond to suicide-related online comments.

Hope Upstream believes there is value in adopting the #chat safe guidelines, in addition to running similar outreach training projects with social media influencers in New Zealand.

CONCLUSION

VI. CONCLUSION

Suicide prevention in New Zealand can benefit communities and deliver positive outcomes due to the commitment and passion of people working in suicide prevention.

Currently, the landscape of suicide prevention work in New Zealand is fragmented, with a lack of national coordination and strategy, inconsistent pathways, and limited and inconsistent application of technologies. Furthermore, much of the sector faces significant capacity constraints to deliver effective and efficient intervention and support measures.

A range of opportunities exist to improve nationwide outcomes to ultimately reduce the number suicides (and attempted suicides) in all communities. Some of the opportunities presented in section III Opportunities, are best addressed by Central Government and the SPO. This includes setting a national strategy and outcomes, promoting and supporting greater integration and consistent pathways, potentially supporting streamlined technology and supporting workforce capacity building measures. It is clear that community-led organisations should be provided with more resources to continue to provide positive outcomes for their communities, with locally led, designed and delivered initiatives likely to have the most impact. These locally led initiatives can still be consistent with, or contribute to, the overall national strategic direction and outcomes.

Hope Upstream welcomes the opportunity to collaborate and support these initiatives and organisations.

Opportunities for Hope Upstream to consider exist in the following options:

- **OPPORTUNITY 3:** Develop real-time data sharing platforms and agreements to enable coordinated crisis response.
- **OPPORTUNITY 6:** Promote trauma-informed and compassionate care principles throughout the health and social service sector.
- **OPPORTUNITY 7:** Expand best-practice "caring contacts" and peer support connections post-discharge to enhance continuity of care.

NEXT STEPS

VII. NEXT STEPS

Hope Upstream will be considering how the opportunities outlined in the conclusion, can be turned into an action plan for our charitable purpose and to supplement, support or enhance suicide prevention in Aotearoa New Zealand. We will look to conduct more in depth research and New Zealand specific validation around some of these themes.

It is worth noting, some of the opportunities are targeted at a national level and require system alignment that are out of the control of an organisation of our size. However, we will continue to advocate and support change within the sector to help achieve our sector wide mission of saving lives.

APPENDIX 1 - STAKEHOLDER PERSPECTIVES

These perspectives are invaluable as they provide a multi-faceted understanding of the challenges and opportunities in New Zealand's suicide prevention landscape.

1. SERVICE PROVIDERS (35% OF RESPONSES):

Service providers, being on the frontlines, offered insights grounded in their day-to-day experiences. Key themes from this group included:

a. The pressing need for additional resources to meet the growing demand for services.
b. The value of continuous training to keep up with best practices.
c. The challenges of navigating bureaucratic hurdles when trying to deliver timely and effective care.

2. COMMUNITY LEADERS (20% OF RESPONSES):

Community leaders, often seen as the bridge between formal services and the public, highlighted:

a. The importance of culturally tailored interventions, especially in areas with a significant Māori or Pacifika population.
b. The potential of grassroots initiatives that leverage community strengths and local knowledge.
c. Concerns about the disconnect between national policies and local realities.

3. LIVED EXPERIENCE PROVIDERS (25% OF RESPONSES):

The insights from those with personal experiences with suicide are particularly poignant. They emphasised:

a. The need for compassionate, non-judgmental care.
b. The value of peer support and mentorship programs.
c. The gaps in post-crisis follow-up, which often leaves individuals feeling isolated and unsupported.

4. HEALTH AND SOCIAL SERVICE EXPERTS (20% OF RESPONSES)

Experts in the fields of health and social services provided a more systemic view, noting:

a. The need for a holistic approach to suicide prevention that integrates mental, physical, and social well-being.
b. The importance of inter-agency collaboration to ensure continuity of care.
c. The potential benefits of leveraging technology, while also recognising its limitations and the irreplaceable value of human connection.

Thank you.

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