Taranaki Suicide Prevention and Postvention Action Plan 2015-2017

Action Plan Contributors

❋ Taranaki DHB ❋ NZ Police ❋ MOE Special Education ❋ Youth Justice ❋ Corrections ❋ Justice ❋ Ministry of Social Development ❋ Tui Ora Limited ❋ Ngati Ruanui Health Services ❋ Suicide Prevention Taranaki ❋ New Plymouth Injury Safe ❋

Supporting families/whānau, hapū, iwi, communities and individuals to prevent suicide, and reduce the impact of suicide.

Messages from the Advisory Group

"We are striving for a system and structures that are integrated and ensure that we as a community do everything we can to help, prevent and support."

"We have a responsibility to hold the hope of the community."

"Recovering families hope their stories can make a difference to others."

"Let's not be scared to talk about suicide."

"History is the best predictor for the future – we need to better make use of what we already know."

"We want to make sure everyone in Taranaki knows about the impact of suicide and the means to prevent it."

"Let's talk about wellness, community, whānau and building resiliance."

"A ground-swell in the community is a key part of the solution."

"We need to listen to people's stories – they are an invaluable part of the healing process."

"What you do not know does not affect you until you feel it."

"We must konohi ki te kanohi with the whole whānau and not just the service user".

"Everyone affected by suicide deserves the services and supports they need when they need it and for as long as they need it."

"There is always something you can do to help."

"We need a tikanga Māori whānau ora approach to building wellbeing."

Introduction

Suicide is a public health issue in New Zealand, and whilst it is difficult to compare figures across countries without understanding the specific societal circumstances, the data does reveal than suicides in New Zealand are higher. At a total level, New Zealand sits in the middle of the range, however for youth suicides in 2011; New Zealand was the second highest in the world. A person's decision to self-harm or attempt suicide can be influenced and impacted by many factors.

The prevention of self-harm, suicide and support after a suicide completion requires a whole of community response. Many factors influence a person's decision to attempt suicide. Research does however reveal that the presence of some factors can act as a catalyst to someone attempting suicide. These factors include mental health issues, exposure to trauma, a lack of social support and connectedness, and experiencing stressful life events (e.g., chronic pain, discrimination, bullying, relationship conflict, job or financial loss, work related stress and rural communities).

Suicide prevention initiatives seek to promote protective factors and reduce risk factors for suicide, and improve the services available for people in distress.

Suicide postvention initiatives seek to provide support for persons affected by suicide that can help the healing process.

The intent of this Plan is to offer those protective factors for those at risk of, or who have been affected by suicide or a suicide attempt, but more so to develop and implement solutions that can support wellbeing, improve social connectedness and build both personal, whānau and community resilience to challenging and difficult life events.

During the development of the Plan it became evident of the importance of having robust Governance Structures in place which are supported by Clinical Leadership. It was also clearly identified that having a suicide prevention coordination role is pivotal to the implementation of the Plan.

Suicide prevention and postvention is everyone's business and we could not have developed such a comprehensive plan without the commitment of other agencies, organisations and community interest groups. This holds the Plan in a place that will ensure cross sector buy-in with the Taranaki DHB acting as the lead agency.

The content of this Plan has been developed with input from the Advisory Group and results of a services stocktake and questionnaire sent out to the agencies, organisations and the community.

New Zealand Suicide Prevention Strategy 2006-2016

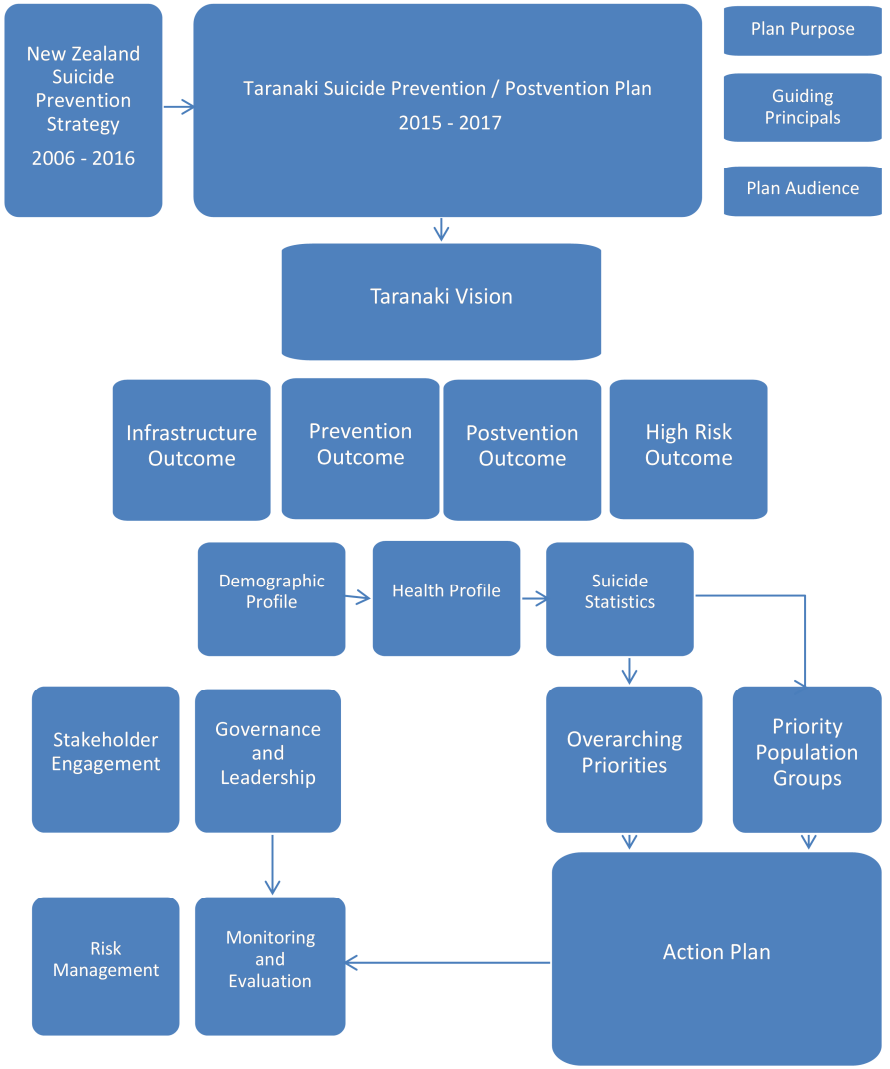
The aim of the Taranaki Suicide Prevention and Postvention Plan is to reduce the rate of suicidal behaviour and its effects on the lives of people in Taranaki. The Plan is aligned to the seven goals of the New Zealand Suicide Prevention Strategy 2006-16.

1. Promote mental health and well-being, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.

4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour by the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about the rates, causes and effective interventions.

Structure of Plan

The organisation of the Taranaki Suicide Prevention and Postvention Plan is shown in the diagram opposite:



Purpose of the Taranaki Suicide Prevention and Postvention Plan

Suicide Prevention and Postvention is a challenging and complex issue that requires a coordinated and sustained commitment across many agencies and at all levels of the community. The purpose of this this Plan is to demonstrate the commitment of Taranaki to work together to make a difference to lessen the attempts of suicide and to improve the support and services to those affected by a suicide or suicide attempt.

