2018-2021

Waikato

Suicide Prevention and Postvention Action Plan

Waikato District Health Board

Table of Contents

Throughout this plan document we have included direct quotations. We thank the many people who have shared their most personal stories, as well as their opinions and comments.

"What if we had done this, what if we had done that.
If we knew how to do it or where to go for it this could have been prevented. Sleepless nights going over different scenarios of what we could have done.
Maybe if we had seen a massive billboard with a phone number or something to point us in the right direction it could have helped."

(Friend)

Welcome Nau Mai

We are pleased to present the 2018-21 Waikato Suicide Prevention and Postvention Plan.

The development of this Plan has been built on the voice of the people in our communities and in collaboration with other government and social agencies, NGOs and support groups.

No one person or organisation can prevent suicide; we all need to be involved from government agencies, to employers, schools, neighbours and families/whanāu.

This Plan is the first time that other agencies and the Waikato DHB have joined together to address suicide prevention in our region.

The Plan sets out ways we can work together to prevent suicide and to strengthen support after a suicide or suicide attempt has occurred.

It outlines a set of priority areas identified through our engagement process, that are a focus of action for our combined efforts to move towards an aspiration of having zero suicides in the Waikato. These priorities support social and cultural well-being and are intended make a strong contribution to building strong, resilient communities.

The relationships created by working together in developing this Plan form an enduring strength of the Plan.

This Waikato Suicide Prevention and Postvention Plan is just the beginning – and we will be transparent in the progress we make over the next three years

Having agreed the means, the focus must now be on implementation. We invite you to continue this journey with us to build safe, resilient communities together.

Derek Wright
Interim CEO Waikato District Health Board

Mo Neville
Chair, Suicide Prevention / Postvention Health Advisory Group

1. Introduction and Background

Suicide is a major issue of concern to New Zealanders. Multiple risk factors and life events are involved in a person ending their life. The link between mental illness and suicidal behaviour is well known, however many people who suicide are not mental health service users and, as the Ministry of Health[1] explain, some of those contributors include:

- individual experiences and that person's personality in respect of those experiences
- relationship issues
- the support or perceived level of support that person has
- the community in which that person lives
- the context and economic environment (such as are there jobs available) where that person lives.

While the statistics do not show that Waikato DHB is amongst the highest rates, any single suicide is devastating for those family members and friends directly affected and has reverberations far beyond in their communities. We must work hard to reduce the suicide and self-harm rates in our district, not simply because it is required of us as a DHB, but because it has the potential to save lives and reduce distress for those affected. One suicide is one too many.

Over the past three years Waikato DHB has been working to our Suicide Prevention and Postvention action plan 2014-2017. We have made some good progress and this plan builds on the progress made over the last three years but there is still more to be done and improvements to be made.

1.1. The new plan

The 2014-2017 plan has been reviewed over 2017 and 2018 through a series of interviews, focus groups, community presentations, surveys and, lastly, an intersectoral stakeholder workshop in order to confirm our focus areas for the next three years. See Appendix C for the Engagement Report and the list of who has been involved in the development of the new plan.

In addition to the input received through the above process, we have ensured that our plan aligns with and reflects:

- the Ministry of Health's draft Strategy to Prevent Suicide in New Zealand 2017;
- the current literature on both suicide prevention and postvention;
- the Waikato DHB's strategy for all people living within the Waikato DHB geographical area. These values are at the core of what we do with people at the heart of our work.

[1] Ministry of Health. 2017. A Strategy to Prevent Suicide in New Zealand: Draft for public consultation. Wellington: Ministry of Health.

1.2. Information on National Suicides

Although at present, we have only provisional statistics, nationally the subgroups of the New Zealand population with the highest suicide mortality rates in 2017/18 were: males, Māori (compared with non-Māori), male youth (those aged 20–24 years). Māori males and Māori youth showed particularly high suicide mortality rates.

See Appendix A for further information.

Rates per 100,000 people by DHB

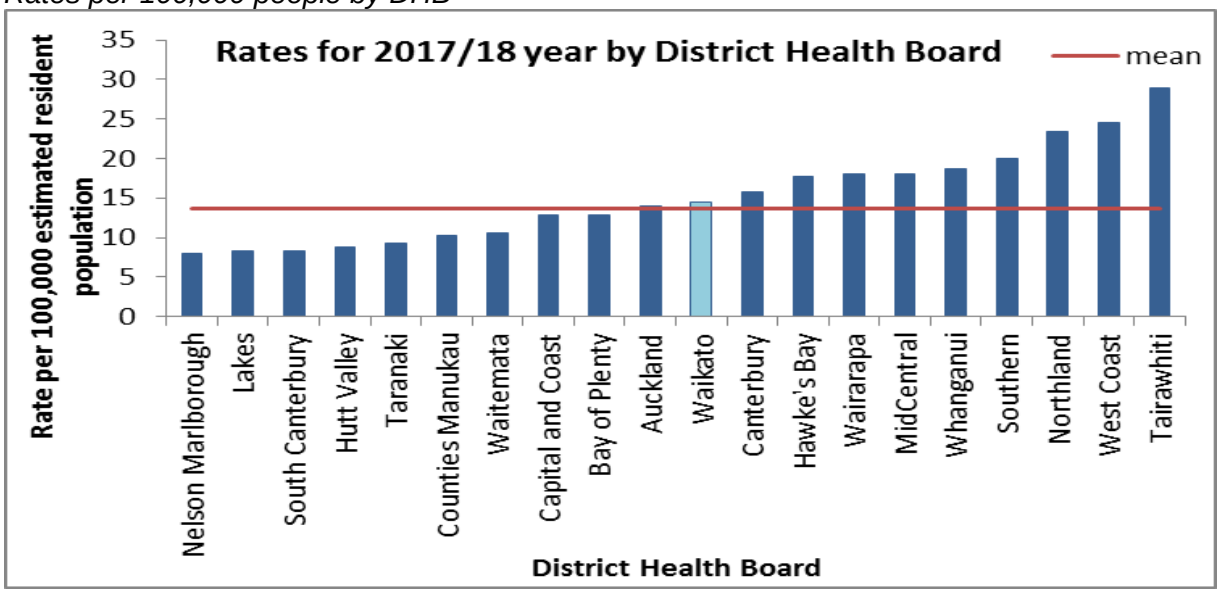


Figure 1. Provisional suicide numbers and rate per 100,000 of the estimated 2017 usually-resident population by District Health Board area. (Sources: Coronial Services of New Zealand. (2018); Statistics New Zealand. (2018)). (NB due to variations in numbers of deaths, the rates can be unstable with large variation year on year).

