Te Hiringa Mahara
Mental Health and Wellbeing Commission

1 November 2024

Submission on the draft Suicide Prevention Action Plan for 2025-2029

Summary

The draft Suicide Prevention Action Plan (the Plan) for 2025- 2029 provides an opportunity to make real change for some of the most vulnerable people in Aotearoa, New Zealand their families, whānau and communities.

Addressing suicide, suicidal distress, and the factors that lead to them are a serious challenge for Aotearoa, and many countries. Dealing with the complexity and very real cost of suicide in our communities requires a large scale and comprehensive response. However, while the Plan provides some useful elements, it is limited in scope and action. We appreciate the intent to design and deliver a focused and achievable plan, but there are gaps that should be addressed.

This submission highlights the key elements that we consider need strengthening in the draft Plan, with suggested steps that could be taken to improve it. It draws on a range of research, and evaluation from recent years, with recommendations to bolster and improve the draft Plan.

In short, we recommend that:

- Key actions from the 2019-2024 Suicide Prevention Action Plan be included to deliver workforce, monitoring and evaluation, and national research plans, which will guide future action;
- Critical analysis of the 2019-2024 Plan's actions and impact be made available, to shape the draft 2025-2029 Plan;
- Action to address inequities based on evidence of need to be added– particularly for Māori;
- Action be included on the factors that affect suicide risk, underscored by a "suicide prevention in all policies" approach;
- The desired outcomes, measures, and actions are strengthened to better monitor impact and support oversight and leadership.

Te Hiringa Mahara | The Mental Health and Wellbeing Commission (the Commission) would welcome the opportunity to talk about our feedback in person, provide any assistance we

can with developing actions and measures, and we would also be happy to review the final draft Plan before it is published.

Evaluation of Every Life Matters and the 2019-2024 Plan should inform the Draft Suicide Prevention Action Plan 2025-2029

The foundation of the draft Plan necessarily builds on the outgoing 2019-2024 Plan, and the overall implementation of Every Life Matters Strategy. However, it is not clear if the initiatives from the 2019-2024 Plan have had the desired impact, or if they are continuing. The Strategy identifies that "The Suicide Prevention Office will collect information and report on progress around implementing Every Life Matters" – however no detailed progress reports have been made publicly available.

There is currently limited evidence, in the draft Plan, of assessment of past actions, and we have been unable to ascertain the extent to which the 2019-2024 Plan has made a difference, or even if it has been evaluated as such. The gaps identified in the draft Plan – which it then seeks to address – relate largely to the work undertaken in the 2019-2024 Plan. It is not clear if those actions were therefore successful and should continue or need expansion, or unsuccessful and need improvement or replacement.

For example, the draft Plan highlights as evidence of a 'stronger suicide prevention system', the implementation of 'National leadership: a Suicide Prevention Office' with no critical analysis of what was achieved by this. The draft Plan implies that there is on-going national leadership through this, without reflecting on the impacts on the Plan, and its delivery, of recent structural changes in the Ministry.

> Recommended improvements
>
> The Plan should include analysis of the work delivered so far, to allow evidence-based decisions on what to continue, expand, or remove in the Plan.

Key undelivered actions should be completed to build the evidence base

As well as limited evidence of the impacts of the past Plan, there are outstanding actions from the 2019-2024 plan that need to continue. These include actions to '*develop a national research plan*'. Continued focus on better research would support high-quality suicide related data with a local focus. (McKenzie, et al., 2024)

A research plan will provide greater visibility of ongoing commitment to data and research, and should fill knowledge gaps, build the information infrastructure to understand and target responses, and support evaluation of both the Plan and the initiatives under it. To do so, it will need to include improvements to how we collect better, more complete data, and make it safely accessible, to support research.

This could include gathering more information on the factors that may have contributed to a

crisis, as well as the means of suicide used. This will require partnership with a range of stakeholders, including academics and researchers, people with lived experience, and evaluation and analysis teams from across government.

