Submission to the Ministry of Health on the Draft Suicide Prevention Action Plan 2025 - 2029

Introducing Mana Mokopuna – Children and Young People's Commission

Mana Mokopuna – Children and Young People's Commission is the independent Crown entity with the statutory responsibility to advocate for the rights, interests, participation and wellbeing of all children and young people (mokopuna) under 18 years old in Aotearoa New Zealand, including young persons aged over 18 but under 25 years old years if they are, or have been, in care or custody.

We independently advocate for and with mokopuna within the context of their families, whānau, hapū, iwi and communities, based on evidence, data and research, including direct mokopuna experiences and views.

Our work is grounded in the United Nations Convention on the Rights of the Child (the Children's Convention), Te Tiriti o Waitangi and other international human rights instruments. We are a National Preventative Mechanism under the Optional Protocol to the Convention Against Torture, meaning we monitor places where mokopuna are deprived of their liberty, including in the care and protection, youth justice, youth mental health and intellectual disability spaces.

We have a statutory mandate to promote the Children's Convention and monitor the Government's implementation of its duties under the Convention, and to work in ways that uphold the rights of mokopuna Māori including under Te Tiriti o Waitangi. We place a focus on advocating for and with mokopuna who are experiencing disadvantage, and we recognise and celebrate the diversity of mokopuna in all its forms.

Our moemoeā (vision) is *Kia kuru pounamu te rongo – All mokopuna live their best lives,* which we see as a collective vision and challenge for Aotearoa New Zealand.

For more information please contact:

Natarsha Orsman

Senior Advisor

Natarsha.Orsman@ManaMokopuna.org.nz

Suicide prevention must address the drivers of mokopuna mental distress

1. Mana Mokopuna – Children and Young People's Commission welcomes the opportunity to provide this submission on the Draft Suicide Prevention Action Plan 2025 – 2029.
2. In this submission, we echo calls from children and young people who are urging action to tackle the immense and enduring challenges in child and youth mental health. This not only encompasses Aotearoa New Zealand's high rates of suicide and suicidality,[1] but also the underlying factors that contribute to it. We must address the systemic, intersectional, and intergenerational inequities that drive these harms.
3. Alongside the Ministry of Health's focus on prevention, growing the workforce and cross-agency collaboration, Mana Mokopuna advocates for a public health approach to suicide prevention that places a specific focus on youth suicide, and which identifies and addresses the risk factors underlying suicide. These include financial hardship, family history of mental distress and suicide, experiences of violence and abuse, and societal factors such as colonisation, racism, discrimination, and views of, attitudes towards, and communication about suicide and self-harm.[2]

[1] Suicidality is a term used to describe suicidal thoughts, plans, and ideation, including behaviours and attempts to take one's own life. *From* Understanding suicidality in Pacific adolescents in New Zealand using network analysis - Gossage - 2023 - Suicide and Life-Threatening Behaviour

[2] Preventing suicide: a public health approach to a global problem (thelancet.com)

"Mental health. Waitlists crisis teams & youth lines need to change! Young people are dying but nothing is changing."

(What matters most? Mokopuna Māori and Rainbow, 12-17 years old)[3]

4. In Aotearoa New Zealand, our suicide rates – including youth suicide rates – are unacceptably high, as are the rates of those with lived experience of suicidal thoughts and behaviours.[4] As the Draft Suicide Prevention Action Plan for 2025–2029 notes, the impacts of suicide and related harms are disproportionately experienced by our mokopuna, especially among those who are tāne, whakapapa Māori, are Pacific peoples, are from the rainbow community, and/or are care-experienced.[5,6]

5. The factors contributing to these rates are complex, multiple, and overlapping. anxiety, depression, feelings of hopelessness and self-harm are risk factors consistently associated with mokopuna suicidality, and these must be addressed by comprehensive mental health services.[7] However, these forms of mental distress are underpinned by social and structural risk factors, such as poverty, colonisation, inequality and discrimination, and biases in healthcare and education, as well as individual risk factors such as child abuse and neglect, mental illness.[8] It is critical that suicide prevention strategies recognise these broader risk factors and the government must invest in comprehensive and holistic approaches.

6. It is also important to consider mokopuna who have lost a loved one, whānau member or peer to suicide and we note that this is also a risk factor for mokopuna suicidality.[9] We acknowledge that the Action Plan has a focus on suicide bereavement support, and advocate for child-centred and -friendly approaches to these services and supports.

7. Mokopuna in Aotearoa New Zealand report the highest level of unmet need for mental health care of any age group in the population.[10] Our youth suicide rates are among the highest across OECD countries, with rates for mokopuna Māori, exponentially higher than the rest of the youth population.[11] In many instances, mokopuna who are advocating for better mental health prevention, support and responses have called the state of mental health for children and young people in Aotearoa New Zealand a crisis.