1.3. Provisional information on Waikato Suicides

The Waikato DHB district has a larger proportion of people living in areas of high deprivation than NZ as a whole. More than half of the South Waikato (64%), Ruapehu (58%) and Hauraki (53%) populations are living in the most deprived NZDep quintile. While our population is getting proportionately older (the 65-plus age group is projected to increase from 15% in 2015 to 22% by 2033), the proportion of our population aged less than 25 years (slightly higher than NZ as a whole) is projected to remain relatively static. See Appendix B for further information on the Waikato DHB area.

There were 59 deaths during 2017/18 in the Waikato DHB district giving a rate of 14.43 per 100,000 people (see Figure 1 above).

Suicide amongst young Māori in the Waikato is disproportionately high. In the middle and older years, the deaths are almost exclusively New Zealand European and European. The majority of people who took their lives in the Waikato in 2017/18 were male.

1.4. At-risk populations in the Waikato DHB area

A key focus for our action plan is to ensure delivery of services is targeted to at-risk populations. When developing the action plan we considered both the Waikato DHB's demographics and the populations identified as at-risk through our data.

It is an important point to remember; that anyone may at some point in their lives be at-risk of suicide.

Population groups at risk of suicide in the Waikato

At-risk populations

- Males
- Rural communities
- Lesbian, Gay, Bisexual, Transgender/Transsexual and Intersex
- Māori
- People experiencing mental illness and/ or addiction issues or significant life stressors
- People 65 years and older
- Youth
- People bereaved by suicide
- People who have made a previous suicide attempt

Waikato DHB Demographics

1 in 5 (74,000 people)
people in Waikato DHB region
are Māori
(compared to 14% nationally)

44% (32,600 people)
of the Māori population in Waikato DHB live in
high deprivation
(compared to 20% for all population nationally)

(Census 2013)

High deprivation – NZ Deprivation Index 2013 deciles 9-10

1 in 4 (108,200 people)
residents within Waikato DHB boundaries live in areas of high deprivation
(compared to 1 in 5 nationally)

(Estimates 2017)

Rurality

A third
(137,000 people)
of the population in Waikato DHB live in
rural areas

More than 20% (28,500 people)
of the population in rural areas in Waikato DHB is
65+ years old

(Estimates 2017)

References

Ethnic group (grouped total responses) by age group and sex, for the census usually resident population count, 2001, 2006, and 2013 (RC, TA, AU)
Subnational population estimates (TA, AU), by age and sex, at 30 June 1996, 2001, 2006-17 (2017 boundaries)

2. Zero Suicide Concept

In early 2018 the Waikato DHB Board endorsed the above approach, believing that a target for suicide reduction as such is not appropriate to set in this sensitive area.

The foundational belief of Zero Suicide is that suicide deaths for individuals under care within health and mental health systems are preventable. Internationally this concept is increasingly being extended to justice systems as research indicates that those within this system are at a greater chance of death by suicide. It presents both a bold goal and an aspirational challenge.

The zero suicides approach represents a commitment to:

- patient safety, the most fundamental responsibility of health care
- the safety and support of clinical and community based staff, who do the demanding work of treating and supporting suicidal patients
- our partners working with families, whānau and communities - that best practice and culturally appropriate practice will be used for people who are being treated and supported for mental illness.

The approach of Zero Suicide is based on the realisation that suicidal individuals often fall through the cracks in, sometimes fragmented and distracted health care and justice systems. A systematic approach to quality improvement in these settings is both available and necessary.

The challenge and implementation of Zero Suicide cannot be borne solely by the practitioners providing clinical care. Zero Suicide requires a system-wide approach to improve outcomes and close gaps.

The concept was briefly outlined at the Waikato DHB Intersectoral Workshop on Suicide Prevention held in June 2018, and there was interest from other agencies. It will form the basis of ongoing conversations in the suicide prevention space.

It is not something that the DHB or even the general health system could do alone.

3. Governance

In order to successfully review progress against the Action Plan, clear lines of accountability are required.

The Waikato DHB Suicide Prevention and Postvention Plan governance is provided by Intersect Waikato, a multi-sector group of government agencies. Intersect provides oversight and guidance. The governance structure and roles are included as Appendix D.

A Waikato DHB Suicide Prevention and Postvention Health Advisory Group was established in December 2015 to provide direction to the Suicide Prevention and Postvention Coordinator. There is senior representation on the group from hospital departments which can have the greatest influence on suicide prevention, and all the Primary Health Organisations with enrolled practices within the Waikato DHB area are represented. There is also representation from our largest Māori NGO.

Significant progress in supporting people who have been bereaved by suicide and initiating suicide prevention strategies has been made.

See Appendix E for achievements.