The Plan

- Establishes a suicide intervention model across the Taranaki area that enables communities to plan and respond to their needs.
- Builds on existing suicide prevention and postvention planning and activity.
- Strengthens and formalises relationships, systems and processes between agencies, services and communities to enable effective and efficient responses to suicide.
- Establishes multi-agency leadership, governance, information sharing and monitoring to ensure that resources are available and deployed to ensure that the Plan commitments are achieved.

Who is the Plan for?

This Plan is for Taranaki and applies to all people across all ages, their families/whānau, geographical community and community of interest.

The Plan is built from a strengths based approach, and recognises the inherent strength within individuals, families and whānau and community.

This is a Plan for professionals, a guide that can support them in their work to recognise the signs of suicide, and to work across disciplines and agencies to support those in need.

The Plan calls for a whole of community response to suicide prevention and postvention and asks families/whānau, communities and agencies to take responsibility for the issue of suicide.

Guiding Principles

The Plan has been developed in partnership with health, social service, education, community health providers and interest groups and is guided by the following principles. It is:

1. Informed by evidence and good practice.
2. Culturally appropriate and safe.
3. Respectful of diversity and difference.
4. Reflecting a coordinated and multi-sectoral approach.
5. Demonstrating sustainability and long-term commitment.
6. Promoting a community led response.
7. Action and outcome focused.
8. Committed to reducing inequalities.

Overarching Vision

The Taranaki Suicide Prevention and Postvention Advisory Group developed a Vision for the Action Plan as follows:

Taranaki will promote wellbeing to eliminate suicide

The vision is supported by four outcomes which align to the NZ Suicide Prevention Strategy.

1. **Infrastructure Outcome**: Agencies collaborate and are resourced to embed sustainable coordinated responses to support community wellness.
2. **Prevention Outcome**: Everyone in Taranaki is aware of the impact of suicide and knows how to access and navigate appropriate effective pathways for help.
3. **Postvention Outcome:** Everyone affected by suicide has access to the right help and support at the right time.
4. **High Risk Outcome:** Frontline staff are trained and mobilised to consistently, cohesively and appropriately recognise and respond to a suicide risk.

Demographics and Population Profile

Our Geography and Population

Taranaki DHB serves a population of 118,560 (2015/16 Projection – Statistics NZ) and covers a geographic area of 723,610 hectares. It stretches from Mokau River in the north to Waitotara River in the south.

Source: Ministry of Health.

Taranaki's population has been growing steadily over the past 20 years, and is projected to increase steadily into the future. New Plymouth remains the dominant population centre within the region. South Taranaki has the youngest population in the region and the largest number of Māori resident.

Taranaki's population is ageing, but at a slower rate than at the previous Census. The region currently has the sixth oldest age structure in New Zealand.

Table: Taranaki DHB population by age and ethnicity – 2015/16 Projection Statistics NZ

Age Group	Ethnicity		
	Māori	Other	Total
00 – 24	11,060	27,485	38,545
25 – 44	5,110	23,905	29,015
45 – 64	3,930	27,175	31,104
65 – 74	860	10,213	11,073
75+	475	8,348	8,823
Total	21,435	97,126	118,560

The population of the Taranaki region is somewhat less multi-ethnic than that of total New Zealand, with greater proportions of European and Māori (European, 75.8% compared with 64.9% nationally; Māori, 15.0% compared with 12.8% nationally, and smaller proportions of Pacific Island, Asian, Middle Eastern/Latin American/African (MELAA) and 'Not Elsewhere Included'. The region's Māori and Pasifika populations are markedly younger than the European demographic.

Table: Ethnic group (grouped total responses)Taranaki Region usually resident population count- 2013 Census[i]

Ethnicity	Total	% of total
European	89,802	86.2%
Māori	18,150	17.4%
Pacific Peoples	1,701	1.6%
Asian	3,594	3.5%
Middle Eastern/Latin American/African [2]	447	0.4%
Other Ethnicity [3]	2,112	2.0%

Health Profile

Having an understanding of the Taranaki health profile is an important part of decision making processes. Having this knowledge enables the region to understand where the focus should be to support making health gains, and can provide a context for the allocation of resources, as well as for planning and prioritisation of programmes at an operational level. Māori are adversely disadvantaged in health terms in the region.

- Around 43% of the Taranaki population live in NZDEP2013 Decile 6, 7 and 8 compared to 30% nationally. Non-Māori are over-represented in the wealthiest socio-economic decile and Māori are over-represented in the lowest socio-economic decile.
- Within Taranaki, 32% of Māori live in the most deprived 20% of areas compared to 14% of non-Māori. In contrast, 7% of Māori live in 20% of the most affluent areas compared to 16.3% of non-Māori.
- Māori in Taranaki experience a shorter life expectancy than non-Māori. Based on the 2011/12 HEALTH NEEDS ASSESSMENT[1], Māori females have a life expectancy of 75.5 years compared to 82.5 years for non-Māori, a difference of 6.9 years.
- Based on the 2011/12 HEALTH NEEDS ASSESSMENT Māori males have a life expectancy of 72.4 years compared to 79.0 years for non-Māori, a difference of 6.6 years. This difference is less than that for the general New Zealand population at 7.7 years for females and 7.9 years for males.

[1] Taranaki DHB's Whānau Ora Health Needs Assessment† (Ratima and Jenkins, 2012)

Suicide Statistics and At-risk Populations

What the Statistics Show

Suicide and suicidal behaviours are a major public health issue across New Zealand, with on average 500 people taking their lives, and 2,500 people being admitted to hospital because of intentional self-harm. The numbers of people completing a suicide averages at 12.2 deaths per 100,000 population. At a national level the highest levels of suicidal deaths occur amongst males, those aged 40-44 years and Māori. There is also a correlation between completed suicides and intentional self-harm within lower levels of deprivation.

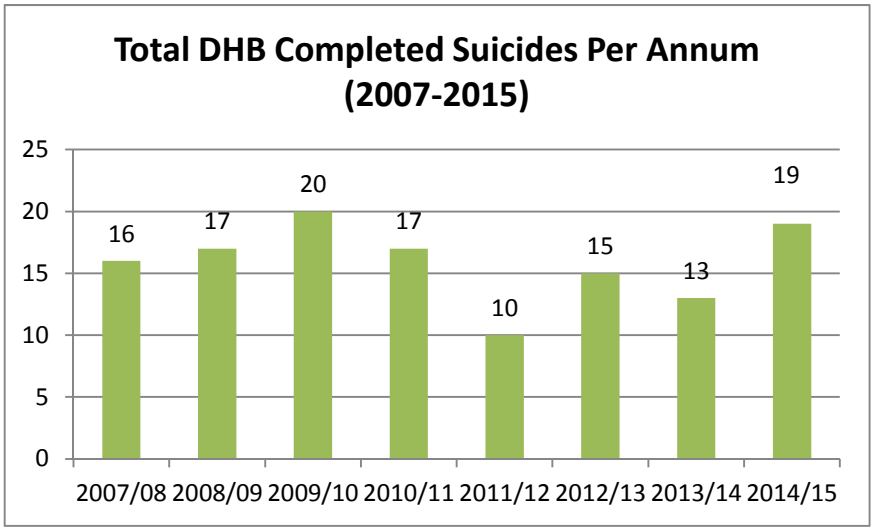
Completed Suicides

The suicide trends in Taranaki in part mirror the national picture; however they deviate in other areas.