8. The statistics paint a bleak picture of the rates of suicide and mental distress that a significant proportion of our child and youth population is experiencing. We also need to consider the broader data and evidence as well, including the high rates of bullying experienced by young children and the high rates of psychological distress experienced by teenagers and young adults.[12] There is no question that investment in increased mental health services for mokopuna is urgently needed, however in order to enable equitable and sustainable change, suicide prevention efforts must also address these social and structural contributors.[13]

9. In our view, as the independent advocate working for and with mokopuna, the disproportionate rates, experiences and impacts of suicide and suicidality among mokopuna requires that **children and young people** are a **priority group** for the Suicide Prevention Action Plan. Explicitly identifying and focusing on children and young people as a priority group in the Action Plan and its implementation is a crucial way to ensure mokopuna are at the centre of this issue. This is important so that a distinct focus on their specific rights and needs receives the focus it requires, and so we can ensure no mokopuna turns to suicide.

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[3] What Matters Most in your World? Survey, Mana Mokopuna 2023. Voices of mokopuna | Office of the Children's Commissioner | Mana Mokopuna
[4] The UNICEF Report Card (New Report Card shows that New Zealand is failing its children | UNICEF Aotearoa
[5] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[6] Meeting the mental health needs of young New Zealanders (oag.parliament.nz)
[7] Adverse Childhood Experiences and Suicide Risk: Toward Comprehensive Prevention - American Journal of Preventive Medicine (ajpmonline.org)
[8] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[9] suicide-in-nz-snapshot-march-2022.pdf (www.parliament.nz)
[10] Summary of our report — Office of the Auditor-General New Zealand (oag.parliament.nz)
[11] University of Waikato (2024) NZ is bound by international mental health agreements – statistics for Māori show we're failing to uphold them; Sutcliffe, K et al (2023), "Rapid and unequal decline in adolescent mental health and well-being 2012-2019: Findings from New Zealand cross-sectional surveys", Australian & New Zealand Journal of Psychiatry, Vol. 57, no. 2, page 267 and UNICEF Office of Research Innocenti (2020), Worlds of Influence: Understanding What Shapes Child Well-being in Rich Countries, page 13;
[12] In 2019, the Education Review Office surveyed ākonga and found that 46% of primary-age students and 31% of secondary-age students reported beung bullied at their school. Retreived from: https://ero.govt.nz/sites/default/files/2021-05/Bullying-Prevention-and-Response-in-New-Zealand-Schools-May-2019.pdf
[13] Ministry of Health, New Zealand Health Survey 2022/23 annual data explorer: "Mental health care indicator: Unmet need for professional help for their mental health in the last 12 months"

Mokopuna have rights to life, survival and development

10. All children have rights under the United Nations Convention on the Rights of the Child (Children's Convention), to which New Zealand is a States Party. Mokopuna rights to life, survival and development under Article 6, and to live free from discrimination (Article 2), are core components of a children's rights approach.[14] Of particular relevance for this kaupapa is Article 24 of the Children's Convention, which requires State Parties such as New Zealand to ensure the right of the child to the enjoyment of the highest attainable standard of health.[15] This includes all sides of Te Whare Tapa Whā, including mental health.

11. The New Zealand Government's obligation to enable the conditions for mokopuna physical and mental health sit within our international and national human rights obligations. This includes the right to non-discrimination in public and primary health care. It also includes the rights of mokopuna Māori to health care approaches that strengthen indigenous protective and preventative factors against suicide, such as self-determination, and to mātauranga and kaupapa Māori approaches (preventative and response) to mental health and wellbeing.[16]

12. We remind the Government of its duties and obligations to uphold and protect children's rights, and of the impact that the enjoyment of these rights has on reducing the prevalence of suicide among our mokopuna.

13. It is also important for the Ministry of Health to further consider Article 12 of the Children's Convention, which establishes the right for mokopuna to have a say in decisions that impact them.[17] A recent report of the cross-party Mental Health and Addiction Wellbeing Group, *Under One Umbrella,* highlighted the importance of youth voice and participation, emphasising that there is significantly more potential for services to be successful if mokopuna are involved in the planning, design and delivery of them.[18] This includes in the space of youth suicide prevention.

14. Mokopuna Māori have particular rights under Te Tiriti o Waitangi (Te Tiriti). The Crown is required to uphold and give effect to Te Tiriti and to progressively implement the Children's Convention for all mokopuna under the age of 18. Both these treaties form an important basis to uphold and progress the rights of mokopuna. These rights include not to be exploited, to be safe, to be protected and to have equitable outcomes.

15. For mokopuna Māori, the Children's Convention can be read through the lens of Te Tiriti to ensure Māori retain tino rangatiratanga over their taonga, including whānau, mokopuna and their mana or inherent rights. We recognise that Māori, particularly mokopuna Māori, are overrepresented in mental health spaces, experiences and statistics.[19] Therefore, we advocate for kaupapa Māori approaches that give effect to Te Tiriti o Waitangi and support the mana motuhake, self-determination of mokopuna Māori, whānau, hapū and iwi.