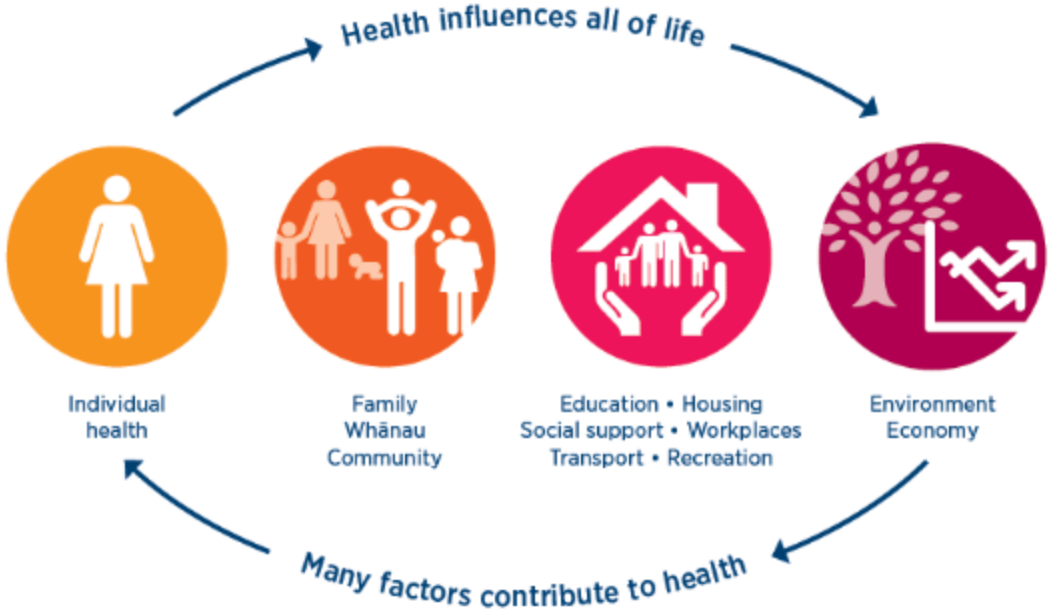
4. Putting the Jigsaw Together

We asked you as residents within the geographical area that is covered by the Waikato DHB, what we can do to help reduce suicides and to support families and friends after a death and you told us.

We have identified people at risk in our DHB population, and where there are opportunities to co-design solutions or there are national / regional trials or pilots to see whether ideas work, we will focus within these groups:

- young Māori, in particular young Māori men
- people living in the most deprived rural areas
- men generally
- people 65 years and older
- people who have made a previous suicide attempt
- people experiencing mental health and/or addiction issues or significant life stressors (including relationship break-downs)
- lesbian, gay, bi-sexual, transgender, trans-sexual and intersex people

With people at the very heart of our work, we have incorporated what we learnt into our suicide prevention and postvention plan for 2018-2021. This information was then shared at an Intersectoral workshop with our major partner organisations and members of our consumer council. Together we determined collaborative and cross-sector objectives. This workshop has also been an opportunity to reinforce that suicide prevention needs to be embedded in all social services' work as it is so much wider than a health-sector issue.



Source: Ministry of Health (2016). Health in the wider context of people's lives. Retrieved May 28, 2018 from https://www.health.govt.nz/new-zealand-health-system/new-zealand-health-strategy-future-direction/health-wider-context-peoples-lives

The section that follows outlines what you told us and what practical steps we will be taking in partnership with communities and other agencies/organisations over the next three years to focus on reducing suicide in the Waikato DHB.

Overarching objective

All of the objectives outlined on the following pages have been developed to attain our zero suicide aspiration.

"It's about mindset – used an integrated service delivery model – every door is the right door. Look at social, housing, education, and do the assessment with whānau. Look at the total needs and bring all the services together for them."

(Community based health provider)

4.1. Understand me

What you told us:
One of the big things that you felt about the services that are helping, is the way you are talked to. People said that they know everyone is really busy but just pronouncing your name properly or asking you about your lives is really important.

Some people commented that when they did get someone who showed they really cared, it made all the difference.

“Stigma continues to be a barrier to prevention – it’s harder than the illness itself in some cases”

“It means a lot to be asked about my circumstances”

What you want:
Staff/people/communities that are non-judgmental.
An inclusive society; one that accepts difference.

Young people ask that their parents are informed about some things. These include the importance of talking about emotions and when necessary, suicide, as pretending that it does not exist, is not helpful. They know it is because their parents love them and want to protect them, but sometimes talking about it is needed.

The other thing that young people asked us to do was to talk to parents about how to approach LGBTI issues. “Sometimes parents just react and the result is a torn apart family.”

Clinicians need to learn about asking patients (and their families) how they are feeling emotionally. Physical health and emotional wellbeing are inter-related.
Education for health workers around the language they use to their patients; attitude and pronunciation. People explained that all these things will have an impact on an emotionally vulnerable person.

The message is that difference is okay and being different is difficult and everyone needs love and support – not exclusion.
All support for a person in distress has to be focused on them and what is going on in their lives. If we do not understand the context, then we are less likely to be able to really help them for the long term.

What we are currently doing:
Translating our DHB value te iwi ngakaunui (people at heart) into action for all staff.

We have a Suicide Prevention Consumer Group of people with lived experience.

Working with the Suicide Prevention Consumer Group to develop appropriate messages for clinicians and workers when working with people who have attempted suicide.

Increase use of te reo Māori by DHB staff.

“…but I was bullied out so I just didn’t go, I didn’t go to school. Mum took me to the doctors for migraines, as I had migraines at the time and the doctor never asked why I had migraines or why I wasn’t going to school. Nobody asked about mental health, nobody asked about reasons and I ended up being able to get a lot of medication through the doctor for migraines and nobody ever asked me, asked me why …”

(Community member)

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 1 Understand me

ACTIONS	Develop or support workshops for parents run by Rainbow Youth Support workshops for parents about talking to young people about suicide	Explore a working group comprising mental health & addictions professionals, education specialists, local government, people with lived experience to create platform for discussion about how to destigmatise suicide in local communities.	Work with organisations such as Te Rau Matatini to increase cultural competence, improve pronunciation and to raise awareness of the importance of attitude	Standardize training for frontline staff in social sector agencies and develop a schedule of training using suite of best practice tools	Set up subgroup to explore how we can best support women when they are dealing with a pregnancy termination or miscarriage and identify and document a clear pathway to support.
LEAD AGENCY	Waikato Queer Youth in partnership with Waikato DHB	Waikato DHB	tbc	Waikato DHB	Waikato DHB
SUCCESS WILL BE MEASURED BY	Number of workshops held	Local communities run their own destigmatisation - one social media campaign per year for 3 years	Number of programmes held Reduction in number of complaints relating to pronunciation	Schedule of training available Number of training sessions held	Pathway for support available to women

4.2. Support communities to find our own solutions to suicide prevention

What you told us:
Community connection was one of the main themes that came through in all the conversations during our consultation.