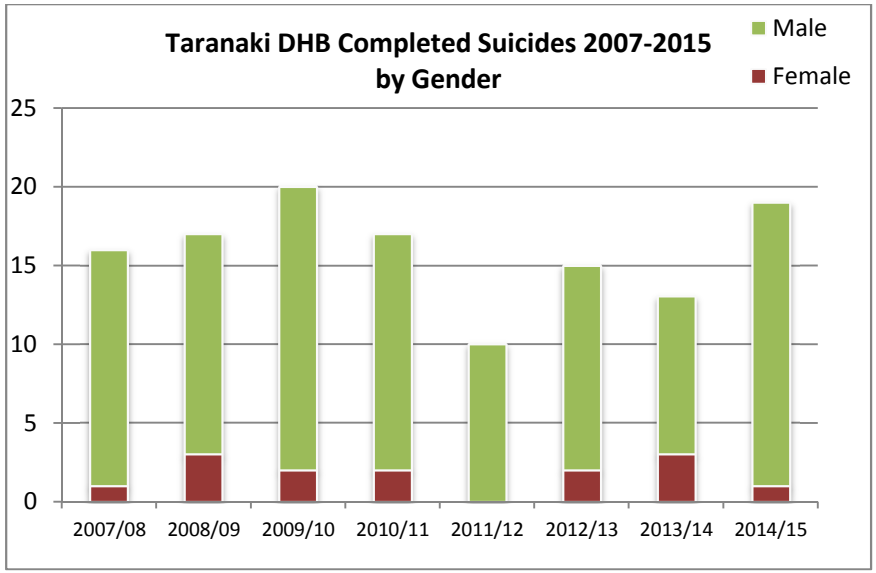
The Ministry of Health's Suicide Facts Report (2012) revealed that between 2008 and 2012 Taranaki had an average of 13.4 suicides per 100,000 population compared to a national average of 11.6 per 100,00 population. However, youth suicides were lower than the national average with 15.5 completed suicides compared to a national figure of 19.8 per 100,000 people[ii].

The Coroner's Office has provided information based on suicides in Taranaki from July 2007 to May 2015, almost eight full years. The information received for the 2014/15 year remains provisional, because the cases remain active.

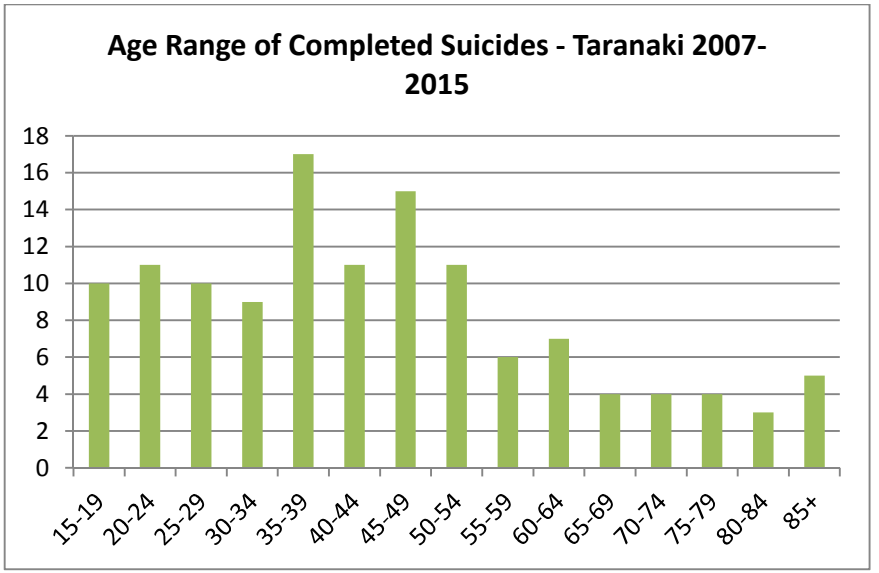
Between July 2007 and May 2015 there were 127 suicides in the Taranaki region, an average of 15.8 suicides per annum. The two years with the highest suicides was 2009/10 with 20, followed by the 11 months in the 2014/15 with 19. The years with the lowest numbers of suicides were 2011/12 with 10 and then 2013/14 with 13 suicides.



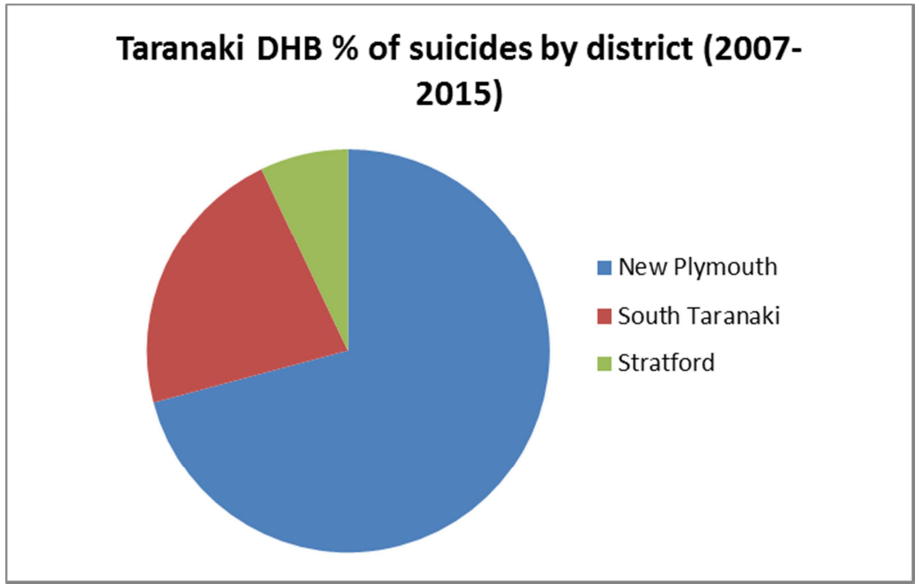
Of the 127 suicides 13 were female which means 90% of the completed suicides in Taranaki continue to be male.



The highest number of suicides fall within the 25-44 year age band, 46 (39% of the total) followed by those in the 45-65 year age band 39 (31% of the total). Within these two age groups female suicides are slightly higher at 13% of the total.