16. He Ara Oranga, the report of the Government Inquiry into Mental Health and Addiction, urged that more must be done to uphold the rights of tangata whaiora in order to improve mental wellbeing in Aotearoa New Zealand. It also highlighted that the Government has a crucial role to play in addressing inequities and discrimination in our society. This is especially important for whānau Māori, who are inequitably impacted by income inequality, child poverty, homelessness, and family violence.[20]

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[14] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child#Article-6 and Article 2

[15] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child#Article-24

[16] Universal Declaration of Human Rights | United Nations; International Convention on the Elimination of All Forms of Racial Discrimination | OHCHR; UNDRIP_E_web.pdf; NZ is bound by international mental health agreements – statistics for Māori show we're failing to uphold them :: University of Waikato

[17] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child#Article-12

[18] Under One Umbrella. Integrated mental health, alcohol and other drug use care for young people in New Zealand

[19] Wai 2575, B026.pdf (justice.govt.nz)

[20] He-Ara-Oranga.pdf (inquiry.govt.nz)

Mokopuna mental health and well-being must be a priority for Aotearoa New Zealand and within suicide prevention

17. Mokopuna have identified mental health as one the biggest threats to well-being. In 2023, we surveyed mokopuna asking, "I tou ao, he aha ngā mea nui? In your world, what matters most?". Mental health was identified as one of the most important concerns for mokopuna, alongside them highlighting the importance of their whānau, friends and relationships, being able to participate in education, safety and security and having what they need. A 2023 literature review carried out by the Ministry for Youth Development revealed mental health as the primary concern for mokopuna in Aotearoa.[21]

18. Mokopuna are concerned for the mental and emotional wellbeing of themselves, their peers and other mokopuna.[22] In 2021/22, nearly one in four (23.6%) young people aged 15–24 years experienced high or very high levels of psychological distress, up from 11% in 2020.[23] With this in mind, it is likely that each and every mokopuna in Aotearoa New Zealand has either experienced mental distress themselves, supported a peer with their emotional or mental health or knows someone close to them experiencing high levels of psychological distress or suicidal ideation. [24]

19. We wish to emphasise the risk of suicide contagion for mokopuna and their communities, particularly for those under 25 years old.[25,26] Postvention is crucial for suicide prevention, and we advocate for national and regional youth-specific postvention actions, alongside strategies addressing the long-term causes of contagion risks.

20. As mentioned above, mokopuna Māori, Pacific mokopuna, and mokopuna from ethnic communities consistently face greater socioeconomic and mental health disparities compared to Pākehā groups. Over the past 20 years of Youth2000 surveys, experiences of racism and mental health inequalities have grown, and the findings indicated that racism is a core factor contributing to mental health disparities, with different indigenous and ethnic groups experiencing it in varied ways. The study also emphasised significant mental health inequities for mokopuna whaikaha and Rainbow mokopuna.[27]

21. The mental health and well-being of rainbow mokopuna must be a key consideration of a suicide prevention action plan, as we are highly concerned with the high rates of suicidality for this identity group. A survey identified that 64% of rainbow young people had thought about suicide in the past 12 months and 10% had attempted suicide.[28] There are also many intersections to consider for rainbow mokopuna, including involvement with Oranga Tamariki. For example, care-experienced trans and non-binary mokopuna were more likely to report a suicide attempt compared to cisgender care-experienced mokopuna.[29]

22. In 2021, the rate of suspected suicides for the 15–24-year-old cohort was the highest amongst the age ranges, with a rate of 18.1 per 100,000 population.[30] As noted in the Draft Suicide Prevention Action Plan, young people aged 20-24 have the highest suspected suicide rate of 20.1 per 100,000.[31]

23. We must recognise the intersectional nature of mental distress for mokopuna in Aotearoa New Zealand and highlight the compounding factors of both being young and belonging to certain groups that face systemic discrimination.[32] A suicide prevention action plan must be grounded in a public health and rights-focused approach. This requires a range of interconnected, mutually

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[21] appendix-three-gathering-voices-youth-plan-literature-review.pdf (myd.govt.nz)
[22] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[23] Ministry of Health. 2022. Annual Data Explorer 2021/22: New Zealand Health Survey [Data File].
[24] He-Ara-Oranga.pdf (inquiry.govt.nz)
[25] file (casa.org.nz)
[26] Coroner investigates six Northland youth suicides, searching for solutions - NZ Herald
[27] He-Ara-Oranga.pdf (inquiry.govt.nz)
[28] Fenaughty, J., Ker, A., Alansari, M., Besley, T., Kerekere, E., Pasley, A., Saxton, P., Subramanian, P., Thomsen, P. & Veale, J. (2022). Identify survey: Community and advocacy report. Identify Survey Team. Retrieved from: community_advocacy_report.pdf (squarespace.com)
[29] Fenaughty, J., Cooper, G., Harrison, K., Padlie, K., Pasley, A., Mackie, K., Stewart, O., & Stonex, Z. (2024). Identify Survey Findings for Young People with Oranga Tamariki Involvement: Health and Wellbeing Report. Identify Survey: Auckland. Retrieved from: 4-Health-and-Wellbeing.pdf (orangatamariki.govt.nz)
[30] Rate of suicide deaths across 0-14, 15-24, 25-44, 45-64, 65+ life stages, 2009–2022. Suicide data web tool (shinyapps.io)
[31] Suicide Prevention Action Plan for 2025-29 (health.govt.nz)
[32] Meeting the mental health needs of young New Zealanders (oag.parliament.nz)

reinforcing and simultaneous efforts into prevention, intervention, and response/healing. This systems approach identifies that all three (prevention, intervention, and response/healing) need to be active at the same time to reduce risk factors and increase protective factors for wellbeing and prevent suicide.[33]