Suicide is a societal issue that requires a societal response: "preventing suicide is everybody's business. Garnering cross-sectoral commitment from all levels of government and meaningfully involving all stakeholders at every step on the journey will be transformative." (Hawton & Pirkis, 2024) To support cross-sectoral work, the Plan should be clearer on what the 'suicide prevention workforce' it mentions will cover. This should then inform delivery of the uncompleted action '*Develop a suicide prevention and postvention workforce development plan*'.

The action to '*Develop a monitoring and evaluation framework for Every Life Matters in partnership with Māori and people with lived experience of suicidal behaviour*', should also be included. It is not clear how the specified measures in the Plan, in particular the short-term measures, relate to the outcomes being proposed. The lack of a monitoring and evaluation framework appears to be a gap that still needs to be addressed, in order to both show and select actions that will best help achieve the intended longer-term outcomes.

Recommended improvements

Include delivery of a *national research plan*, through work with researchers and data users, to support ongoing up to date high-quality research and data on suicide prevention.

Include delivery of a *suicide prevention and postvention workforce development plan*, recognising the broad workforce that has a role to play in preventing suicide.

Include delivery of the *monitoring and evaluation framework for Every Life Matters in partnership with Māori and people with lived experience of suicidal behaviour* that links the intended outcomes with measures and actions to be delivered.

Targeted action will help address the differences in need highlighted by the evidence, particularly those faced by Māori

Research, data, and the Plan's own opening section are clear – there are strong and pervasive inequities in suicide outcomes for different groups in Aotearoa, including Māori, and young Māori men in particular. It is important that the Plan allocates resources based on need, and seeks to address inequitable suicide rates for these groups.

Effort to address factors that affect mental health and wellbeing is key to addressing inequities in outcomes, as highlighted in the 'current insights' section of the Plan. However, the Plan does not provide any actions that are specific to addressing these factors – this is explored in the next section of this submission.

Apart from actions for youth, and limited actions for people in prisons and older people, the Plan appears to rely on the '*establish a suicide prevention community fund'* action to address the inequities highlighted.

The Commission has repeatedly called for funding and partnership with community organisations to best provide support and services in those communities (Te Hiringa Mahara, 2021; 2022; and 2024), and we welcome expansion of the fund as proposed in the Plan. However, as outlined above, it is not clear if the existing fund (for Māori and Pacific community organisations) has been effective, or is sufficient to meet the needs of those communities. We believe that community suicide prevention organisations face challenges accessing funding, so simply doing more of the same is unlikely to achieve the intended outcomes. That means the fund will need to be accessible, flexible, and sufficient to meet the needs of those communities.

Further, given that fund already exists for Māori and Pacific communities, there does not appear to be any new targeted action to address the large burden of suicide in those communities, beyond making bereavement services more culturally appropriate. This is also an important action, but more will be needed to address the pervasive inequities represented in the data. Māori health and wellbeing experts and communities have outlined many of evidence-informed approaches that will support better outcomes. Sir Mason Durie outlined some key considerations from a Māori perspective in terms of suicide prevention:

"The determinants of indigenous suicide can be linked to personal risk factors and collective risk factors. Personal factors include social disadvantage (e.g. material hardship, physical and sexual abuse, unemployment, educational nonachievement, alcohol and drug use), family adversity (e.g. marital disharmony, foster care, diminished communication between generations and between parents), a mental health problem (e.g. substance abuse disorder, depression) and stress and adolescent adversity (e.g. breakdown of inter-personal relationships, bullying, fear of retaliation)".

"In contrast to personal factors, collective factors reflect the journeys and realities of indigenous peoples over time. They include culture (e.g. loss of language, loss of access to culture), spirituality (e.g. disconnect between self and environment, aimlessness, and a languishing spirit), and colonisation (e.g. oppression, alienation from resources especially land, loss of autonomy). Collective factors provide a backdrop against which individual stamina is shaped". (Durie, 2017)

The 2023 *He Arotake suicide prevention and postvention review* (PwC Health, 2023) lays out the challenges specifically related to the needs of Māori and provides action areas that the Plan could use. These include: the need for more kaupapa Māori services and support, particularly in the crisis and postvention spaces; ongoing support for and access to holistic support grounded in te ao Māori, and targeted action for rangatahi and tāne Māori.