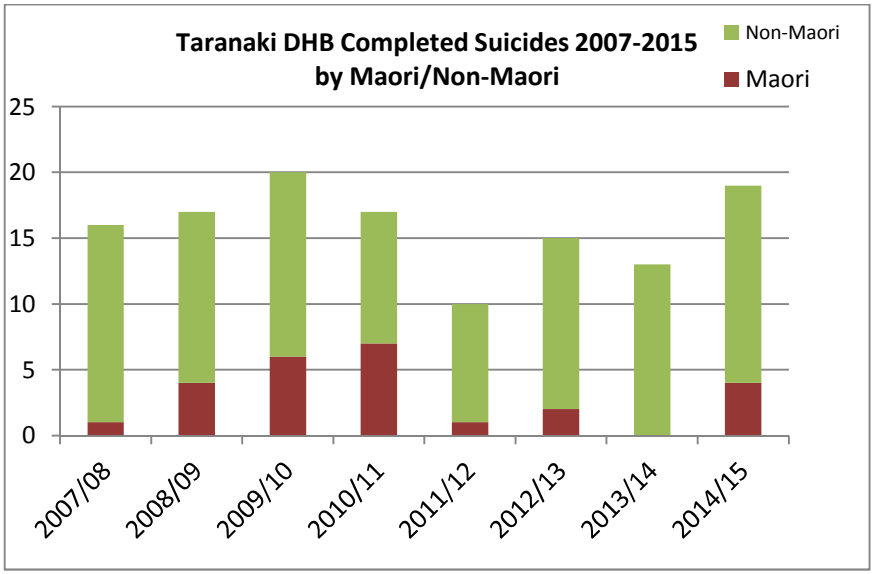


In comparing percentage of population by Territorial Local Authority (TLA), New Plymouth District is 68% of the total Taranaki population (2013 Census), Stratford 8% and South Taranaki 24%. The numbers of suicides by TLA are New Plymouth District 90, (71% of the total), Stratford District 9 (7% of the total) and South Taranaki District 28 (22% of the total). This shows the New Plymouth District (which is predominantly urban) is 3% higher as a proportion of the total suicides than the percentage of the overall population. This figure is in contrast to the national picture where completed suicides were greater per 100,000 population in rural areas.



Geographic Spread of Suicides in Taranaki in 2007-2014.

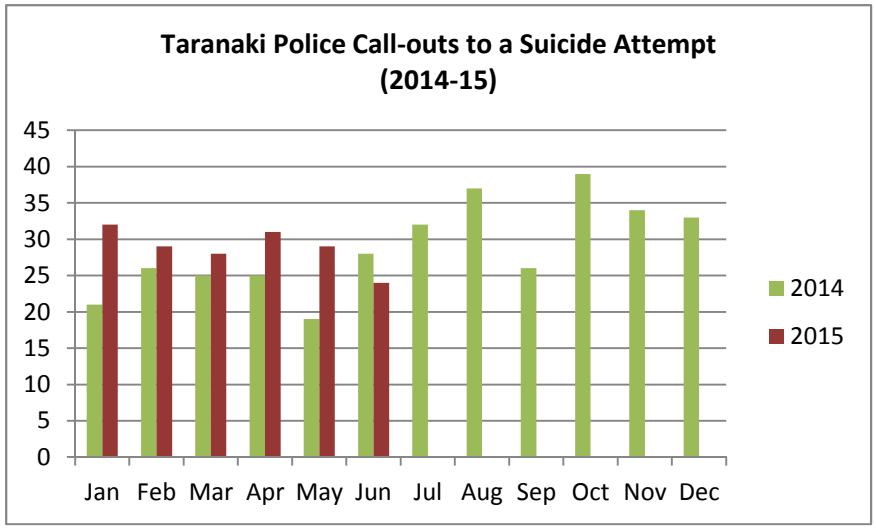
New Zealand Māori represented 19% of the suicides in Taranaki for the eight year period.



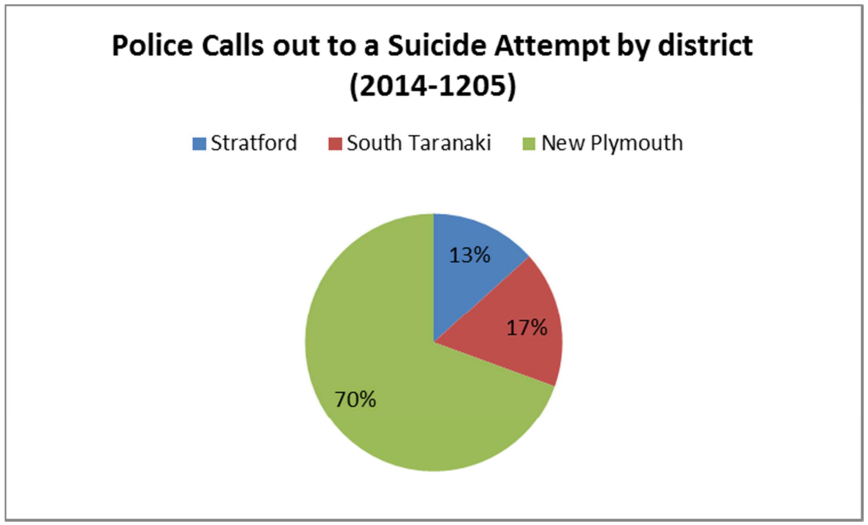
Suicide Attempts

Taranaki Police[iii] record the number of suicide attempts that Officers are called out to. When reading this section it is noted there are some limitations with how Police data is coded therefore there is a level of inaccuracy. The data also does not provide an indication of the severity of the attempt.

Between January 2014 and April 2015, Police attended 518 suicide attempts across the region between Mokau in the north and Patea in the south. Two hundred and fifty six of attempted suicides were recorded as female, 245 were recorded as male (there was no gender information for 17 of the call outs). This is a similar percentage for both genders.



The Police call out data is recorded against the attending Police station. The Taranaki Police area does not extend as far south as Waverley which forms part of the District Health Board and District Council boundary, so the numbers for South Taranaki may be marginally higher than shown below. The chart below does reveal a larger number of call outs per head of population in the Stratford District (Stratford represents 12% of the regional population, Census 2013), and a marginally higher number in the New Plymouth area (which represents 67% of the regional population, Census 2013.



Self-harm

In New Zealand in 2012 there were 3031 intentional self-harm hospitalisations. Two thirds of these were female, one third of which were from youth aged 15-24 years, and one fifth were by Māori. At a national level in 2012, there were 71 intentional self-harm hospitalisations per 100,000 population. In Taranaki we have the eighth lowest rate out of the 20 DHBs in this age group.

In Taranaki between 2010 and 2012 there were 78.3 intentional self-harm hospitalisations per 100,000 population, which is higher than the national rate of 71.0. When disaggregated by gender there were 99.7 occurrences per 100,000 of the female population.