24. We acknowledge the Ministry of Health's recognition of inequity within our youth suicide rates, and we advocate for a greater investment and focus on intersectional approaches that respond to the diverse realities and barriers to wellbeing among mokopuna. The data and evidence in support of this approach is truly overwhelming.[34] Please see Appendix 1 to refer to an intersectional analysis in relation to mokopuna rights and wellbeing data.

> "We believe a society where the treasuring of our children's well-being is paramount is the only way to ensure that children have what they need to grow and develop. Sadly in New Zealand childhood exposure to maltreatment and relational trauma is extremely common and along with poverty can most often be found in the narratives of children diagnose[d] with mental health conditions. As a nation it is imperative that we increase our awareness and understanding of childhood trauma and its bio-psycho-social impact as a critical factor in determining child and family functioning and dysfunction." (Mental Health Inquiry, He Ara Oranga 2018, NGO)[35]

25. **We recommend** that the Ministry of Health works with other agencies to develop actions that see **mokopuna as a priority group** and that target the wider risk factors contributing to mokopuna suicide rates. This must be developed with input from mokopuna to meet their diverse and intersecting needs, which is particularly important for groups of mokopuna who are most impacted by mental distress. Mana Mokopuna would be open to supporting child and youth engagement to help inform this work. This would align well to our strategic advocacy aspiration/priority of *all mokopuna growing up safe and well,* and our priority of mokopuna '*participating in what matters to me*'.

26. Actions that are bespoke to mokopuna lived and living experiences of suicide are critical. With mokopuna so disproportionately affected here in Aotearoa New Zealand, we must ensure that sufficient resource is dedicated to the unique experiences and needs of mokopuna. By making mokopuna a priority group, the Suicide Prevention Action Plan has the potential to support a truly mokopuna-centred approach. This would align with Article 12 of the Children's Convention and Article 3, which asserts that the best interests of the child should be a primary consideration of the State.[36]

27. Mana Mokopuna recommends considering the previous New Zealand Youth Suicide Prevention Strategy (NZYSPS). As highlighted in the evaluation of the NZYSPS, the mokopuna and/or end-users were unaware of the NZYSPS and had limited understanding of how to use or implement it in the wider community. Therefore, alongside prioritising mokopuna, there must be effective and practical implementation as well as resource that sits behind it, to ensure mokopuna and their whānau and communities affected by suicide are well supported.

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[33] Preventing suicide: a call to action - The Lancet Public Health

[34] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey

[35] He-Ara-Oranga.pdf (inquiry.govt.nz)

[36] https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child#Article-3

Calls from mokopuna to address the drivers of mental distress and other contributing risk factors

> "I care alot about climate change over all because it affects everyone and everything. I also care about equality and making [sure] everyone has the [resources] they need like mental health support, housing and food."
>
> (What matters most? Pākehā mokopuna, 12-17 years old)[37]

28. Mokopuna have repeatedly called on the Government to address the high rates of mental distress and for the government to prioritise mental health reform to ensure an equitable and accessible mental wellbeing system.[38]

29. The evidence illustrates that mokopuna experiences of mental distress are linked to a wide range of causes and effects, such as childhood hardships and trauma, poverty, family violence, sexual violence, racism and discrimination, and many other stresses, such as uncertain futures, the climate crisis, online harm and intergenerational outcomes.[39]

30. We amplify the voices of mokopuna who have bravely shared their experiences of mental distress, as well as their ideas and solutions to address the enduring challenges in child and youth mental health. In a report by Te Hiringa Mahara, rangatahi emphasised solutions to enhance wellbeing and highlighted key areas that impact their well-being:
    - **Uncertain futures** - young people in Aotearoa today feel they are facing an uncertain future with inherited social, economic, and environmental challenges.
    - **Racism and discrimination** - discrimination, including anti-rainbow discrimination, ableism, racism and the impacts of colonisation are significant issues facing young people, particularly affecting rangatahi Māori and ethnic minority groups.
    - **Social media and safety online** - social media and digital spaces are deeply integrated into many young people's lives, with both benefits and harms.
    - **Whānau wellbeing and intergenerational connections** - connection to whānau, and culture develops identity and resilience which is integral to wellbeing.[40]

