Appendix 2: Suicide prevention package

Description of the initiative and problem definition	
What is this initiative seeking funding for?	The individual, community and societal impact of suicide and suicidal behaviour[1] is both significant and preventable, yet New Zealand's suicide rate remains among the highest in the OECD[2]. Substantial investment in current and new suicide prevention activities is needed to address this problem. This proposal seeks funding for a package of suicide prevention initiatives at an ongoing cost of s 9(2) million per annum. This package includes funding for: a) new suicide prevention initiatives based on international experience and evidence, and b) enhancement of suicide prevention initiatives currently being delivered in New Zealand with evidence of sustainable positive impact in meeting the needs of priority populations, meeting service demand and cost pressures, and widening service scope and coverage. This package of initiatives will increase the protective factors and reduce the risk factors[3] for suicidal behaviour by providing a range of services across the continuum of suicide prevention – (1) promotion, (2) prevention, (3) intervention and (4) postvention[4] s [redacted] **1. Promotion of wellbeing and resilience (promotion)** People who have higher levels of wellbeing and resilience are more likely to manage life challenges well and less likely to experience suicidal behaviour. Population-based strategies such as mental health, wellbeing and resilience education has been shown to increase help-seeking behaviours for poor mental health and suicidal behaviour. It can also reduce discriminatory attitudes and behaviours toward people who experience mental health problems and suicidal behaviour. This education is best targeted at the frontline youth, education, health and social sector workforce who are well positioned to support people experiencing mental health problems or suicidal behaviour. In order to meet increasing demand for services, funding is sought to: a) s 9(2)(f)(iv) [redacted] b) **Expand the suicide media response service** (delivered by the Mental Health Foundation) which ensures that suicide reporting follows the suicide reporting guidelines and doesn't put vulnerable people at risk of taking their own lives.

[1] Suicidal behaviours refers to suicide, attempted suicide, deliberate or intentional self-harm and suicidal ideation.

[2] He Ara Oranga: Report of the Government Inquiry into Mental Health and Addiction, https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

[3] Risk factors include (but are not limited to): adverse childhood experiences, trauma or abuse; ongoing family harm; mental health or addiction issues; poor physical health; lack of social support; interaction with the criminal justice system; intergenerational impact of colonisation; poverty; homelessness; lack of employment; relationship issues; isolation and loneliness. Protective factors include (but are not limited to): stable family relationships; community support and connectedness; employment; good physical health; access to timely, appropriate mental health and addiction services; positive cultural and / or spiritual beliefs; and a strong sense of self-identity.

[4] The term 'postvention' is used in New Zealand to refer to all activities undertaken after a suspected self-inflicted death or suicide, but has also become synonymous with cluster and contagion management.

c) **Expand the Family and Whānau Suicide Prevention Information Service** (delivered by the Mental Health Foundation) which provides resources to support courageous conversations about suicide, suicide prevention safety planning and supporting those bereaved by suicide.

These health promotion components will be complemented by s 9(2)(f)(iv) [redacted] the initiative to *Expand Access and Choice of Community-based Mental Health and Addiction Responses.*

2. Targeted suicide prevention activity (prevention)

In New Zealand, some groups, such as Māori, young people and men, experience disproportionately high levels of suicidal behaviour than other groups. These population groups often experience a greater number of risk-factors for suicidal behaviours, such as adverse childhood experiences, trauma or abuse, mental health or addiction issues, poverty, unemployment and intergenerational impact of colonisation. This initiative seeks funding for the following suicide prevention activities that are responsive to the needs of these groups:

a) s 9(2)(f)(iv) [redacted]

b) **Support additional Māori and Pacific providers to design and deliver culturally responsive suicide prevention initiatives.** Many Māori and Pacific providers deliver targeted suicide prevention activities in response to community need with limited, or sometimes no, funding. These providers have the potential to significantly impact on suicidal behaviour. It is proposed that additional funding be made available to Māori and Pacific providers delivering mental health and suicide prevention services to Māori and Pacific populations.

c) **Additional support for district health boards (DHB) suicide prevention services.** DHBs are responsible for managing suicide prevention and postvention services for their population. Most DHBs have employed a Suicide Prevention Coordinator (SPC) to lead this work but resourcing remains an issue. Additional funding will i) provide sustainability to the SPC role in all DHBs and ii) require DHBs to deliver a post-discharge follow-up service to people who have presented at mental health or emergency services with suicidal behaviours to reduce the likelihood of a further self-harm event. Failure to provide follow-up care after a suicide attempt is associated with increased risk of re-attempt[5]. International evidence supports the use of a tele-health, or peer-based service which provides 'caring connection' post-discharge. This post-discharge follow-up service is expected to reach the 20,000 people who attempt suicide each year.