The reasons why a person may not have good links were wide but included being newly arrived in an area; loss of physical capacity to be able to maintain relationships; family rifts; not having a strong cultural identity; left school but can't find a job; coming out of prison or a mental health inpatient service; and for older people living in rural areas, losing the ability to drive.

The out of hours times are when people feel worst.

Māori know what is best for Māori.

What you want:
Make mental health services more accessible. "We often don't need a psychiatrist or any one like that - just someone to talk to. It's lonely and scary waiting". A buddy system would be a good approach.

People understand that crisis support is not always possible because of the geographical size of the Waikato but if a hub was available, some of that demand might be reduced and thus allow for a more consistent rapid-response when required.

Māori ask for a workforce that understands tikanga Māori, offer whānau based support and use kaupapa Māori interventions.

This would include the development of a community-based and, in some cases, less formal Māori workforce.

All those groups of our population that are most adversely affected (rangatahi, Māori men, men, the LGBTI community, older people, rural dwellers and some specific territorial authorities) want information and services that are targeted at them.

Follow up in the community after a person has been discharged from clinical services was one of the things that you felt would really help. "Being sent home is scary. I really wanted to go home but when it came to it, I was scared". This follow up could be by phone but it needs to be for a bit to make sure that things are going okay.

What we are currently doing
Translating our DHB value kotahitanga (stronger together) into action.

Health Hubs will continue to be held in communities that request them. We undertake to hold a health hub within three months of it being requested.

Working with some communities and community groups to support their local plans.

"When I first started in the industry in 1997, suicide was like a taboo subject – nobody wanted to talk about it…"
(Funeral director)

"Yet, I guess it will remain a very real issue in our communities and it needs to be able to have mature, honest open discussions about in a positive non-threatening way – I know it is not a positive topic but I think there are ways that we can have this conversation in a way that frames life and the complications of life and the experiences of life positively as there is still so much good stuff that is happening in our society…"
(school staff member)

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 2	Support communities to find our own solutions to suicide prevention				
ACTIONS	Development of local social support registers to ensure people know what help is available in their communities.	Work with clinical services to improve communications and follow up when someone has been discharged.	Develop culturally appropriate strategies for suicide prevention and explore the co-design of a whānau or marae champion training package such as Mana Akiaki/LifeKeepers (Le Va) Build social awareness and encourage well-informed social attitudes around suicidal behaviour in Māori communities.	Assist communities with reducing social isolation by working with identified community leaders and champions Identify and support young people at risk through their schools Reduce truancy	Support communities to develop circles of support and accountability for identified groups eg, people coming out of prison and mental health & addiction services.
LEAD AGENCY	Hauraki PHO	Waikato DHB	Hauraki PHO in partnership with our Māori providers	tbc	tbc
SUCCESS WILL BE MEASURED BY	Improved access to services Better informed communities	1. % 7 day post discharge follow up (given that transitions between services are at risk times) 2. % Recovery plans up to date (given that plans should define interventions that are appropriate) 3. DNA rates (given that not being seen is likely to increase risk).	Training package developed Number of Marae that have a trained champion	Number of communities with a plan/strategy for social inclusion Reduction in truancy	Number of communities with identified support for re-integration

4.3. Help us to help ourselves

Give us information and training so we can help ourselves, and give our health services information so they know how to help us.

What you told us

You said that people living rurally and in regional towns, older people and people in crisis did not know where to find support. You asked "tell us where there is help when we need it!"

People also want to know who is most at risk and what they can do. Because there has been a lot of media coverage about teenage suicide, people think that they are the only group affected. This is not the case for the Waikato. If they had more knowledge, people say that they can help too; it shouldn't just be the DHB.

Young people told us they need to know that they are a valued and trusted member of their community.

Communities already acknowledge the value of using standardized training rather than having all sorts of different options on offer.

What you want

Local role models with lived experiences positively sharing their story to their community.

Train people through sensitive and safe workshops about the signs of distress and what to do.

Helping people to find a strong cultural identity is important to a number of groups. Opportunities to link with kaumātua and kuia and discuss suicide prevention have been suggested as being helpful.

"Saturate" with wellness messages. Both the use of traditional methods and innovative methods were suggested. Tech tikanga is one but also using a variety of media (Facebook, blogs, performing arts, the back of buses) to show people where to get support if required.

Another community-based initiative is that of a "safe-place". A person could be given training and ongoing support in how to help someone who is distressed. This training might be much broader than suicide prevention and include a number of other social issues that can cause someone to think that there is little or no hope. The "safe-place" could have a sign denoting that there is a person available to help/listen or just be a buddy.

Set up youth groups. These are where meaningful and fun activities can take place and young people know that this is their place.

Train community members and they will train whānau.

Use Māori strengths - tikanga, forums for kōrero, Māori workforce, community willingness to tautoko, entrepreneurial spirit.

What we are currently doing

Translating our DHB value whakarongo (listen to me, talk to me) into action for all staff.

Continue to support WAVES groups.

Continue to support Safetalk, Lifekeepers for community members and a standardised training package for clinical staff.

Continue to hold health hubs where communities invite us to.

Working with others nationally to develop a wallet card with how to recognise signs of distress and numbers to ring.