31. The numerous calls of action from mokopuna urge the government to transform the mental health system alongside addressing systemic issues such as poverty and discrimination.[41] Addressing the key drivers of mental distress are essential to improving outcomes for mokopuna and reducing suicide rates. Approximately half of mental health disorders start by the age of 14 and childhood adversity such as poverty accounts for about a third of all adult mental disorders. Reducing poverty, would therefore, have a huge impact on reducing mental distress.[42]

> "So there's that additional, I guess, challenge for our people who experience stigma and discrimination due to their mental health. So it's kind of layer, upon layer, upon layer. It's age, it's gender, it's race, and it's mental health, and disabilities as well."
>
> (Young person, Complex Care Group, Te Hiringa Mahara)[43]

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[37] What Matters Most in your World? Survey, Mana Mokopuna 2023. Voices of mokopuna | Office of the Children's Commissioner | Mana Mokopuna

[38] https://www.mhmi.org.nz/the-open-letter

[39] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey Youth Wellbeing Insights Report | Te Hiringa Mahara—Mental Health and Wellbeing Commission (mhwc.govt.nz)

[40] Ibid.

[41] Britten, 2023. Young People's Voices on Mental Health and Wellbeing in Aotearoa New Zealand. Retrieved from: Britten-2023-thesis.pdf (auckland.ac.nz)

[42] Research-based ideas to tackle youth mental health - The University of Auckland

[43] Youth Wellbeing Insights Report | Te Hiringa Mahara—Mental Health and Wellbeing Commission (mhwc.govt.nz)

The Committee on the Rights of the Child has repeatedly called for action to address inequities in youth mental health in Aotearoa New Zealand

> "Being heard and recognized. Having mental health support."
>
> (What matters most? Mokopuna Māori, Pacific, European, 16-24 year old)[44]

32. The United Nations Committee on the Rights of the Child (UN Committee) reviews the implementation of the Children's Convention by State Parties, including Aotearoa New Zealand, through a periodic review process. States Parties are required to submit periodic reports to the UN Committee detailing the measures it has taken to uphold children's rights, any challenges faced, and progress made. The UN Committee then provides concluding observations, including specific recommendations to the Government regarding actions that need to be taken to improve children's rights in New Zealand.[45]

33. The UN Committee has made numerous repeated recommendations for government action to address inequalities in mental health outcomes for different groups of mokopuna and to prioritise children's access to affordable, quality, age-appropriate mental health and counselling services in a timely manner. For example, under the sixth periodic review of New Zealand's implementation of the Children's Convention, the concluding observations and recommendations from the UN Committee in 2023 pertinent to the kaupapa of suicide prevention can be summarised as follows:

    - The UN Committee expressed serious concern regarding the ongoing discrimination faced by mokopuna in vulnerable situations, particularly Māori and Pacific mokopuna, those in out-of-family care, and those with disabilities. As these mokopuna often do not have an adequate standard of living and struggle to access basic services such as education, healthcare and protection.
    - The Committee on the Rights of the Child also highlighted the heightened risks of suicide, violence, bullying, mental distress, and homelessness that these groups of mokopuna encounter. It recommended targeted measures for mokopuna Māori, Pacific, and boys into New Zealand's Suicide Prevention Strategy and Action Plan and advised the Government to address poverty, discrimination, and intergenerational trauma.
    - The UN Committee called for the strengthening of the Suicide Prevention Office with sufficient resources to effectively implement and evaluate the Suicide Prevention Action Plan. It also noted the limited availability of child-friendly reporting channels and mental health services for mokopuna who had experienced trauma.
    - It recommended strongly investing in strategies developed by Māori communities to reduce mokopuna Māori placement in out-of-home care was deemed essential, alongside ensuring adequate support during and after such placements.
    - The UN Committee recommended an informed focus on mokopuna in the work of Te Hiringa Mahara, also addressing inequalities of mental health outcomes for Māori, Pacific and rainbow mokopuna, and prioritising access to affordable, quality, age-appropriate mental health and counselling services in a timely manner.
    - The UN Committee urged the protection of family unity for asylum-seeking, refugee, and migrant mokopuna and called for improved case management that included comprehensive pathways to health services, education, and legal aid, particularly for unaccompanied, separated, and disabled mokopuna.[46]

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[44] What Matters Most in your World? Survey, Mana Mokopuna 2023. Voices of mokopuna | Office of the Children's Commissioner | Mana Mokopuna

[45] UNCROC reporting - Ministry of Social Development (msd.govt.nz)

[46] The UN's Concluding Observations to Aotearoa New Zealand | Mana Mokopuna

Giving effect to Te Tiriti o Waitangi

> "I did have one therapist who like… mentioned a lot about intergenerational trauma and colonisation and was just really understanding and recognised how that impacts mental health for young Māori. That really meant a lot to me because of my own activism traits."
>
> (Experiences of rangatahi Māori with mental health services in Aotearoa, Rangatahi Māori)[47]

34. As previously noted, inequitable mental health outcomes must be a key focus of the Suicide Prevention Action Plan. Unfortunately, many of these inequities are apparent for mokopuna Māori and the Māori population, and data suggests significant under-reporting, assessment, and treatment of emotional conditions relative to non-Māori and non-Pacific.[48] We advocate for solutions, actions and responses to mental distress and suicide rates, that are grounded in kaupapa Māori approaches and give effect to Te Tiriti.