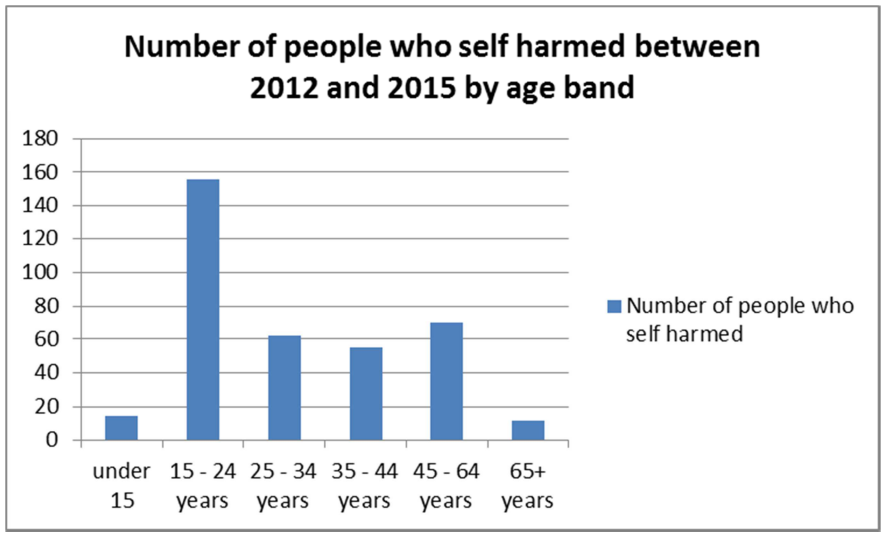
Between 2012 and 2015, Taranaki admitted 370 people for a total of 809 self-harm incidents. Two thirds of the total self-harm acts in this period occurred amongst females.

There was also a particularly high prevalence of repeated self-harming, with many people being admitted for three or more episodes in one year. The largest admission for repeated self-harming in one year was 18 times.

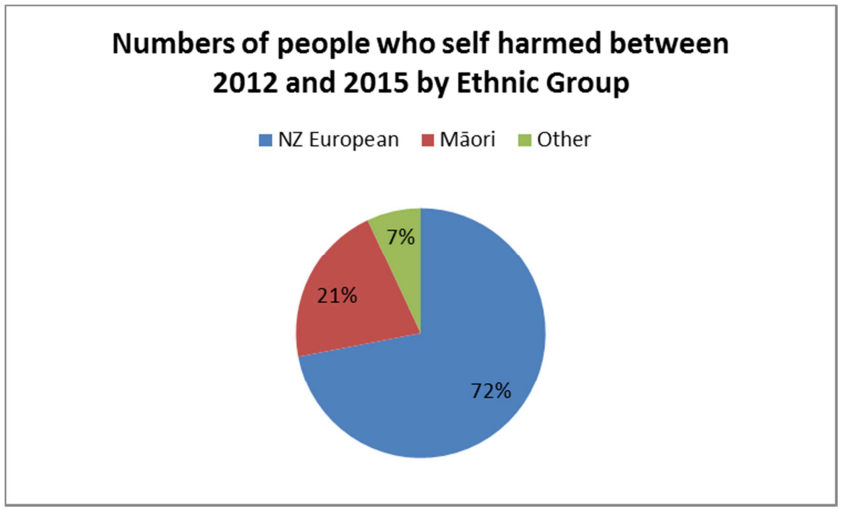
Count of Repeat Admissions by Female			Count of Repeat Admissions by Male		
No. of people	# Admissio	% of Total	No. Of people	# Admissions	% of Total
96	1	40%	71	1	54%
77	2	32%	37	2	28%
28	3	12%	11	3	8%
19	4	8%	5	4	4%
4	5	2%	0	5	0%
6	6	3%	3	6	2%
2	7	1%	2	7	2%
3	8	1%	0	8	0%
0	9	0%	1	9	1%
3	10 to 18	1%	1	10 to 18	1%
238			**132**		

The most common type of self-harm amongst females and males was intentional self-poisoning.

Of the 370 people who were admitted for self-harming, the youngest age was 11 years, and the oldest 85 years. The split according to age is shown below.



Māori were statistically over represented according to their overall population numbers in the region.



The data only tells a partial picture, as there will also be data and information held at a General Practitioner level and with schools. Within Taranaki there is a strong reason to believe that the rates of self-harming are high in particular with our young people.

Future Data Needs

The Advisory Group recognised the limitations with the current data, and has prioritised the need to improve surveillance systems and methods of data recording and sharing as part of their suicide prevention and postvention responses.

Stakeholder Engagement Process

Engagement Process

During June 2015, the Taranaki District Health Board facilitated a plan development process. Engagements took place in three main ways:

- Stakeholder stocktake research.
- Multi-agency engagement via four Advisory Group meetings.
- One-on-one / small group conversations.

The stocktake survey was sent to Taranaki agencies, organisations and iwi working within, or with an interest in the area of suicide prevention and postvention. This included stakeholders who deliver education, health and social services to individuals and communities. Kaupapa Māori health providers and support groups were actively engaged. Ten agencies provided information to support the population of the current service status. The stocktake survey also sought information about the actions and priorities that have informed the development of the Action Plan.

Four dedicated meetings were undertaken to support the development of the Plan identifying the key themes, priorities and action planning and the approach towards information. The meetings involved a wider group of representatives including the Taranaki District Health Board, Ministry of Justice, Ministry of Social Development, Child Youth and Families, Ministry of Education, New Zealand Police, Māori Health Providers, Suicide Prevention Taranaki, Corrections, New Plymouth Injury Safe, counsellors, Tui Ora and Ngati Ruanui Health.

In addition, a number of one-on-one engagements and smaller group conversations were undertaken to help gain an understanding of what work was currently occurring in suicide prevention and postvention. Insights were gathered from specialist and targeted providers working with youth, Māori, rural and men.

Current Status

As part of the process to develop the Taranaki Suicide Prevention and Postvention Plan, agencies and organisations were invited to provide information about their current suicide prevention and postvention activities. There was limited data received, indicating limited activity in this area. Responses were received from 11 individual organisations. A summary of the stated activities is detailed below. While the services provided do cover both some agency activity, NGO's and community interest groups, there is more work that will be done as part of implementation to understand how the services/programmes that are being delivered are resulting in positive outcomes to our communities.

Taranaki has a significant strength in supporting rural populations, in particular rural farming communities. The proactivity of community interest groups over recent years has resulted in a decline in suicides of Farmers.

Objective 1: Strengthen the infrastructure for suicide prevention.

a) Supporting access to subsidised or free training in suicide intervention for families.

b) Raising the profile of suicide as an issue in Taranaki.

c) Liaison and networking between service providers, understanding the gaps in service provision.

d) Reducing stigma and discrimination about mental illness and suicide.

e) Promoting training to up-skill the community (making sure people know what to say and do if they are around a suicidal person).

f) Helping the community to understand how to access and navigate their way through to the right services for them.

g) Website giving information about how to prevent suicide and guidance about services that are available. Provisions of a suicide prevention handbook.

Objective 2: Supporting families, whānau, hapū, iwi, and communities to prevent suicide.

a) Monthly Peer Support Group facilitated by a combination of counsellor, social worker and bereaved family member with facilitation training. Monthly Peer Support Group has speakers from Police, Lifeline, and Psychologist etc.

b) Supporting access subsidised or free training in suicide intervention for families.

c) Weekly visitation service for older people who are experiencing loneliness or isolation.

d) Fortnightly shopping service for older people to support the person to remain physically, emotionally and mentally engaged in their community.

e) Field Officers provide programmes and outings to aid social inclusion and minimise loneliness.

f) Providing relevant targeted expert support to farmers and rural communities.

g) Early intervention programme where coordinating meetings will support whānau/family through their mental health journey.

h) Crisis intervention for adults with mental health problems.

i) Counselling, education and information to persons at risk of suicide.

j) Website offering information and guidance about how to prevent suicide.