"Is it mental health or mental illness?"
(DHB staff member)

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 3	Help us to help ourselves - Give us information and training so we can help ourselves, and give our health services information so they know how to help us.				
ACTIONS	Work with the Rainbow community to develop information for frontline staff to strengthen inclusive practice. Standardised training packages/ workshops for frontline staff or communities	Explore and potentially trial the 'safe place' idea with communities. Develop an allied communication strategy	Work with communities to encourage setting up youth groups and improve information about available youth services.	Working with national campaigns around suicide prevention to develop local media messages and saturation strategies.	Identify how to progress Waka Hourua for our area.
LEAD AGENCY	Waikato Queer Youth and Waikato DHB	Hauraki PHO	Hauraki PHO	Waikato DHB	tbc
SUCCESS WILL BE MEASURED BY	Develop a training package/communication strategy Number of frontline staff by agency who have been trained Number of workshops delivered	Number of 'safe places' identified Number of community awareness campaigns delivered	Number and location of youth groups set up Improved information on Youth services available	Number and location of local saturation strategies delivered	Plan developed and approved

4.4. We need to do things differently

We need to do things differently to stop suicides. So we need to look at what works and abandon what has not worked.

What you told us

Alcohol and other substances have been shown to be a factor in some suicides. It is important to ensure that the abuse of alcohol or the use of drugs which have been shown to increase psychosis is picked up early so that interventions can be offered.

There is lots of research that social connection is really worthwhile. Even within towns, isolation is quite common and, of course, out in the rural locations, it is also a factor for people feeling distressed or depressed. We need to find good ways to connect.

Although there are many similarities between urban and rural health, there are also many differences. Understanding these differences in relation to suicide prevention and emotional wellness is vital in order to be able to address them.

But also from the rural dwellers point of view, being able to say "what could I do to develop ways in myself to cope and if I am not coping, what am I going to do about it. Am I going to recognise it?

What you want

New Zealand has a history for internationally renowned longitudinal studies. We have to use that information to help us learn what can help people. Often those things that can help are based on strengths rather than trying to address issues. A couple of examples of strengths are that we have a strong ability to get things done through resourcefulness and Māori can have very strong whānau based connections. Use these strengths.

One of the things that has also been clear is that we have to address the issue of men and so ensure that our suicide prevention messages are well-targeted at a male audience.

For services to work together to ensure that the person can be supported in a comfortable place - rather than trying to find help.

Raise awareness that use of drugs and alcohol will affect mood and can cause worse depression.

Strengthen the relationships between primary and secondary mental health services.

There needs to be a programme that encourages people to seek help before suicide becomes a thought. More emphasis on free and easily accessible counselling services.

Raise awareness that no matter how many times people threaten, it still needs to be taken very seriously as previous self-harm does increase likelihood of suicide.

Raise importance of being engaged with primary care. A GP is usually the first point of call for threats to wellbeing.

Funerals are a key risk time for families and the wider circle of friends. It would have been good to have brochures with information about suicide associated grief and where support is available.

Develop pathways and models that work for the most affected. These include Māori men, rangatahi, and people impacted by mental illness.

Support community workers - not necessarily qualified social workers but those who can provide early intervention.

What we are currently doing

Translating our DHB value whakapakari (growing the good) into action.

Developing Map of Medicine pathway for suicidal presentations at GPs.

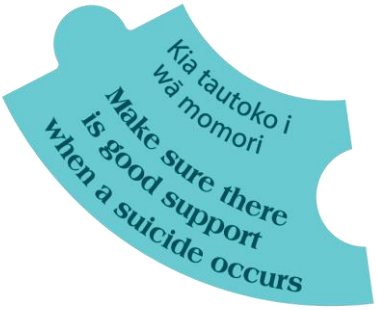
Providing free counselling sessions via GPs.

Ensuring Funeral Directors can provide information about assistance available for the bereaved.

Holding rural wellness days where health literacy is discussed, and health checks (physical and emotional) are done (Health Hubs).

What we and our partners in other sectors are going to do over the next 3 years

OBJECTIVE 4 We need to do things differently - so we need to look at what works and abandon what has not worked.								
ACTIONS	Implement the quality improvement measures of the zero suicide framework to close gaps in provision of service and transition of care.	Share generic profiles of those at risk so all agencies are aware of triggers, risk factors and actions if someone at risk presents to front line staff	Focus on men. Develop community options that men feel comfortable to use Annual primary care assessment and green prescriptions available to men on long term job seekers benefit	Participate in the ACC Pilot to reduce suicide attempts and repeat deliberate self-harm injuries.	Support all agencies/organ-isations to adopt the principles of whānau ora in their response to those at risk of suicide Annual multi-agency suicide prevention forum to share progress and ideas	Multi-agency suicide prevention community action plans for each community	Co-design preventative initiative with rangatahi with defined evaluation measures	By locality, connect with industry groups to identify gaps in suicide prevention Work in partnership to develop initiatives to close gaps
LEAD AGENCY	Waikato DHB	Waikato DHB	Hauraki PHO	Waikato DHB/ACC	Waikato DHB	Communities as identified	Rangatahi group with Waikato DHB	Waikato DHB
SUCCESS WILL BE MEASURED BY	Implement clinically-based systems' improvements.	Number and type of agencies who are aware of risk factors	Number of new men's initiatives by locality/type Annual increase green pres. to male long term job seekers by locality	Reduced attempted suicide/deliberate self harm presentations to Waikato Hospital ED	One forum per year	Number and names of communities where a plan has been developed	Implementation of initiative Evaluation of initiative	Gaps and initiatives documented by industry and location



4.5. Make sure there is good support when a suicide occurs

What you told us

We don't know what happens when there is a suicide in our community. We don't know who is involved or how to get help afterwards.

Families/whānau particularly with rangatahi are really vulnerable at this time. How do we help them?

How can we be sure the right people are involved when they need to be?

What you want

When a suicide happens, the right people know so they can support people and the community.

Make sure the affected people are supported so it doesn't happen again.

Make sure that all the organisations involved are co-ordinated and know what the others are doing.

What we are currently doing

Translating our DHB values Te iwi Ngakaunui (people at heart) and Kotahitanga (stronger together) into action.