35. Whilst we recognise that the Suicide Prevention Strategy includes reference to honouring Te Tiriti o Waitangi, Mana Mokopuna advocates for an Action Plan and practical actions that uphold the Articles of Te Tiriti and addresses inequities for mokopuna Māori and their whānau, hapū and iwi.

36. Article 1 of Te Tiriti granted the provision of kāwanatanga, which means that the Crown has a duty to ensure that mental health services are effective, accessible and culturally responsive for tangata whenua. This includes recognising the historical trauma faced by generations of Māori and addressing the systemic barriers that contribute to poorer mental health outcomes. For example, He Ara Oranga highlighted that Māori participation in mental health services is often hindered by whānau exclusion, stigmatisation, over-medication, racism, and a lack of understanding of te ao and te reo Māori by clinicians.[49]

37. The provision of tino rangatiratanga, or self-determination, is asserted in Article 2 of Te Tiriti. To respect Māori autonomy and protect taonga such as mokopuna, oranga and Māori identity - Māori must be involved in creating and implementing mental health strategies and empowered to lead actions under the Strategy.

38. The provision of ngā tikanga katoa rite tahi under Article 3 of Te Tiriti affirms the equal enjoyment of all rights and privileges for all peoples. Recognising the inequities for mokopuna Māori, the government must ensure equitable access to mental health services. This can be achieved by providing targeted support, increasing funding for Māori mental health services, and ensuring wider services are culturally competent. We note there are funds under the Strategy and Action Plan for Māori communities and Rangatahi Māori Suicide Prevention (i.e., Rangatahi Manawaroa)[50], however, as mokopuna Māori are still the most susceptible to mental distress and suicide, more must be done to achieve better outcomes for whānau Māori.

39. Article 4 of Te Tiriti outlines the provision of wairuatanga - religious and spiritual freedom for Māori and all peoples. Therefore, the Suicide Prevention Action Plan must incorporate a holistic approach that respects and nurtures Māori spirituality and religious freedoms. By honouring wairuatanga, the Ministry of Health can better support Māori in their healing journeys and promote a more holistic understanding of mental health.

[47] Experiences of Rangatahi Māori with Mental Health Services in Aotearoa (aut.ac.nz) Rihari, Teina, 2022.

[48] mental-health-inequities-for-maori-youth-a-population-level-study-of-mental-health-service-data-open-access.pdf (nzmj.org.nz)

[49] 3.4 Whakawātea te Ara – Māori health and wellbeing | Mental Health and Addiction Inquiry

[50] Rangatahi Manawaroa (tpk.govt.nz)

Recommendations

1. **We recommend** that the Ministry of Health works with other agencies to develop and adequately resource child- and youth-specific actions under the Suicide Prevention Strategy that are developed, designed and implemented by, with and for mokopuna. Mana Mokopuna envisions a future where all mokopuna live their best lives and by prioritising mokopuna in the Suicide Prevention Action Plan, we believe we can respond to the calls of mokopuna to address inequitable mental distress and suicide rates in Aotearoa New Zealand.

2. **We recommend** that an intersectional and prevention-focused approach is developed to:
   a. Respond to the individual, social, and systemic factors that perpetuate the inequities causing suicide to disproportionately impact different groups of mokopuna, rangatahi and their whānau.
   b. Strengthen opportunities for general mokopuna mental health support and suicide-specific support (e.g. postvention, experiences of suicide bereavement) while at the same time investing in building protective factors that improve conditions for mokopuna wellbeing.[51]

3. **We recommend** implementing recommendations from the United Nations Committee on the Rights of the Child regarding mental health and its key drivers as noted in the CRC/C/NZL/CO/6 Concluding observations on the sixth periodic report of New Zealand, particularly in relation to Article 24 of the Children's Convention, which requires State Parties to ensure the right of the child to the enjoyment of the highest attainable standard of health.[52]

4. **We recommend** giving effect to Te Tiriti o Waitangi and upholding its provisions in the Suicide Prevention Action Plan and working with mokopuna Māori and their whānau, hapū and iwi to ensure the plan addresses inequities for Māori.

5. **We recommend** that youth voice and participation is a key driver of all parts of the Suicide Prevention Strategy and Action Plan as mokopuna have the right to be involved in decisions that impact them. It is important to work with mokopuna to design actions at a national level and **we recommend** that services under the youth-specific community fund have a compulsory mokopuna voice and participation element.

6. **We recommend** that actions focusing on mokopuna mental health, such as the 'crisis café' model have a specific children's rights and youth development approach, and that such actions are strengths-based, and therefore renamed to something more hopeful.