In 2016, Ngāti Pikiao convened an international conference to discuss global approaches to the prevention of suicide. The resulting *Tūramarama Declaration* "*acknowledged the grief*

associated with suicide, recognised avenues to promote indigenous resilience, identified opportunities to decrease risks to suicide, and challenged local, national, and international authorities to take definitive measures to reduce indigenous suicide" (Durie, 2017). The Declaration also encouraged indigenous people to work together to provide an integrated response and collective, networked leadership.

The Plan should recognise this advice, and of similar research, and both support and draw on the expertise, networks and resources of iwi, hapū, whānau, and Māori communities to develop and design efforts to address the inequities Māori face (Lawson-Te Aho & McClintock, 2020).

Recommended improvements

The Plan should include clearer action on how it will address inequities in need, as shown by the suicide burden disproportionally carried by Māori, that it describes in the 'current data' section.

The Tūramarama Declaration (see Appendix) included the challenge to make meaningful action on a range of factors that affect mental health and wellbeing, and called on elected leaders to work together to address inequitable outcomes for Māori. These parts of the declaration could shape the cross-government elements of the draft plan.

Six recommended actions (see image below) were highlighted in *He Arotake* (PwC Health, 2023), of which only three are partially included in the draft plan. These should be delivered through the plan. Some of these actions overlap with other recommendations in this paper – as they will benefit both Māori and non-Māori.

1.3 Summary of recommendations

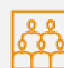
Recommendation 1: Explore options for a significant increase in investment in kaupapa Māori suicide prevention

Recommendation 2: Enhance the focus on priority groups in efforts to prevent and respond to suicide by Māori

Recommendation 3: Strengthen the cultural competence of staff supporting the delivery of all-of-population suicide prevention and postvention services

Recommendation 4: Increase efforts to equip whānau and communities with the knowledge and practical tools to prevent and respond to suicide

Recommendation 5: Explore options to simplify the suicide prevention system and strengthen system leadership


Recommendation 6: Accelerate the development and implementation of the national suicide prevention and postvention workforce development plan

A greater emphasis on prevention and promotion will prevent suicidal distress and suicide

We agree with the draft Plan that a broad approach is required: across and beyond

government, and across the continuum from prevention to postvention. However, the actions in the Plan do not reflect this intent.

A comprehensive suicide prevention programme typically employs a combination of universal, selective and indicated interventions (World Health Organization, 2018). Every Life Matters states that "*Suicide prevention efforts must support the wellbeing of all people in Aotearoa New Zealand and effectively respond to people's needs when and where required. Key to supporting wellbeing is to work across the suicide prevention continuum to increase protective factors and reduce risk factors, including:*

- *promotion – promoting wellbeing*
- *prevention – responding to suicidal distress*
- *intervention – responding to suicidal behaviour*
- *postvention – supporting individuals, whānau and families, and communities after a suicide*." (Ministry of Health, 2019)

Beyond this description though, the Strategy and Plan do not explore the balance of these activities.

In 2020, the cross-party Mental Health and Addiction Wellbeing Group released *Zero Suicide Aotearoa*, to discuss policy settings that might reinforce efforts to prevent suicide. That group, including members of the then and current governments, highlighted that:

- "*a comprehensive, multi-sectoral approach is required in order for a national suicide prevention response to be effective.*
- *Those countries that invest in a comprehensive range of targeted selective, indicated and universal interventions have been demonstrated to make more progress than those that do not.*
- *The insights of people who have lived experience of suicide is critical to the success of any suicide prevention activities*
- *Te Tiriti o Waitangi should underpin all systems, structures, operating models and resourcing approaches for Māori*." (Gaines, 2020)

The draft Plan contains almost no action that can be seen as promoting wellbeing, or addressing the factors that affect mental health and wellbeing, suicide and suicidal distress. This is despite knowledge that the protective factors for suicide include good whānau and family relationships, access to secure housing, stable employment, community support and connectedness, secure cultural identity, ability to deal with life's difficulties, and access to support and help. (Gaines, 2020) (Ministry of Health, 2019)

The recently released suite of papers on suicide prevention by the Lancet (The Lancet Public Health, 2024) calls for a public health approach, as does the recent suicide prevention expert brief 'Calling for action on suicide prevention in Aotearoa' (McKenzie, et al., 2024). These papers have good alignment with the sources outlined above. These papers highlight how treatment services are critical for people in a suicidal crisis, but upstream measures that address social factors must also be included in national suicide prevention strategies to

prevent people reaching crisis point. Examples of potential interventions to address social factors suggested by the Lancet Series include:

- Economic policies to reduce poverty such as minimum wage legislation and income protection policies.
- Regulation of commercial products such as policies that limit alcohol consumption and increased regulation of social media platforms.
- Policies, legislation, and cultural change that can help reduce domestic violence and abuse.