We all know that the information that a person has died of suspected suicide is very sensitive information. The Chief Coroner has permitted the release of the name so that a small group of people in each DHB can support the bereaved and those close to the person who has died. Our small group is called the Postvention Action Team. When we learn of a death, the group is informed so that support can be offered as soon as possible to family, friends and workmates.

This is usually offered by Victim Support but another agency will take over if they already know the bereaved.

Free bereavement counselling or psychological services is offered through GPs or a social agency.

When there is a suicide Waikato DHB works with the Community Postvention Response Service to identify communities where there is risk of contagion and work with the relevant local personnel as part of the postvention process.

Relationships with the Postvention Action Team members and stakeholders are managed to ensure effective interactions and participation.

Postvention processes and outcomes are continually monitored and updated to ensure they are working so that the bereaved are offered support in a timely and appropriate way.

Support is provided to communities experiencing suicide clusters[2] or suicide contagion.

We invite community members from our most vulnerable areas to work with our Postvention Action Team. This way we can all have a deeper understanding of communities; the effects for a community when a suicide occurs and how we can best support that community in the short, medium and longer term.

Wallet cards that can be given to the bereaved family by Victim Support or the Police have been developed. These cards give information about counselling (funded by the DHB) or other forms of no-charge bereavement support (such as the WAVES suicide-bereavement courses).

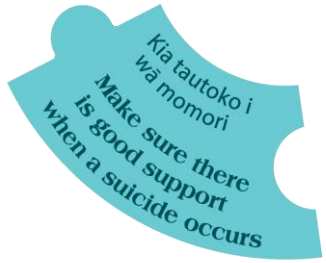
We regularly review our postvention response to learn what could be done better so that the whānau, and wider community is supported.

"To see a man you love more than life itself, crumble and break down and finally let it all out is the most heart breaking and humbling thing you can imagine."

(wife of a man whose father died of suicide)

[2] A suicide cluster is when multiple suicides or suicide attempts, or both, occur closer together in time, geography, or through social connections, than would normally be expected for a given community

What we and our partners in other sectors are going to do over the next 3 years



OBJECTIVE 5 Make sure there is good support when a suicide occurs.

ACTIONS	Implement the remaining recommendations that came from research about supporting grief commissioned by the Waikato DHB.	Liaise with other DHBs to review their postvention responses so we can all learn from each other.	Work with community groups and kaupapa Māori organisations to learn what will be most appropriate to support whānau and friends through suicide-related grief.	Establishment of a bereaved whānau support network	Development of locality-based acute postvention support groups	Support training workshops for staff of social agencies on how to talk to people who have been bereaved.
LEAD AGENCY	Waikato DHB	Waikato DHB	Hauraki PHO	Commissioned whānau member (Waikato DHB)	Waikato DHB	tbc
SUCCESS WILL BE MEASURED BY	Bereavement approaches used are supported by best practice	Postvention responses are informed by other DHBs approaches	Post suicide support for whānau and friends is appropriate	Implementation of a sustainable bereaved whānau network	Number and location of acute postvention support groups	Number and location of workshops

4.6. Ensure a focus on identified at-risk groups

Our statistics tell us that those most at risk in the Waikato DHB area are:

- young Māori, in particular young Māori men
- people living in the most deprived rural areas
- men generally
- people 65 years and older
- people who have made a previous suicide attempt.
- people experiencing mental health and/or addiction issues or significant life stressors
- lesbian, gay, bi-sexual, transgender, transsexual and intersex people

The previous section outlines what we and our partners will be doing over the next three years. In all actions the above at risk groups will be prioritised and we will continue to focus our resources on these groups.

"When it isn't someone we are working with, we immediately question our deficiencies as a service. How come we didn't know of this person? How come people aren't coming in for help? What more can we do as an agency and as individuals? These are all questions that are often, frustratingly, unanswered."

(Social service agency manager)

"[after a death] trust me the years don't make it any easier. All I can hope is that my love for him and my support helps him, just that little bit."

(wife of a man whose father died of suicide)

5. Roadmap

Zero suicides

Waikato Suicide Prevention and Postvention plan 2018-21

Guided by:

- Intersectoral Governance Group
- Suicide Prevention and Postvention Health Advisory Group
- Consumer Group
- Consumer Council
- Evidence-base
- International and New Zealand-based literature

Using:

- Co-designed new initiatives
- Strong links with agencies, organisations and people working within communities
- Well validated training tools
- Safe, caring and inclusive approaches

Actions 2018/19

- Improved communications and follow up following discharge from Waikato DHB facilities
- Share generic profiles of those most at risk so all working with vulnerable people are informed about the main risk factors
- Explore opportunities to reduce repeat deliberate self-harm
- Establishment of bereaved whānau support network
- Strengthened community-based postvention response (learning from other DHBs)

2019/20

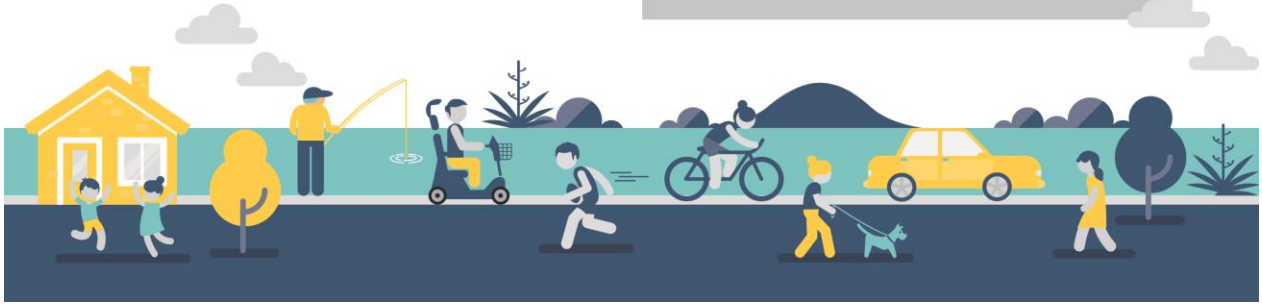
- Identify best practice standardised training modules for various different audiences and provide training
- Programmes to destigmatise suicide/seeking support
- Connect with industry groups to identify gaps in suicide prevention/enhancing wellbeing
- Collaborate to support most at-risk youth
- Community development of circles of support for people during risky transition periods
- Work with Rainbow community to increase inclusive practice by frontline staff
- Reduction of social isolation in older people
- Culturally appropriate postvention support