7. **We recommend** that greater responsibility and leadership is taken by the Ministry of Health, Te Whatu Ora, the Suicide Prevention Office, the Ministry of Education, Oranga Tamariki, the Department of Corrections, and other agencies as relevant to strengthen system leadership as noted in the report by the Office of the Auditor General[53].

8. **We endorse** the following actions in the draft plan: establishment of a youth-specific community fund; establishment of more crisis recovery cafés (while noting our recommendation 6 above); improving the cultural appropriateness of Aoake te Rā; creating safer environments in inpatient mental health and addiction facilities; launching a wellbeing promotion campaign including targeted resources for youth; and the proposed actions led by the Ministry of Education and Department of Corrections to ensure safer environments for children and young people.

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[51] Addressing key risk factors for suicide at a societal level (thelancet.com)

[52] Advice on the implementation of children's rights to health can be found within CRC General Comment No. 4: Adolescent Health and Development and CRC General Comment No. 15 on the right of the child to the highest attainable standard of health. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-rights-child#Article-24

[53] Our recommendations — Office of the Auditor-General New Zealand (oag.parliament.nz)

Appendix 1: Analysis to support an intersectional approach to Suicide Prevention

The table below indicates key data and statistics which highlight the disproportionate impact of mental distress and suicidality for different groups of mokopuna.

We share this with the Ministry of Health to highlight the overrepresentation of the following population groups of mokopuna. Based on this, we strongly suggest considering the intersecting issues for these mokopuna and addressing inequities for mokopuna in the Action Plan.

Mana Mokopuna – Children and Young People's Commission is available to work with the Ministry of Health in relation to bringing a priority mokopuna-specific focus into the Suicide Prevention Action Plan, to provide specialist, children's rights-focused advice, including in relation to the intersecting issues highlighted in the table below.

Population Group	Key Data and Statistics
Mokopuna and Rangatahi Māori	• Rangatahi Māori reported an increase in depressive symptoms 13.8% in 2012 to **27.9%** in 2019.[54] • In 2019, the suicide rate for Māori males was 29.7 per 100,000 Māori male population. This was about 1.8 times that of non-Māori males, who had a rate of 16.6 per 100,000 non-Māori male population. In the same year, the suicide rate for Māori females was 13 per 100,000 Māori female population. This was about 2.3 times that of non-Māori females, who had a rate of 5.7 per 100,000 non-Māori female population.[55] • Suicide was the cause of one third (33.8%) of all deaths in rangatahi Māori, compared with just over one-quarter (26.1%) of all deaths in non-Māori, non-Pacific children and young people; for every non-Māori, non-Pacific person aged 10–24 years who died by suicide there were approximately three rangatahi Māori who died by suicide.[56] • Despite known high levels of mental health concerns for rangatahi Māori, administrative data suggests significant under-reporting, assessment, and treatment of emotional conditions relative to non-Māori and non-Pacific.[57] • Rangatahi Māori were 56% more likely to be admitted to hospital for self-harm than non-Māori and non-Pacific.[58] • Structural disadvantage affects rangatahi Māori mental wellbeing in various ways including through differential exposure to stressors (e.g. racism, discrimination, poverty) and stressful life events (e.g. moving, death of a family member, contact with police, being a victim of violence).[59,60]
Pacific mokopuna	• Around a quarter (**25.8%**) of Pacific mokopuna reported significant depressive symptoms in 2019, increasing from 17.6% in 2001. Over a quarter of Pacific students reported serious thoughts of suicide in the last year (**26.4%**) in 2019.[61] • 13.1% of Pacific students living in a high-deprivation area had attempted suicide in the past 12 months compared to 2.9% of Pacific students living in low-deprivation areas.[62]

[54] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[55] Suicide data web tool (shinyapps.io)
[56] TeMauriTheLifeForce_final.pdf (hqsc.govt.nz)
[57] mental-health-inequities-for-maori-youth-a-population-level-study-of-mental-health-service-data-open-access.pdf (nzmj.org.nz)
[58] Ibid
[59] Reid P, Cormack D, Paine SJ. Colonial histories, racism and health—The experience of Māori and Indigenous peoples. Public Health. 2019 Jul
[60] Structural disadvantage and rangatahi Māori mental wellbeing (growingup.co.nz)
[61] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[62] Ibid