Objective 3: Supporting families, whānau, hapū, iwi, communities after a suicide.

a) Monthly Peer Support Group facilitated by a combination of counsellor, social worker and bereaved family member with facilitation training. Monthly Peer Support Group has speakers from Police, Lifeline, and Psychologist etc.

Objective 4: Improve services and support for people at high risk of suicide who are receiving government services.

a) Supporting access subsidised or free training in suicide intervention for families using services.

b) Supporting people with mental health or are affected by a person close to them experiencing mental health problems.

c) Weekly visitation service for older people who are experiencing loneliness or isolation.

Governance and Leadership

Integrating Clinical Leadership with Communities as Partners

Response to Suicide Prevention and Postvention is a whole of Taranaki response. Proposed partners to the Action Plan include, but are not limited to:

- Community
- Iwi
- Taranaki District Health Board
- Midlands Health Network
- Victim Support
- Rural Support Trust
- New Plymouth Injury Safe
- Suicide Prevention Taranaki
- Ministry of Social Development / Work and Income
- Ministry of Justice
- Ministry of Education
- Schools
- Tui Ora
- Ruanui Health
- Community Health and Social Services
- Territorial Local Authorities

What Needs to Happen?

The Suicide Prevention and Postvention Advisory Group has identified the need to develop an overarching governance structure to support Taranaki's approach to suicide prevention and postvention.

The Advisory Group explored a number of models that could work, and in the short term has resolved to continue with the current membership of the Suicide Prevention and Postvention Advisory Group during the early stages of Plan implementation.

There is a need for multi-agency, whānau and community centred governance/representative structure that can serve a number of functions.

- Clinical leadership
- Networking, peer support and information sharing
- Advocacy and education
- Plan implementation and monitoring
- Agency coordination and cooperation

The Advisory Group are continuing to explore whether there is a need for an independent governance structure i.e. a trust model, or whether the current collaboration is the most effective and efficient means of developing and implementing the plan. The interim structure is set out below.

Proposed Interim Governance Structure

Forward Plan

Overarching Priorities

The Suicide Prevention and Postvention Advisory Group have endeavoured to create an Action Plan that is future focused and innovative. In doing so, it has identified that a number of infrastructure changes and improvements need to take place that can facilitate improved interagency connection, support enhanced service delivery and build a workforce that is knowledgeable and responsive to the risks of suicidal and self-harm action.

The Action Plan provides a response and a commitment to support communities and individuals to be able to build their resilience and wellness. However, the region recognises that there is a strong need to provide support structures for those whose lives are touched by self-harm, a suicide attempt or a completed suicide.

Taranaki has identified that targeted and appropriate responses are needed for at risk groups and vulnerable populations. A 'one approach fits all' will not work, and there is a need for agencies to draw upon their strengths with particular population groups, and for broader services and support systems to provide individualised response programmes. The overarching priorities span each of the outcome/objective areas:

- The Taranaki community is a kaitiaki for suicide prevention and postvention support.
- Community wellbeing is promoted and supported.
- Leadership and commitment exists across Taranaki to prevent suicide attempts and support those after a suicide or suicide attempt.
- Families/whānau and communities have access to appropriate services and supports.
- Support for high risk groups and populations are culturally and socially appropriate, coordinated and available.
- Workforce development and education is actively promoted and delivered.
- Referral pathways are clear and service responses are efficient and effective.
- Mental illness and Suicide postvention is de-stigmatised, and suicide prevention is encouraged.
- Resources are coordinated to ensure effectiveness of outcomes.

Priority Populations

The suicide (completed and attempted) and self-harm statistics provide a picture of those groups and life stages which may increase a vulnerability to suicide, but the quantitative data collected by agencies only reveals some of the story. There are other intentional acts that may in fact have been a suicide, but it is difficult to know for sure, as the data does not tell the story. In order to develop a community response to suicide attempts and acts, the community needs to know the stories to understand the problem and get to the right solution. Within Taranaki, the Advisory Group who developed this Plan have drawn upon both the agency data and their expert knowledge to identify community groups in Taranaki, who are vulnerable, and who will be prioritised in the Plan.

- **Men (aged 25+ years).** Understanding the story (and the lack of knowing the story) from men is a concern to Taranaki. There is a need for Taranaki to reflect on the services and supports that are offered for men, because there is a belief amongst agencies that current systems and supports are not adequately helping men. There is a sense that there is less targeted support for this group than any other vulnerable cohort in Taranaki.
- **Rural Communities** (within the township versus rural workers i.e. farmers). Taranaki is an economy that is heavily reliant on dairying, and the rural communities are very vulnerable to the stressors that are connected to the economic environment.
- **Satellite Urban Town Areas**. There are a complex suite of community and economic stressors that are evident in the satellite towns, e.g. Patea, Opunake and Waitara. This includes a loss of community services, higher levels of poverty, sometimes lower levels of educational attainment and employment, higher rates of addictions and violence and a feeling on lesser wellbeing and connection.
- **Users of Specialist Mental Health Services**. Whilst most people who have a mental health condition do not die from a suicide, there is an increased risk of self-harm behaviours amongst these people. Early identification and response is an important mechanism to minimise the risk of an adverse event occurring.
- **Young People** (including rangatahi Māori) (Taranaki had the highest completed suicide rate amongst youth in New Zealand in 2012). Whilst youth are not the highest suicide group in Taranaki, there are other features and considerations that make youth a priority group for Taranaki. This includes the Plan's focus to build wellness and resilience and the high rates of self-harming.
- **Māori.** Whilst the rates of Māori suicide are commensurate with the overall rates at a national level, the priority for Taranaki is to raise awareness in the Māori community and to ensure that the programmes are culturally appropriate and relevant and accessible to Māori.
- **Elderly Persons**. Taranaki has an ageing community and sixth fastest ageing community. When the ageing of the community is compounded with rurality, potential loneliness and isolation of elderly people makes them a priority population group within the region.

Early Intervention and Prevention Priorities

The early intervention and prevention priorities include:

1. Early identification of at risk behaviours and signs.
2. Multi-agency commitment to screening, and sharing information, and providing a 'one plan' support response.
3. Targeted programmes for priority population groups.
4. Building community knowledge, education and support systems.

Suicide Postvention

The suicide postvention priorities include:

1. The development of multi-agency postvention support plans for those whose lives have been touched by suicide or a suicide attempt.
2. Building community knowledge and awareness of suicide and removing the stigma around suicide and mental illness.
3. Growing understanding about the recovery and healing pathways and the time involved.
4. Reducing the potential for contagion.

Agency Integration and Coordination

The integration and coordination priorities include:

1. The employment of a dedicated suicide prevention and postvention coordinator.
2. Development of robust surveillance systems, information sharing and referral pathways.
3. Improving information availability and access to knowledge.
4. Coordinating efforts drawing on the strengths and expertise of agencies and community

Workforce Training and Development

The workforce training and development priorities include:

1. Training more professionals who work with at risk and vulnerable groups to understand and recognise the suicide signs and the pathways for support.
2. Educating and training the community to understand and recognise the suicide signs and to know where to find and receive help.
3. Educating and training the wider workforce to understand and recognise the suicide signs and to know where to find and receive help.