2020/21

- Development of culturally appropriate suicide prevention strategies include co-design of model of whānau or marae champions
- Development of local social support registers
- Work with organisations to increase cultural competency
- Support workshops for parents
- Trial a "safe place" within a community
- Strengthen communication strategies for communities to be informed about their local health and wellbeing services
- Develop community options that are in places where men feel comfortable and engaged
- Offer of an annual primary care assessment for all men on long term job seekers benefit
- National messaging campaigns

Ongoing

- Hold an annual forum to support agencies to adopt the principles of whānau ora in their response to risk of suicide; to share progress and ideas around suicide prevention
- Support suicide prevention action plans developed and driven by local communities
- Support Waka Hourua suicide prevention initiatives
- Use evidence-base to identify most at risk groups and ensure that all prevention work is appropriate or adapted to those groups of our population



6. Conclusion

Suicide is a catastrophic issue and affects us all, whether directly or indirectly. Waikato DHB and our partners are determined to make a difference to our suicide rate.

This plan represents our commitment to the inclusion of our communities and partner agencies in a zero suicide aspiration. It reflects the voices of the people and communities we have engaged and the joint planning and responsibility for outcomes.

While the plan does not have timeframes as such we will review actions annually and will be transparent in our progress.

We acknowledge and gratefully thank the people who took the time to speak with us.

"We also question ourselves, did we miss some indication? Could we have prevented this?"

(GP clinic staff member)

"it's hard to believe that that person is gone."

(Funeral director)

"Everyone has their ways of dealing with it. Some don't deal with it at all. The cumulative stress/trauma builds up over time and you have to find ways of dealing with it, take regular breaks and spend time with family and friends who are not in emergency services."

(Police officer)

"We had no idea at all that there was anything wrong, he was the class clown, he made everybody laugh and he was always smiling and out socialising with his friends."

(sister)

Appendix A National Suicide Information

National suicide data[3] (please note this information is still provisional) for the period 1 July 2016 and 30 June 2017 shows:

- A total of 606 people died by suicide in New Zealand. This is a rate of 12.64 suicides per 100,000 population), which is 27.4 percent below the highest recorded rate in 1998
- New Zealand's suicide rate for both males and females is slightly above the median for the OECD countries.
- The male rate was 19.36 per 100,000 and the female rate was 6.12 per 100,000 of the population.
- The national rates for men 40 to 44 years were the highest at 33.90, followed by men 85 years and over (33.67 per 100,000 population) and men between 20 and 24 years old.
- The rate for Māori was 21.73 (all stated as a standardised rate per 100,000 people) whereas the rates for Asian were 5.73, 9.15 for Pasifika and 14.66 for European and other.

The Ministry of Health[4] state that:

- There were also over 7200 hospitalisations (including short-stay Emergency Department events[5]) for intentional self-harm injuries in New Zealand in 2013

[3] Coronial Services of New Zealand (2018). Annual suicides. Retrieved on August 24, 2018 from https://coronialservices.justice.govt.nz/assets/Documents/Publications/2017-2018-Annual-Provisional-Suicide-Statistics-Final.pdf

[4] Ministry of Health. 2016. Suicide Facts: Deaths and intentional self-harm hospitalisations: 2013. Wellington: Ministry of Health

[5] Not comparable with previous years' data as this is the first time the data includes Emergency Department short stays

Appendix B The Waikato District Health Board area

Waikato DHB serves an estimated population of 390,700 (usually resident in 2015) and covers 21,220 square kilometres across ten Territorial Local Authorities (TLA). Waikato DHB covers almost eight percent of New Zealand's population, from Northern Coromandel to close to Mt Ruapehu in the south, and from Raglan on the West Coast to Waihi on the East. It takes in the city of Hamilton and towns such as Thames, Huntly, Cambridge, Te Awamutu, Matamata, Morrinsville, Ngaruawahia, Te Kuiti, Tokoroa and Taumarunui. It extends north to Meremere. Sixty percent of our population live outside Hamilton city.

We have a larger proportion of people living in areas of high deprivation than NZ as a whole. More than half of the South Waikato (64%), Ruapehu (58%) and Hauraki (53%) populations are living in the most deprived NZ Dep quintile. While our population is getting proportionately older (the 65-plus age group is projected to increase from 15% in 2015 to 22 percent by 2033), the proportion of our population aged less than 25 years (slightly higher than NZ as a whole) is projected to remain relatively static.

The Māori population (around 23 percent of our population in 2015) is growing at a slightly faster rate than other population groups and is estimated to be 26 percent by 2033. Pacific people represent around 3 percent of our population, and Asian 8 percent.

For those identified as Māori, Pacific and Asian, the population is projected to increase in all age groups from 2015-2033. By 2033, three in five children aged 0-14 years in the Waikato DHB area are likely to be Māori, Pacific or Asian.