	• Rates for Pacific peoples aged 20–24 years are approximately 1.4 times higher than for non-Māori, non-Pacific, non-Asian people.[63] • Pacific peoples in Aotearoa New Zealand have higher rates of mental disorder than the general population yet, are less likely to access mental health services than all other New Zealanders (25.0 per cent compared with 58.0 per cent of New Zealanders overall).[64]
Asian mokopuna	• One in five Asian mokopuna reported not being able to get healthcare when they needed it in the last year.[65] • In 2019, **30%** of Asian girls (up from 16% in 2012) and **19%** of Asian boys (up from 9% in 2012) reported significant depressive symptoms.[66] • The majority of Asian young people who died by suicide were born outside of New Zealand (80.7%), consistent with the fact that the majority (77%) of the Asian population in New Zealand were born overseas.[67]
Rainbow mokopuna	• Almost two thirds (**64%)** of rainbow young people had thought about killing themselves in the past 12 months. Just over one quarter (29%) had made a plan about how they would kill themselves, and one in ten (10%) had attempted suicide.[68] • For rainbow mokopuna involved with Oranga Tamariki, one half are affected by poor mental health, and for takatāpui Māori this figure is slightly higher at 53%.[69] • Rainbow mokopuna often reported less positive family, school and community contexts than non-Rainbow young people, as well as some large health disparities, particularly in mental health. • A substantially higher proportion of rainbow students report mental health challenges, including depression, self-harm, and suicidal thoughts and suicide attempts. Despite their greater needs in terms of health and wellbeing challenges, a higher proportion of rainbow students were not able to access health care when needed, compared to non-Rainbow students. • **57%** of trans students reported significant depressive symptoms and had self-harmed in the past year. **52%** had serious thoughts about suicide in the past year, four in ten (**40%**) reported they had made a suicide plan, and one in four (**26%**) reported they had attempted suicide in the past year.[70]
Mokopuna whaikaha	Mokopuna whaikaha report high levels of mental health concerns: • Fewer than 60% of young people with disabilities reported good wellbeing. • More than one in three reported clinically significant depressive symptoms. • Close to one in three reported serious thoughts of suicide in the last year. • Young people with disabilities also faced difficulties accessing healthcare, with 31% saying that they did not get the healthcare they needed in the previous year, compared to 20% of those without disabilities.

[63] Suicide Prevention Action Plan for 2025-29 (health.govt.nz)
[64] Pacific peoples, mental health service engagement and suicide prevention in Aotearoa New Zealand (researchgate.net)
[65] Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey
[66] Ibid
[67] suicide-among-asian-young-people-aged-under-25-years-in-aotearoa-new-zealand-different-methods-warrant-different-preventive-init.pdf (nzmj.org.nz)
[68] Fenaughty, J., Ker, A., Alansari, M., Besley, T., Kerekere, E., Pasley, A., Saxton, P., Subramanian, P., Thomsen, P. & Veale, J. (2022). Identify survey: Community and advocacy report. Identify Survey Team. Retrieved from: community_advocacy_report.pdf (squarespace.com)
[69] Rainbow youth in care (orangatamariki.govt.nz)
[70] The above statistics on rainbow mokopuna were retrieved from: Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey

	• They also face major inequities compared to their peers, including increased concerns about housing, poor healthcare access, ethnic discrimination by healthcare providers and feeling safe at school. • Mokopuna whaikaha reported less positive family, school and community contexts than those without a disability or chronic condition. They generally reported less positive health than those without a disability or chronic condition, particularly on indicators of mental health.[71]
Young people who have been involved with Oranga Tamariki	Compared to young people never involved with Oranga Tamariki, those ever involved were: • less likely to report good wellbeing • more than twice as likely to report depressive symptoms • more than twice as likely to have had serious thoughts of suicide in the last year • more than four times as likely to have attempted suicide in the last year • more than twice as likely to have been unable to access a health provider when they needed to.[72]
Youth in Alternate Education (AE)	For youth in AE, evidence shows that: • AE students were exposed to difficult family and social environments. Many have experienced significant childhood hardships and trauma with high levels of poverty, violence, and ethnic discrimination. • Extremely high levels of distress and poor mental health – 74% reported clinically significant depressive symptoms (RADS), 53% reported anxiety symptoms (PHQ-4), 37% reported self-harm in the previous 12 months, and 16% reported a suicide attempt in the previous 12 months. • Poor access to healthcare – 23% reported not being able to get the healthcare they required over the past year, with 14% having not gone to a health provider in more than 2 years.[73]
Youth who are Not in Education, Employment or Training	For youth not in education, employment or training, Youth-19 found: • Extremely high rates of poverty and deprivation, the study reported high levels of any kind of housing deprivation (70%), food insecurity (35%), period poverty (42%), electricity insecurity (19%) and transportation worries (38%) • High levels of exposure to violence and ethnic discrimination – 17% felt unsafe in their current home, 47% had experienced sexual violence and harm, 49% had been physically hit or harmed in the last year, and 30% had experienced ethnic discrimination by police. These mokopuna also reported: • Very poor mental and emotional health – 70% reported significant depressive symptoms • 66% have signs of anxiety (PHQ-4) • 44% reported self-harm • 29% had made a suicide attempt in the past year.[74]

[71] All statistics in relation to mokopuna whaikaha were retrieved from: Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey

[72] All statistics in relation to Young people who have been involved with Oranga Tamariki were retrieved from: Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey

[73] All statistics in relation to Youth in Alternate Education were retrieved from: Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey

[74] All statistics in relation to Youth who are Not in Education, Employment or Training were retrieved from: Leveraging 25 Years of mental health research from the Youth2000 survey series — Youth19 - A Youth2000 Survey