Action Plan 2013-2016

The Suicide Prevention and Postvention Action Plan starts from the notion of supporting and growing wellness. The desired focus of effort is to invest in suicide prevention supports to minimise and reduce the rates of suicide. The Action Plan is premised on an assumption that there is a commitment amongst the key statutory partners to provide leadership and resources to deliver the desired change and that action will take place in partnership with the community. The Action Plan also assumes there will be a commitment amongst agencies to provide a dedicated resource to re-shape the region's response to suicide.

The Action Plan is organised according to the Government's four suicide prevention objectives, but addresses the objective relating to infrastructure first, because the infrastructure is the critical component that can support effective responses in the areas of suicide prevention, postvention and support for at risk groups.

Infrastructure Outcome: Agencies collaborate and are resourced to embed sustainable coordinated responses to support community wellness to eliminate suicide.					
Objective 1: Strengthen the infrastructure for suicide prevention					
Area of Activity	**Action**	**Milestones**	**Lead/Support**	**Expected Outcomes**	**Timeframe**
Coordination of Leadership	Taranaki leadership for suicide prevention and postvention will be established.	Commitment to appoint a Suicide Prevention and Postvention Coordinator. Appointment of Suicide Prevention and Postvention Coordinator. Suicide prevention and postvention governance structures are established.	Suicide Prevention and Postvention Advisory Group Taranaki District Health Board Taranaki District Health Board supported by Suicide Prevention and Postvention Advisory Group	Appointment of a Suicide Prevention and Postvention Coordinator. Governance structures are in place for Taranaki. Leadership commitment towards the delivery of the Prevention and Postvention Plan. Suicide Prevention Taranaki Group is maintained and supported.	December 2015

Postvention Coordination	Establishing the Coordinator role	Suicide postvention governance structure is established.	Taranaki DHB supported by other agencies	Relevant policies, procedures, MOU's are in place to respond in the event of a suicide.	March 2016
Communication and Community Education	A communication/community awareness and education strategy is developed.	Conduct an information audit: -what is in place -existing awareness and education campaigns -available information and resources Community engagement about information and education needs.	Suicide Prevention and Postvention Governance Group	Communication and community awareness strategy informed by community feedback and research is developed. Interagency commitment to deliver the priorities identified in the community awareness and education strategy. Community Education and Training Strategy provides a framework for low cost/free, accessible education appropriate to different needs. 500 community people in Taranaki are trained in suicide prevention/ awareness by 2017.	October 2016
Workforce Development and Training	A community Training and Education Strategy/Plan is developed - QPR training - MH101 - ASIST Training	Directory of available training is developed. Programme of training is developed for Taranaki. Training providers are identified, trained and resourced to deliver.	Suicide Prevention and Postvention Coordinator	Low cost/free training is available to professionals and in workplaces. 500 workplace individuals/ professionals are training in suicide prevention and postvention awareness.	June 2016
Information	An information portal /repository is developed detailing -supports and services - referral pathways - training and guidance	One page road map is developed (one page visual). One stop shop for information is developed.	Suicide Prevention and Postvention Coordinator	Information is accurate and comprehensive. Information is disseminated across the community. Information repository is used and reported as useful by both professionals and community.	June 2016

Primary Health Support Services.	There will be more access to counselling for those suffering mild to moderate Mental Health and depression.	A review of access to a broader range of services across the continuum will be undertaken. Activity identified on expanding resources to mild to moderate.	TDHB Planning and Funding and Midlands Health Network	Services are received and accessed promptly. Services are affordable/ free. There is reduced need for secondary health services.	June 2017
Early Intervention in Education	Work more closely with school communities to increase wellness and wellbeing and reduce the risk of self-harm and suicide.	Appointment of Consult Liaison Officers for Schools. CBT approaches for Schools are in place. Development of peer support networks. Continued roll out of CHEaADSSS assessment tool.[2]	Ministry of Education with Planning and Funding and Child and Adolescent Mental Health and Addictions Services	Multi-disciplinary support teams are available to all schools. Training and education is available to school professionals that enable them to identify at risk signs, to support wellbeing and to know how to access help. Education and awareness and support programmes are developed in all schools.	December 2016
Cluster Prevention	Development of a Contagion/ Cluster Response Team and strategy.	Work with CASA[3] to develop a contagion. Contagion Response Team is in place.	Taranaki District Health Board	Cluster/Contagion Response Team is in place. Cluster/contagion strategy is developed, known and understood in the professional community.	March 2017
Best Practice	Taranaki builds on and learns from good practice exemplars.	Best practice exemplars are identified. Research is conducted about global innovations and learning's.	Suicide Prevention and Postvention Coordinator	Learning and resources are shared across agencies and disciplines. Best practice is implemented across services and supports. Learning is shared across the community.	On-going

[2] CHEeADSSS – definition, Cultural, Home, Education, eating, Activities, Drugs, Sexuality, Suicide/Depression, Safety, Spirituality.
[3] Clinical Advisory Services Aotearoa

Service Coordination	Agencies and services are coordinated.	Road map is developed. Referral pathways are identified and communicated. Memorandums of Understanding are developed to cement cooperative working.	Suicide Prevention and Postvention Governance structures	Multi-disciplinary approach is in place. One support plan for each person and their whānau/family.	December 2016
Information and Surveillance	Information sharing strategy is developed.	Information audit is conducted. Data/knowledge gaps are identified. Protocols for information gathering and sharing are developed.	Suicide Prevention and Postvention Coordinator	Information collections and data sharing and consent protocols are established. Agencies share their data to inform improved understanding about suicide trends and behaviours in Taranaki.	March 2016
Performance Management	A results based accountability (RBA) evaluation framework is developed.	Population health outcomes are identified. Programme outcomes are identified. Plan agencies are RBA trained.	Taranaki District Health Board - Planning and Funding	RBA Framework in developed with clear measures, indicators, evaluation tools and methods of collection identified. All agencies who are signatory to the Plan provide data and information to support an assessment of impact and outcome.	December 2015