These papers also reflect that tackling the social factors which contribute to suicide requires a policy re-set with a whole of government commitment for suicide prevention efforts – identified in the Lancet as a "suicide prevention in all policies" approach.

A suicide prevention in all policies approach "holds politicians and policy makers from all sectors accountable for decisions that affect health and health inequities" (Pirkis, Dandona, Silverman, Khan, & Hawton, 2024), and would be well supported by the new portfolio of Minister for Mental Health, with a view across a range of sectors. This could be a key part of the Plan, and a practical tool for improving oversight and leadership to achieve a whole-of-government approach that the Plan describes.

Further, the actions identified as prevention in the Plan mostly relate to preventing suicide by people who are already suicidal, or relate to postvention, rather than preventing suicidal distress in the first place. These actions are important, but are insufficient to deal with the high and inequitable suicide rates in Aotearoa: *"interventions are entirely appropriate for people who have reached a point of crisis and should be a mainstay of national suicide prevention strategies. However, […] selective and universal interventions [are needed] that tackle the pervasive problem of suicide in a more upstream way, preventing people reaching a crisis point."* (Hawton & Pirkis, 2024)

The 2024 Ministry of Health's evidence brief (Ministry of Health, 2024) outlines the evidence-based approaches to addressing suicide rates – but only one of those nine approaches is reflected in the Plan. The Plan should include action (largely cross-government action) to deliver all nine approaches, to provide a better balance between preventing people reaching a 'crisis point', and intervening after reaching a crisis point:

1. Reducing the societal factors associated with suicide such as poverty, loss of land and language, discrimination and violence.
2. In times of recession investing in keeping people in employment, return to work schemes and welfare support.
3. Good adherence to responsible media reporting guidelines.
4. Restricting access to and installing barriers, signs and advice in locations associated with jumping from height.
5. Continued restrictions on lethal means for suicide such as guns, carbon monoxide gas and pesticides.
6. Stronger restrictions on medicines able to be misused and linked with suicides.

7. Initiatives to reduce alcohol intoxication and misuse by restricting access or increasing price.
8. Workplace interventions for first responders (police, firefighters, ambulance staff, military) and health and social care workers under significant pressure.
9. Prevention of all forms of violence and particularly sexual violence.

For example, the Plan's actions on 'safe environments' are focused on reducing access to means, but not cover the role of safer environments in preventing people reaching a crisis point. A wider understanding of safe environments would have a much more meaningful impact on outcomes.

We could look to the recent Mates in Construction report (MATES in Construction, 2023) and activities as an example – and the Plan could seek to develop similar approaches in other industries, with practical support such as toolkits, surveys, training and advice. We know that racism, discrimination, and lacking a sense of belonging have an impact on mental health and wellbeing, and suicide rates. The Plan could seek to do more through partnership with schools to ensure they are safe environments and teaching children and young people valuable life skills to navigate life transitions, as well as postvention support.

Recommended improvements

The plan should provide a better balance of prevention and intervention. To find an appropriate balance, we could consider the public health 'iceberg' model, though note that 'indicated interventions' should include both clinical and non-clinical approaches. We could also look to the draft suicide prevention strategy currently being consulted on by the Australian Mental Health and Wellbeing Commission (see appendix).

The Lancet papers provide both a model for understanding how to prevent suicide and a suite of responses that could be included in the plan (see appendix). The plan could include a number of these actions, to deliver the nine approaches from the Ministry's own evidence brief.

Partnership with communities and industries that experience high suicide rates should be pursued, and all of the cross-government action described could be supported by the development of a 'suicide in all policies' approach, with appropriate resources and support to implement.