Note: Demographic information sourced from the document Health Needs Assessment – Waikato District Health Board Mental Health and Addiction Service Utilisation, National Institute of Demographic and Economic Analysis, University of Waikato, March 2017

Appendix C Engagement Report

[separate attachment]

Appendix D Governance structure

Role	Role Definition	Membership
Monitoring	Ministry of Health will monitor specific activities via quarterly and annual reporting	Ministry of Health
	Suicide Prevention Postvention Health Advisory Group will monitor actions in the action plan via 6 weekly meetings.	Senior DHB managers/clinicians from Strategy & Funding, Te Puna Oranga, Population Health, Mental Health & Addictions, Emergency Department along with Primary Care.
	Quality & Patient Safety will provide oversight of the Suicide Prevention Postvention Coordinator	Executive Director Quality and Patient Safety
Governance	Provides guidance and direction to the Suicide Prevention Postvention Coordinator who provides governance with information and needs of the Suicide Prevention Postvention Health Advisory Group, communities and stakeholders and people in need	Intersect Waikato - Senior managers from Government Agencies in the Waikato
		CPHAC - Waikato DHB Board members
Suicide Prevention and Postvention Coordinator	Uses the plan as their direction for activity and provides co-ordination, facilitation and information and responds to the needs of communities and stakeholders and people in need	Suicide Prevention and Postvention Coordinator
Suicide Prevention Post-vention Health Advisory Group	Advises the Suicide Prevention Postvention Coordinator and approves areas of focus and activity. Reports to the Health Strategy Committee	
Communities and Stake-holders	To be kept informed of activities that are occurring. To provide specialist knowledge as required	Clinical Advisory Services Aotearoa, Police, Education, Corrections, Victim Support and others as required
People in need	Any person or group who identifies themselves or is identified through other means as being at risk of suicide, attempted suicide or self-harm.	Anyone

Appendix E Achievements 2014-17

Establishment of the Suicide Prevention and Postvention (SPP) Coordinator position
The role of the coordinator is to carry out and/or coordinate the actions set out in the SPP plan. The position is based in Quality and Patient Safety at the Waikato Hospital campus. As well as data collection, the role is largely about relationships and ensuring that all the prioritised subgroups of our population are actively engaged. The coordinator has had the benefit of working with a wide range of community agencies, service providers and individuals.

Collaboration
In particular, a good working relationship exists with the following organisations external to the DHB:

Accident Compensation Corporation
Age Concern
Centre 401
Clinical Advisory Services Aotearoa (CASA)
Department of Corrections
Hamilton City Council
Hamilton Coronial Services
Huntly Rangatahi forum
Kainga Aroha, Te Awamutu
Kokiri Trust
LeVa
Lifeline
Ministry of Education
Ministry of Health
Ministry of Social Development
NZ Police
Oranga Tamariki
Otorohanga Support House
Progress to Health
Rauawaawaa Kaumātua Trust
Raukawa Trust, Tokoroa
Riders Against Teenage Suicide
Rural Health Alliance of Aotearoa New Zealand
Rural Support Trust
SPARX, University of Auckland
StayWell (wellness checks for the rural communities)
Te Kuiti Community House
Te Rau Matatini
Tokoroa Council of Social Services
University of Waikato Health Services
Victim Support
Waikato Queer Youth
Waikato District Council – Youth Engagement Advisor

DHB Suicide Prevention and Postvention Coordinators teleconference monthly to share ideas, provide updates, and identify issues.

Webpage
A series of webpages have been developed and available since the middle of 2016. In accordance with the importance placed on suicide prevention and postvention by the Waikato DHB, the SPP webpages can be accessed directly through the front page on the Waikato District Health Board website http://www.waikatodhb.health.nz/ or https://www.waikatodhb.health.nz/your-health/wellbeing-in-the-waikato/suicide-prevention/

Postvention
Early notifications
The process of receiving the early notifications following a suspected suicide has been in place since 2014 with the Medical Officer of Health being the nominated senior staff member to receive the alerts. The process ensures that key agencies and hospital departments are informed of the death.

Following a workshop of stakeholders in March 2016, it was recognised that several improvements could be made. These included informing Victim Support Bereavement Team directly, giving the general practitioner of the deceased the offer of emotional support and having a more formalised process of notifying key agencies and departments.

The consequence of this last improvement was the establishment of a subgroup of the SPPHAG, the Postvention Action Group in April 2016.
The members of the Postvention Action Group are:

- NZ Police, Injury Prevention
- NZ Police, Coronial Officer
- Ministry of Education, Manager Traumatic Incident
- Team Practice Leader, Oranga Tamariki
- Senior administrator, Mental Health and Addictions Service
- Bereavement specialist, Victim Support Bereavement Team
- SPP coordinator

The Medical Officers of Health and the Team Leader of the Waikato DHB's Clinical Records Department are also advised when a death has occurred.

Quarterly meetings are held to ensure that the postvention process is working for all members and that the bereaved are being offered timely and appropriate support. If there are any identified barriers, these are addressed.

Further refinements continue including that the PHO with whom the deceased's GP is affiliated, is now routinely informed of the death to assist with support to the practice.

Grief support
The SPPHAG has been explicit in its intent to ensure that families bereaved by suicide, will be offered grief support rather than having to seek it for themselves. In order to achieve this:

- a discrete fund is available for bereavement counselling. All primary care practices and funeral directors within the Waikato DHB area are now informed of the availability of the fund for counselling or psychological services.
- two WAVES facilitator training courses were co-funded by the DHB– one in Hamilton and one in South Waikato. A total of 18 facilitators have been trained in running a closed suicide bereavement support group.
- the webpage has information about what support is available after a death.
- research was commissioned to research four areas specifically around supporting grief. This research was undertaken to determine what would be appropriate and

sustainable to ensure that people bereaved by suicide in the Waikato DHB are supported through the grieving process. Several recommendations have already been implemented and further recommendations are being considered.

Ongoing review of postvention support

The postvention process is reviewed on an ongoing basis to see what quality improvements can be made to ensure that the people most affected and also those potentially affected are given support that is timely and appropriate. Clinical Advisory Services Aotearoa (CASA) is the intermediary for the notifications from the Ministry of Justice. The Clinical Advisor of CASA is consulted when there are any possible concerns that one person's death might be connected to another death within a community.

If the SPP coordinator learns that another DHB's residents might have been close to the deceased, CASA is informed so that they can send the notification to the relevant DHB.

The Waikato DHB employs over 6,500 staff throughout the area. Of course, all these people have their own lives and situations and sometimes our staff are affected by suicide. The SPPHAG have developed a flowchart which can be used as a guide in the event of the suicide of a DHB staff member or their family member.