3. Support for people with suicidal behaviour (intervention)

Some people are at greater risk of suicide than others, this includes people currently using mental health and addiction services, people who have previously attempted suicide, and people who

[5] Shand, FL.,Batterham, PJ., Chan, JKY, Plrkis, J., Spittal, J, Woodward, A and Christensen, H (2018) Experience of Health Care Services After a Suicide Attempt: Results from an Online Survey. *Suicide and Life-Threatening Behaviour 48 (6) December 2018 pp779-787*

have ongoing suicidal or self-harm behaviours. Often these people are facing multiple life challenges such as childhood trauma or family violence, unemployment or disengagement with school, or substance misuse and issues with the justice system. These people often receive mental health support only through primary care services, emergency departments or mental health services. These services are not always necessary or appropriate to address the issues driving their distress. s 9(2)(f)(iv) [redacted]

4. Support for people bereaved by suicide (postvention)

People bereaved by suicide experience mental distress and are more at-risk of death by suicide. Providing a rapid response has been shown to increase protective factors and reduce risk factors for people bereaved by suicide. This has also been shown to reduce or mitigate cluster and contagion behaviours within affected communities. This initiative seeks funding to:

a) s 9(2)(f)(iv) [redacted]

b) **Review and improve the coronial data sharing service.** The timely sharing of accurate, sensitive information between the Coroner and DHB Suicide Postvention Coordinators, reduces the impact of the suspected self-inflicted death of those bereaved. This information also supports the early identification of, and response to, suicide cluster or contagion events. Investment is sought to ensure this process remains robust, accurate, supportive and sensitive to the needs of the bereaved. This is also recommended in *He Ara Oranga: report of the Government Inquiry into Mental Health and Addiction*[8].

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[6] A suicide cluster is defined as multiple deaths occurring more closely together geographically and in time that would be expected for a given community, or linked by established familial, psychological or social connections. Suicide contagion is defined as the spread of suicidal activity (thoughts, feelings, behaviours) after exposure to preceding suicide or suicidal activity within one's family, one's peer group, community or through media reports.

[7] Victim Support are funded to provide an initial bereavement response to adults 18 years and over in the immediate aftermath of a suspected self-inflicted death. This service is different to their response to victims of crime, and requires specialist intervention experience.

[8] https://www.mentalhealth.inquiry.govt.nz/assets/Summary-reports/He-Ara-Oranga.pdf

	c) s 9(2)(f)(iv) [redacted] d) **Establish a national suicide bereavement counselling fund with emphasis on high-risk populations, such as youth.** Availability of free, quality, specialist suicide bereavement counselling is considered one of the most effective activities in reducing death by suicide by people bereaved by suicide. Evidence suggests that between 4 and 60 people can be affected by one suicide, in terms of their emotional, social, psychological and economic wellbeing[9]. International research and best practice consistently points to significant mitigation of risk through the provision of specialist suicide-bereavement counselling. s 9(2)(f)(iv) [redacted]. **5. National Suicide Prevention Leadership** Suicide prevention in New Zealand requires leadership and stewardship from the Government and its agencies. The Ministry of Health leads the Government's work on suicide prevention in New Zealand by setting national suicide prevention policy and strategy, funding suicide prevention services and providing guidance for other non-government agencies supporting suicide prevention activities. The Ministry of Health also leads the government Inter-Agency Suicide Prevention working group and works with other Government agencies to support the development and delivery of their suicide prevention work programmes. The demand from the health sector and communities for stronger Government leadership on suicide prevention has increased in recent years. [redacted] s 9(2)(f)(iv) [redacted] This initiative relates to three of the Budget 2019 priorities, namely: • Supporting mental wellbeing for all New Zealanders, with a special focus on under 24s • Reducing child poverty and improving child wellbeing, including addressing family violence • Lifting Māori and Pacific income, skills and opportunities •
Why is it required?	**The problem** Every year over 500 people in New Zealand die by suicide. It is further estimated that around 150,000 people will think about attempting suicide, 50,000 people will make a plan to take their own life, and 20,000 people will attempt suicide[10].

[9] Palmer, S., Inder, M., Shave., AR, Bushnell, J. (CASA) (2018) Postvention Guidelines for the Management of Suicide Clusters. Clinical Advisory Services Aotearoa, Christchurch.

[10] Ministry of Health. 2018. Submission to the Inquiry into Mental Health and Addiction. Wellington: Ministry of Health. www.health.govt.nz/our-work/mental-health-and-addictions/mental-health/mental-health-work-ministry/submissiongovernment-inquiry-mental-health-and-addiction

Suicidal behaviour is a major health and social issue in New Zealand which has a long-lasting incalculable effect on the lives of many: individuals, people's whānau, families, friends, colleagues and communities. Furthermore, the costs of suicide to New Zealand are considerable at an estimated $2 billion per year.[11]

While over the last decade official suicide rates have decreased slightly, the absolute number of New Zealanders dying by suicide has increased and provisional suspected self-inflicted death[12] data from the Office of the Chief Coroner suggests that official suicide rates are likely to continue to increase.