The previously agreed action of '*Develop a suicide prevention and postvention workforce development plan'* should be included – with a scope to match the role of communities, family, whānau and other organisations (including schools and workplaces) in preventing suicide and suicidal distress.

People with lived experience of suicide should have genuine involvement in all of these actions.

Greater detail and specificity of measurement is needed to monitor and evaluate actions to drive improvement and leadership

It is good to see the inclusion of a monitoring framework to help better assess the impact of the Strategy and Plan. The longer-term outcomes and measures are welcome, including the recognition of the need to include a measure of mental wellbeing improvement. The Commission would be happy to provide ongoing advice on what best to measure and how – though we have not been consulted on this in the preparation of the draft Plan and measures.

However, we have concerns with the shorter-term measures identified. None of the short-term outcomes have practical measures: the 'measures' identified are descriptive, with no indication of how they would be measured. All bar one relate to 'increased' or 'improved' actions, without understanding a base to measure from, or a mechanism to evaluate this. This does not give confidence that meaningful measurement will take place. The remaining measure relates to 'positive feedback and engagement from suicide prevention workforces', but there is no clear description in the Plan of who that workforce includes. Developing the workforce plan identified in the previous Plan and discussed above would likely have helped this – and we encourage this work to continue.

Similarly, many of the actions in the Plan – particularly the cross-government ones – describe vague shifts such as 'enhance', 'increase', 'promote', or 'explore'. We would encourage more descriptive and tangible actions that provide confidence in the scale, scope, or impact expected from each action. This will also support a comprehensive approach to assessing and reporting on the delivery of these actions.

As noted previously, there is an apparent disconnect between the longer-term outcomes and the shorter-term measures and actions. The outgoing suicide prevention action Plan included a key action of '*Develop a monitoring and evaluation framework for Every Life Matters, in partnership with Māori and people with lived experience of suicidal behaviour*', which would help achieve the intended longer-term outcomes.

Recommended improvements

The shorter-term measures selected in the plan, and the actions that are planned to lead to them, need to be improved, to include observable and assessable descriptions of the intended change.

The Commission would welcome the opportunity to talk about our feedback in person, provide any assistance we can with developing actions and measures, and we would also be happy to review the final draft Plan before it is published.

Appendix – additional diagrams for reference

Indicated interventions

Clinical approach

Selective interventions

Universal interventions

Public health approach

Individuals who are having suicidal thoughts or engaging in suicidal behaviours

Individuals who are not yet thinking about suicide or engaging in suicidal behaviours but who may be predisposed to do so in the future

Individuals in the broader population

Source: (Hawton & Pirkis, 2024)

