1 November 2024

Kia ora

Thank you for the opportunity to make a submission on the Ministry of Health's Draft Suicide Prevention Action Plan 2025-2029 (the Draft Plan).

Our biggest concern:

Pae Ora Healthy Futures Bill: Rural as a priority population

The Ministry of Health's Draft Suicide Prevention Action Plan 2025-2029 plan fails to acknowledge the significantly higher suicide rates in rural regions – 1.4 times higher than in urban areas. This issue is even more pronounced among Māori and those in the farming industry. Rural men aged 15-44 are 64% more likely to take their own lives compared to their urban counterparts.

There has been inadequate consultation with the rural health sector and communities they care for in the development of this document. Consequently, the Draft Plan omits to acknowledge existing rurally relevant suicide prevention programmes that, in most cases, has funding subsidised by the generosity of iwi providers, rural general practice or hospitals, and community groups. New initiatives proposed in the Draft Plan are unsupported by evidence of their effectiveness in rural populations.

Consequently, the Draft Suicide Prevention Action Plan 2025-2029 is urban centric, and gives no confidence that the prevalence of suicide, suicide attempts, or self-harm, in rural communities will be reduced.

Our Call to the Ministry of Health for Action: A Rural Suicide Prevention Action Plan that:

- Adopts an evidence-based approach, *that is*
- Supported by a clinical advisory group, as they have for other complex health issues such as cancer, and heart disease, *and*
- Whose membership reflects the rural, and rural Māori communities overrepresented in suicide statistics.

Consultation questions:

1. **Under each of the four areas, do you agree with the proposed actions for health and cross-government agencies? How could these actions be improved? Please include reasons for your answer.**

   Our main points:
   We are not aware of any publicly available evaluation of the existing 5-year Action Plan 2019-2024, that demonstrates its effectiveness in reducing the incidence of suicide, or suicide attempts in rural communities.

There is insufficient information or evidence to support new initiatives proposed in the Draft Plan, therefore we are unable to either endorse, or question the proposed actions for health and cross-government agencies.

Proposed health-led actions

1. **Improve access to suicide prevention and postvention supports.**
   Our main point:
   The proposed actions appear irrelevant to the heterogenous nature of rural communities. Before investing in new, unproven ideas, existing well endorsed programmes, must have the clinical and financial support they need to provide safe, effective, and sustainable services.
   - How will 6 crisis recovery cafes/ hubs be able to provide support to rural whanau?
   - Which rural communities will receive community funds, how many, how will these be selected?
   - Will investment in the proposed new initiatives, compromise the ability to fully resource existing, rurally endorsed, community-based programmes e.g. rural iwi provider initiatives that have the cultural and geographic ability to connect with R2 and R3 rural Māori; Farmstrong and Rural Support Trust who are valued in their support across the primary industry sector; Surfing for Farmers that encourages men to take time off farm, and the late Dr Tom Mulholland's programme that takes health and mental health deep into rural communities and notably, forestry sites.
   - Rural general practice and rural hospitals are often the first port of call for many people who are in distress. Some can call on inhouse mental health nurses and health improvement practitioners. Others have leveraged short term Comprehensive Care Team (CCT) funding to boost their ability to support complex, and often disenfranchised people e.g. Golden Bay Health applies CCT funding to boosting nurse care coordination to work in partnership with community providers such as police, social agencies, local Kaupapa Māori mental health and addition, and community focussed employment and education services to provide wrap around services for those in need. The CCT funding expires in January 2025. Golden Bay Health's CCT funding expires in January 2025.

2. **Grow a capable and confident suicide prevention and postvention workforce**

Our main point:
A Suicide Prevention Action Plan must recognise that in 'rural' the suicide prevention and postvention workforce looks different to urban counterparts.