Some groups, particularly Māori, youth, and men, currently experience disproportionately higher levels of suicidal behaviour than other groups. Of the approximately 500 people who die by suicide each year, just over one in five is Māori and around one in five is a young person aged 15–24 years. Male suicide rates are substantially higher than female suicide rates. In the past decade male suicide rates have been at least 2.5 times the rate of female suicides. Current investment into Māori suicide prevention has yet to be realised in a reduction in suicide rates for Māori.

Government currently funds a number of ongoing, evidence-informed specific suicide prevention activities aimed at preventing suicide and building the evidence base about what works best to prevent suicide in New Zealand. Government also funds a range of other services and programmes that contribute to reducing risk factors, such as work to prevent bullying, reduce child poverty, improve mental health and wellbeing, and address family violence and sexual violence. The absolute majority of these services have been evidenced as increasing protective factors and reducing negative factors associated with suicide. However, many of these activities have been maintained with static funding and have therefore become significantly under-resourced as demand and cost-pressures have increased, leading to gaps in service provision.

Suicide rates in New Zealand have remained stubbornly static, although we have not seen the suicide rate increases some other countries have seen over a similar time period. While the existing initiatives appear to have helped keep the suicide rate relatively static, recent trends (based on provisional data) suggest suicide rates may be increasing and over 500 deaths by suicide per year still leaves significant work to be done to reduce this figure.

However, every suicide is one too many and more needs to be done to reduce the suicide rate, and prevent an upward trend. Gaps in service provision have been identified and this package provides a unique opportunity to rectify and fill service gaps.

The solution

[11] In $2015. Ministry of Health. 2016. *The Cost of Suicide in New Zealand*. URL: www.health.govt.nz/system/files/documents/pages/cost-suicide-in-nz-apr17.docx (accessed 22 November 2018).

[12] Suspected self-inflicted death refers to a death which has not yet been investigated by the coroner. Until such time as the death is established by the coroner as a suicide, it is referred to as a suspected self-inflicted death (SSID)

	A series of coordinated, cross-sector and sustained approaches to promoting mental health and wellbeing, preventing suicide and supporting people experiencing suicidal behaviour and supporting people bereaved by suicide are required to effectively prevent suicide. Ministry of Health leadership and coordination of the proposed package of suicide prevention initiatives will make a significant contribution to addressing current gaps in, and ensuring the sustainability of, the mental health system in reducing suicidal behaviours and suicide rates in New Zealand. Investing in suicide prevention also further contributes to improving mental health and wellbeing of New Zealanders, with flow-on effects to cost-saving across the life-span of the individual. **Counterfactual** If this package of initiatives is not funded it is expected that the suicide rate and rate of intentional self-hospitalisation will likely stay at current levels or may even increase. This means that more people are likely to die by suicide every year, and more families, whānau and communities will experience the negative impacts of by suicide and the cost of suicide to New Zealand society will remain at the current high level or increase further.
Implementation, Monitoring and Evaluation	
How will the initiative be delivered?	s 9(2)(f)(iv) [redacted] **Service enhancement** Where service enhancement is proposed, the Ministry of Health suicide prevention team will review the need for contract variation, and where necessary re-tender for services. Where a contract variation is required, the contract manager will negotiate with existing provider(s) on variations to service contracts. **New service provision** Where new services are proposed, tender processes will be completed by the end of December 2019 (half way through Year 1), with service development and delivery (including for evaluations) commencing in early 2020 (half way through Year 1). It is expected that services will be up and running and increasing their capacity in Year 2, and will then require dedicated ongoing support from the Ministry of Health to manage new and current contracts. s 9(2)(f)(iv) [redacted] Some services will be increasing their capacity in Year 3 and Year 4, s 9(2)(f)(iv) [redacted]. By the end of Year 4 and in out years all services will be up and running at the full capacity that funding has been sought for.
How will the implementation of the initiative be monitored?	A small implementation team of s 9(2) are proposed at the Ministry of Health who will be tasked with organising and coordinating the tender, service design, contract negotiation and contract management processes over the next four years. This team will ensure appropriate performance measures are included in contracts and will work with providers to achieve expected outcomes and mintage any contractual risks. This team will also provide necessary progress updates and advice

	on suicide prevention to the Minister of Health and updates to the Social Wellbeing Board (or similar entity). The Ministry of Health implementation team will monitor progress against any Suicide Prevention Strategy and Action Plan. Ongoing monitoring of the suicide prevention programme feed into work with other agencies through the Inter-Agency Committee on Suicide Prevention.
Describe how the initiative will be evaluated	s 9(2)(f)(iv) [redacted]

Detailed funding breakdown

Please provide a breakdown of the costs of this initiative

The operating costs of the suicide prevention package are detailed in the tables below. This table is indicative only and some costings will require further workings and consultation. There is also a risk that there will be insufficient workforce available to implement some initiatives. Workforce development is a key constraint for national roll-out. The proposed phasing reflects feasible capacity of workforce training institutions.