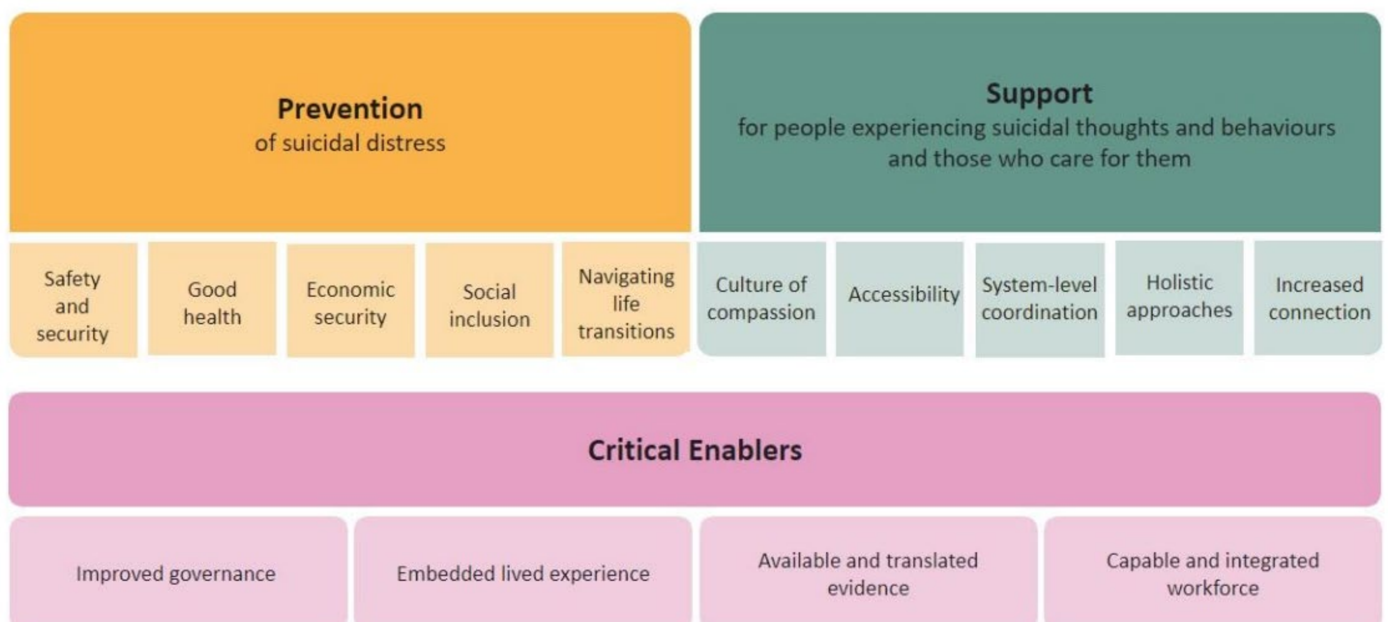


Figure 2: The National Suicide Prevention Strategy model

Source: (National Suicide Prevention Office, 2024)