- At least 60% of those who die by suicide have seen their primary care provider within the previous 6 months, but the workforce health-led actions make no reference to this.
- Specialist rural GPs are a crucial part of the way we can address suicide issues in rural areas but are conspicuously absent from the draft Suicide Prevention Action Plan. The pressures on their capacity to provide this care is evident in the findings of Hauora Taiwhenua 2024 Survey of Rural General Practices:
  - An average rural GP:patient ratio of 1:1598 means there is limited capacity to offer extended consultations even if there is funding for this service.
  - Rural general practice is 'missing' approximately 130 GPs. This results in around 40% of rural general practices having no, or limited capacity to enrol new patients,

and very limited capacity to reach out to the unenrolled populations who may be at increased risk of suicide.

- Rural General Practice works in partnership with Hato Hone St John's responses through the PRIME service. In urgent and emergency situations they are often the first responder to arrive at a PRIME site, frequently alone. In rural areas, it is often police who are there on site with the PRIME responder, before HHSJ arrive, and therefore are highly valued members of rural suicide prevention teams. The reduction in police support for mental health call outs in rural areas will risk the safety of PRIME responders, and those they are called on to assist.
- It is often through PRIME call outs that rural general practitioners help someone who has attempted a suicide, or the whanau of someone who has died by suicide.
- Suicide prevention training needs to be rurally relevant, and accessible e.g
    - Over 3 years, 2017-2018, the Rural Health Alliance Aotearoa NZ, suicide prevention programme, *Safe Hands Safe Plans,* developed specifically for rural communities, reached into 42 rural general practices or health centres. This ensured the training was specific to the rural context, and, resulted in over 3000 rural health professionals participating in the multi-disciplinary training.
    - After 6 local people died by suicide in 2012, the Raglan community undertook a programme to enhance the knowledge of their entire community about mental health issues, safe discussion around suicide, and clear guidelines for getting the appropriate help for people in need.
    - Health Improvement Practitioners (HIPs) are increasingly a key contact for people who are at risk of suicide, yet they lack formal training in suicide prevention. In many remote rural areas there is no, or limited access to HIPs because they are allocated per size of enrolled population, a model that doesn't relate well to the need in sparsely populated, large geographic areas. Regular peer review/ training sessions for HIP could be an action that supports and develops their skills in working with whanau at risk of suicide.
    - Rural Hato Hone St John crew, paid and volunteer, are often at the front line of responding to mental distress or suicide attempts and so must be included in locally based training initiatives.

3. Strengthen the focus on prevention and early intervention

- While preventing youth suicide is undoubtedly important, it overlooks data that shows that heightened risk of suicide in rural areas extends well beyond youth to ages 44-49 years old.
- We agree that the development of a national alcohol screening and brief intervention programme is important. The implementation of this in rural areas must reflect the reality and cost of delivering services in rural areas.
- The omission of any focus on drug abuse is unacceptable, given the extent to which rural communities experience the connection between drug use and suicide risk.

4. Improve the effectiveness of suicide prevention and our understanding of suicide

- Suicide data must apply the Geographic Classification of Health, so that in addition to age and ethnicity, there is accurate reporting on suicide in relation to where people live.

2. **What other actions do you think could be included for government agencies to consider? Please include the reasons for your suggestions.**

Cross Government agencies must take shared responsibility for a Rural Suicide Prevention Action Plan.

The plan must be developed in partnership with rural communities, acknowledging the significant work done across the primary industry sector, led by Federated Farmers:

Primary Industries Mental Health and Wellbeing Strategy, 2023

3. **What do government agencies need to consider when implementing these actions to ensure what is delivered meets the needs of communities? Please include reasons for your suggestions.**

Rural Health Equity Through Principles of Considered Design
Rural-Proofing Decisions Related to Planning, Service Design and Funding in Health

4. **Is there anything else you want government agencies to know about what is needed to prevent suicide?**
   No

Nga mihi,

Dr Fiona Bolden
Chair
Hauora Taiwhenua Rural Health Network

Bill Nathan
Chair
Te Rōpū Ārahi