1. Promotion - promotion of wellbeing and resilience

s 9(2)(f)(iv) [redacted]

Workings and assumptions

s 9(2)(f)(iv) [redacted]

[redacted]

Expansion of the suicide media response and the family and whānau suicide prevention information services

- [redacted]. Additional FTE will allow for the development, tailoring and delivery of resources across these services.

2. Prevention - specific suicide prevention activity

s 9(2)(f)(iv)

[redacted]

Workings and assumptions

s 9(2)(f)(iv) [redacted]

Purchase of new Māori and Pacific suicide prevention initiatives

- Additional funding for 'grass roots' Māori and Pacific suicide prevention services will support Māori and Pacific providers to develop and deliver culturally appropriate services for the populations they serve. These funding streams (Māori and Pacific) will remain separate to provide for the different needs of the two population groups.

Additional support for DHB suicide prevention services

- Assumes the Ministry of Health subsidises s 9(2)(f)(iv) [redacted], towards the Suicide Prevention Coordiantor (SPC) role, based on previous costs of SPC pilot. Funding includes FTE and overheads.
- The remaining funding is to support a follow-up service for people discharged from mental health services who require immediate ongoing support to manage suicide risk.

3. Intervention - support for people with suicidal behaviour

s 9(2)(f)(iv) [redacted]

s 9(2)(f)(iv) [redacted]

[redacted]

[redacted]

4. Postvention - support for people bereaved by suicide

s 9(2)(f)(iv)

[redacted]

Workings and assumptions

s 9(2)(f)(iv) [redacted]

Review of the coronial data sharing service

- This review and relevant improvements to the service will either be completed internally by the Ministry of Health (working with the Ministry of Justice) OR be contracted out to an external evaluator.

s 9(2)(f)(iv) [redacted]

Establish a national suicide bereavement counselling fund

s 9(2)(f)(iv) [redacted]

5. Strengthening the national coordination and leadership of suicide prevention services

s 9(2)(f)(iv) [redacted]

Options for scaling and phasing

Scaling, phasing or deferring - including 75% and 50% scenarios

Each initiative in this package can potentially be scaled down. Scaling is not recommended as this will fail to increase the availability of effective suicide prevention services and address current unmet need.

The following options maintain all components of the full package (excluding the review of the coronial data sharing service), at a scaled rate, as preventing suicide requires quality services across the full continuum of care (promotion, prevention, intervention, and postvention).

Options for scaling have prioritised the new suicide prevention initiatives outlined in this budget package i.e. the Māori suicide prevention fund and s 9(2)(f)(iv) [redacted] The proposal to expand and enhance a range of existing suicide initiatives to ensure sustainability and service quality improvements have been scaled down as outlined in the table below.

	Scaled to 75%	Scaled to 50%
1. Promotion - promotion of wellbeing and resilience		
a. [redacted]	s 9(2)(f)(iv) [redacted]	[redacted]
b. [redacted]	[redacted]	[redacted]
c. Improve the suicide media response service	[redacted]	[redacted]
d. Increasing the family and whānau suicide prevention information service	[redacted]	[redacted]
2. Prevention - specific suicide prevention activity		
e. [redacted]	[redacted]	[redacted]
f. Purchase of new Māori suicide prevention initiatives	[redacted]	[redacted]
g. Purchase of new Pacific suicide prevention initiatives	[redacted]	[redacted]
h. Supporting DHB Suicide Prevention Services	[redacted]	[redacted]

3. s 9(2)(f)(iv)		
[redacted]	[redacted]	[redacted]
j. [redacted]	[redacted]	[redacted]
4. Postvention - support for people bereaved by suicide		
k. [redacted]	[redacted]	[redacted]
l. Enhanced coronial data sharing service	[redacted]	[redacted]
m. [redacted]	[redacted]	[redacted] um)
n. National suicide bereavement counselling fund	[redacted]	[redacted]
5. [redacted]		
[redacted]	[redacted]	[redacted]

There are risks that the scaled version (in particular to 50% of the full packaged) will not be able to achieve adequate economies of scale and that the set up and implementation costs may outweigh the positive initiative outcomes. There is also a risk that insufficient investment in suicide prevention will mean the number of deaths by suicide does not decrease at the rate required.