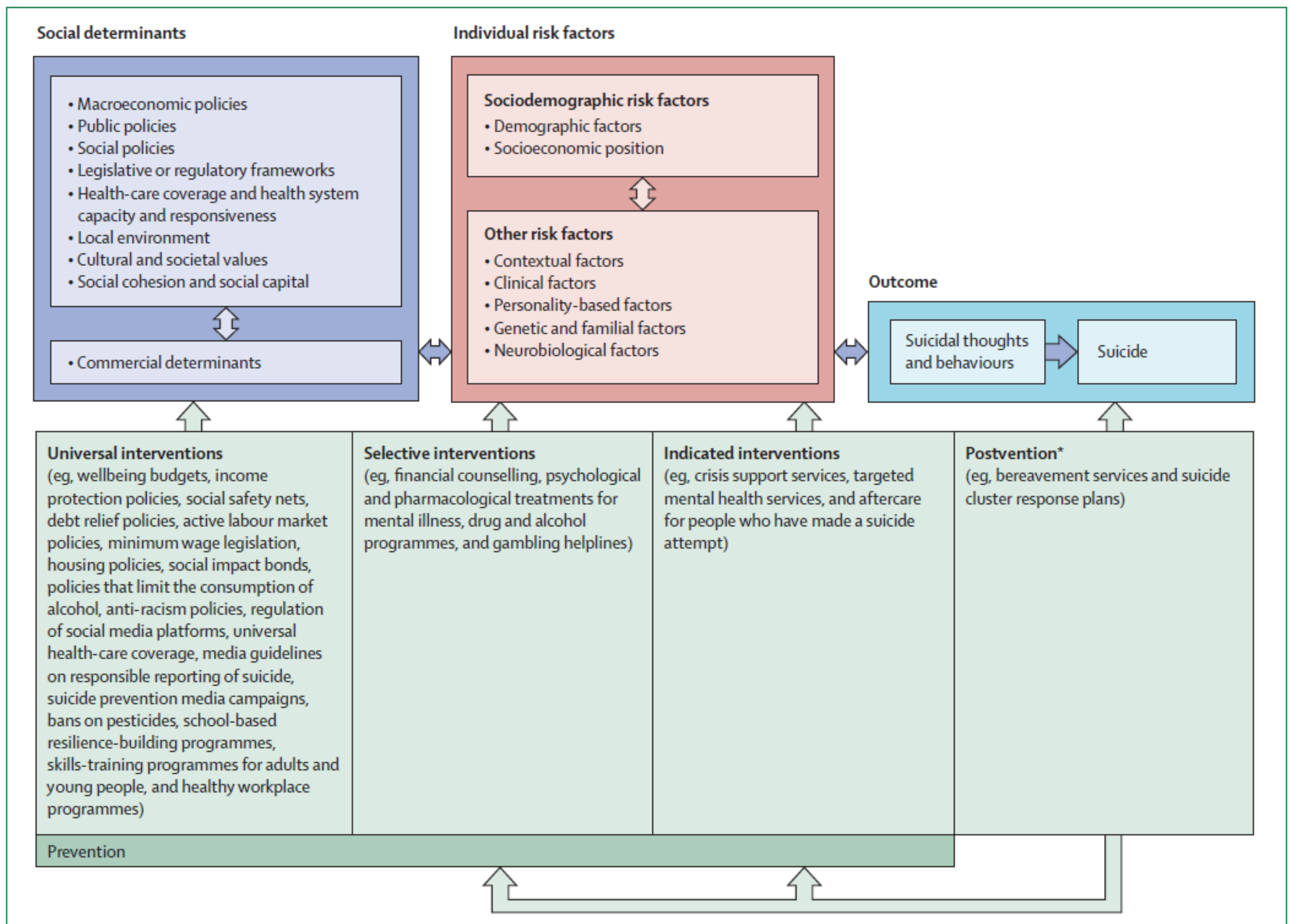


Figure 2: **Preventing suicide under the public health model**
Adapted from Pirkis and colleagues[23] with permission. *The response offered to individuals and communities in the aftermath of a suicide.

Source: (Hawton & Pirkis, 2024)

	Responsibility
Policy	
Develop and implement national suicide prevention strategies that are signed off by prime ministers or their equivalent and delivered via partnerships between the health sector and sectors responsible for macroeconomic, social, and public policies that are likely to have an influence on suicide (eg, finance, welfare, education, employment, housing, communication, climate, and environment)	Whole of government
Implement a Suicide Prevention in All Policies approach that holds government departments accountable for considering the effect of their policies on suicide and its prevention	Whole of government
Establish interdepartmental policy working groups to coordinate activities and monitor current and emerging issues relevant to suicide and its prevention	Whole of government
Provide appropriate resourcing for suicide prevention activities and programmes that are likely to yield substantial benefits across the population; these activities should include but not be limited to restricting access to means, media campaigns, guidelines for responsible media reporting of suicide and safe online discussion of suicide, gatekeeper training, services for people experiencing problematic alcohol use, gambling, or domestic violence and abuse, support for people who have been bereaved by suicide, mental health services, and crisis helplines	Departments of health
Ensure that macroeconomic policies do not exacerbate financial hardship for those who might be at heightened risk of suicide (eg, avoid regressive taxation policies and austerity measures)	Departments of finance and treasury
Implement social policies that provide appropriate supports and safety nets for people who are socioeconomically disadvantaged	Departments of social security, welfare, education, employment, and training
Implement public policies and legislative or regulatory frameworks that place limits on industries whose products can heighten the risk of suicide (eg, the alcohol, gambling, firearm, pesticide, and social media industries)	Departments of health, agriculture, and communication; Auditor General
Support LMICs to bolster their suicide prevention efforts by actively directing foreign aid to support a comprehensive, coordinated approach to suicide prevention in these countries (noting that the approach within each country should be locally driven and that what works in HICs might not be directly transferrable to LMICs)	Departments of foreign affairs and finance
Practice	
Create and distribute media campaigns that promote help-seeking among individuals at risk of suicide and raise awareness about suicide and its prevention among the general population	Community-based suicide prevention organisations in collaboration with campaign developers and relevant target audiences
Provide gatekeeper training to all professionals whose roles mean that they have contact with people who might be or might become suicidal (eg, educators, welfare workers, drug and alcohol workers, financial counsellors, and bereavement counsellors)	Community-based suicide prevention organisations in collaboration with relevant target audiences
Develop and disseminate evidence-based best practice guidelines, tailoring them to specific audiences (eg, guidelines for educators on preventing and containing suicide clusters, guidelines for media professionals on responsible reporting and portrayal of suicide, and guidelines for young people about communicating safely online about suicide)	Community-based suicide prevention organisations in collaboration with relevant target audiences
Provide best-practice care and support to individuals in a suicidal crisis, including asking about and responding to relevant proximal and distal risk factors (eg, access to means, financial hardship, alcohol use, gambling, domestic violence and abuse, and suicide bereavement)	Mental health services and crisis helplines
Ask people presenting to relevant services whether they are experiencing suicidal thoughts, and, if so, refer them to appropriate supports	Welfare services, financial counselling services, drug and alcohol services, gambling support services, domestic violence and abuse services, and suicide bereavement services
Foster community connectedness to mitigate the suicide risk associated with loneliness	Welfare services and community-based organisations
Research and evaluation	
Provide funding to strengthen research and evaluation efforts in suicide prevention	Government departments, philanthropic organisations, and academic granting bodies
Improve the collection, availability, and timeliness of suicide data, to accurately assess the magnitude of the problem and facilitate evaluation of the effect of suicide prevention initiatives	Researchers, policy makers, coroners or medical examiners, and police
Improve the quality and quantity of evaluations to strengthen the evidence around what works (and does not work) in suicide prevention	Researchers and evaluators in collaboration with those who fund, deliver, and receive interventions
Advocacy	
Ensure that suicide prevention is prominent on political agendas within countries and globally, especially in LMICs	All stakeholders
Ensure that people with lived experience of suicide are front and centre of all of the above policy, practice, and research and evaluation actions	All stakeholders

HICs=high-income countries. LMICs=low-income and middle-income countries.

Table 2: Call to action

Source: (Hawton & Pirkis, 2024)

Appendix 1

THE TURAMARAMA DECLARATION

We, participants in Turamarama ki te Ora Indigenous Suicide Prevention Conference, held in Rotorua, New Zealand on 1-3 June 2016, are deeply concerned about the high rates of suicide among indigenous peoples.

1. *We weep* for the increasing number of our people whose lives have been cut short by suicide;
2. *We respect* the courage and fortitude of families and friends who have endured unexpected and often inexplicable losses of dear ones;
3. *We commit* ourselves to healing our own wounds and the wounds of our lineage, and in so doing to exemplify the ways in which light can be brought into the world inhabited by our elders, our peers and our young people;
4. *We declare* that all our people should be able to 'live well', into old age;
5. *We believe* that the will to 'live well' is strong when the human mauri is strong; 'living well' means being able to live as Māori, as indigenous peoples, and as citizens of the world;
6. *We will strive* to build safe and nurturing communities that generate confidence, integrity, inclusion, equity, and goodwill;
7. *We recognise* the key roles that whānau and families play in strengthening the mauri by transferring knowledge, culture, language, values, and love to their children and grandchildren;
8. *We endorse* the benefits of tikanga, kawa, healing, and other cultural protocols to lift the spirit and strengthen our people in schools, health centres, sporting clubs, social media, the workplace, and the streets;
9. *We expect* health, education, and all social service providers to offer services that are accessible, timely and effective for indigenous peoples;
10. *We urge* our own indigenous leaders, tribal authorities, and community champions to create opportunities for our children, youth, women, men, and our older people so they can be part of te ao Māori and the indigenous world, and can be active participants in the communities where they live and work;
11. *We challenge* national and local authorities and city councils to adopt and enforce regulations to reduce the availability of alcohol and other harmful substances, to ensure that homes are warm, comfortable, and affordable, to insist that streets, workplaces, schools, and the internet are all safe places for our peoples, and to combat practices that diminish self-worth and hope;
12. *We call* on our elected leaders in Parliament, especially those who have responsibilities for education, social services, health, housing, employment, indigenous development, and the environment, to work together in order to create a society where equity of access, equitable outcomes, and extended opportunities can prevail;
13. *We recommend* that our people in the United Nations Permanent Forum on Indigenous Issues make all nation states aware of the extent of Indigenous suicide and ensure that suicide prevention is highlighted in the UN Millennium Goals;
14. *We pledge* ourselves to work collectively so that our combined energies can create a world where the mauri can flourish and all our peoples can live well, into old age.

Declared at Rotorua, New Zealand

3rd June 2016

Signatories
(Here follows 220 signatures)

Source: (Durie, 2017)

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