Prevention Outcome: Everyone in Taranaki is aware of the impact of suicide and knows how to access and navigate appropriate effective pathways for help.					
Objective 2: Support families/whānau, hapu, iwi, communities and individuals to prevent suicide.					
Area of Activity	**Action**	**Milestones**	**Lead/Support**	**Expected Outcomes**	**Timeframe**
Supporting Healthy People	Community health and wellness programmes are developed and	A community education	Suicide Prevention and Postvention	Systems exist to enable the community to be mobilised to offer	December 2016

and Healthy Communities	promoted.	training schedule is in place. Community mobilisation training is in place (rural and urban). Community education and awareness literature is developed. Directory of community services (and wellness programmes) is in place and accessible (refer to infrastructure outcome also). Current programmes are identified and future opportunities are developed.	Coordinator	help and provide support when needed and wanted. Support systems are age and culturally appropriate and relevant. Community wellness conversations take place throughout Taranaki. Communities are trained and aware. Learning and outcomes from training and embedded into practice, and reflections are going.	
Building Community Capacity and Capability	Communities and community action groups are supported to design their own solutions.	Support is given to identify and train community support people in suicide risk identification. Peer to peer support systems are developed and resourced.	Suicide Prevention and Postvention Coordinator (and community)	Establishments of community support teams: - Rural communities. - Population groups (Māori, men, youth). Peer support systems are set up - Men to support men. - Youth to educate youth. - Māori to support Māori.	March 2017
Awareness and Education	Community education and awareness campaigns are in place and delivered.	Refer to Infrastructure milestones.	Suicide Prevention and Postvention Coordinator	The community understands the suicide signs and triggers, and pathways for help are clearly understood. The profile of suicide is raised. The impact of suicide is understood. Education and means of messaging is	Ongoing

				appropriate to audience i.e. social media. Taranaki is a trained and suicide aware community.	
Youth Support	Resilience and wellbeing in youth is promoted and supported.	Multi-agency commitment to a one plan approach for youth. Reducing stigma and discrimination towards mental illness. A one plan template/ framework is developed. Schools are supported to develop peer to peer 'spotters' programme. Treatment providers work in partnership with schools (and whānau) to share information and support responsibilities. (Refer to infrastructure outcome also).	Ministry of Education with Child and Adolescent Mental Health	Consult liaison capacity is increased for schools. Educators (including Resource Teachers and Learning Behaviour specialists) are trained and supported. Conversations about mental wellbeing are normalised to improve likelihood of seeking help. Resilience is built in primary school children via appropriate curriculum and community education programmes. Peer to peer support is available in all intermediate and high schools. Young people and schools feel more informed about suicide and know when and how to find help and information. Treatment/support plans are shared by affected youth and their whānau with their schools.	December 2016
Rural Wellbeing	Increasing awareness understanding and responses to rural community wellbeing.	Continue to build a strong partnership and support for the Rural Support Network. Education and training is delivered across rural Taranaki. Reducing stigma and	Rural Support Trust with Suicide Prevention and Postvention Coordinator	Existing rural support initiatives are supported. Strong support and information systems exist across rural Taranaki. Rural GP/nurse mental health leaders are in place in each practice.	Ongoing

		discrimination towards mental illness.		Conversations about mental wellbeing are normalised to improve likelihood of seeking help.	
For Men by Men	Programmes designed by men for men that allow them to connect with each other in a non-judgemental context.	Increased awareness of men's wellness. Increased understanding about men's support needs. Develop men's peer support groups. Reducing stigma and discrimination towards mental illness.	Suicide Prevention and Postvention Coordinator	Men are supported and their wellness is promoted and encouraged. Men's mental health peer support groups operate across Taranaki. Conversations about mental wellbeing are normalised to improve likelihood of seeking help.	December 2016, Ongoing
Older Persons	Awareness is raised about elderly suicide, self-neglect, euthanasia, and the pain and distress of elderly depression.	Elderly services providers' partner with elderly communities and elderly interest groups. Reducing stigma and discrimination towards mental illness	Elderly Services Providers	Elderly people are supported to be well in their homes and remain active in their communities. Be-friending services are supported and maintained. Elderly community support workers are trained to see the signs. Elderly support workers know where to get help. Conversations about mental wellbeing are normalised to improve likelihood of seeking help.	Ongoing
Māori Mana	Programmes designed by Māori for Māori that facilitate culturally appropriate responses to suicide prevention.	Māori are supported to provide responses to suicide prevention. Reducing stigma and discrimination towards mental illness.	Māori Health Providers	Māori suicide prevention and wellbeing programmes are in place. Tikanga Māori programmes are presented on marae by Māori for whānau. Conversations about mental wellbeing are normalised to improve likelihood seeking help.	December 2016, Ongoing

Supporting Children/ Youth and their Families with Mental Illness	Children and young people of parents with mental illness are supported.	Education and awareness support is given to children to help them and know how to help their parents. Programmes and services are in place and accessible to support families and children. A process is in place for developing a 'whole of family' plan. Families who require a 'whole of family' plan are identified.	Supporting Families with Mental Illness in Taranaki	Children and young people are supported to understand the early warning signs and triggers for mental illness as an aid to resilience. Children and young people know what wellness in their parents looks like. Children and young people know how to get help. Children and young people have access to the counselling/ therapeutic support that they need. Families have a 'whole of family' support plan.	December 2016, Ongoing
Supporting Adult Children and their Families with Mental Illness	Adult children with parents with mental illness are supported.	Education and awareness support is given to children to help them and know how to help their parents. Programmes and services are in place and accessible to support families and children. A process is in place for developing a 'whole of family' plan. Families who require a 'whole of family' plan are identified.	Supporting Families with Mental Illness in Taranaki	Adult children feel supported. Families have a comprehensive support plan in place.	December 2016, Ongoing
Early Identification	Professional and community leadership will work together to ensure a quick response to a potential suicide.	Development of multi-disciplinary team approach. Referral and support pathways are developed to respond to suicide attempts. Implementation of multi-	Suicide Prevention and Postvention Governance Group	The professional community understands and can identify the signs and triggers for a suicide attempt. There are clear referral pathways to support families after an attempt. Risk Plans and mitigation (re-attempt	June 2016

		disciplinary teams. Multi-agency surveillance system (coding) is in place to identify risks.		risks) strategies and after event response and support teams are put in place to avoid re-attempts. All suicide attempts and repeat self-harming are referred to community mental health.	

Postvention Outcome: Everyone affected by suicide has access to the right help and support at the right time.					
Objective 3: Support families, whānau, hapu, iwi and communities after a suicide					
Area of Activity	**Action**	**Milestones**	**Lead/Support**	**Expected Outcomes**	**Timeframe**
Healing and Recovery Pathways	Postvention Support Plans are developed that focus on - Long term support - Listening to families - Healing and recovery - Multi-disciplinary approaches	Postvention plan structure is developed. Postvention support teams are developed.	Taranaki District Health Board	Services and supports will be available to families/whānau when needed or wanted. Healing and recovery pathways are understood by professionals and the community. All families/whānau will have access to Postvention Plans. Each Postvention Plan will have a lead person to support the whānau/ family /individual. Postvention programmes focus on wellness and re-building resilience. Postvention support group is established and available throughout the region (i.e. Skylight/Seasons).	October 2016
Community Awareness	Community Education and Awareness Programme is developed.	See infrastructure and prevention outcomes.	Suicide Prevention and Postvention Coordinator	There is increased community awareness about post suicide. Community education and support is	June 2016

				available. Community postvention stories and experiences are shared to aid individual healing and reduce stigma.	
Cluster (potential) Response	A cluster alert response system and network will be put in place.	Commitment to coding of all events (completed and uncompleted) by receiving agencies (Police, ED, Mental Health, CYFs). Data collection and systems for sharing and dissemination are understood. Data sharing protocols are established.	Suicide Prevention Coordinator	Attempt self-harm data is tracked and understood to avoid cluster. Data is shared. A cluster alert response can be mobilised in response to data triggers. Contagion is avoided.	March 2017

High Risk Outcome: Frontline staff are trained and mobilised to consistently, cohesively and appropriately recognise and respond to a suicide risk.					
Objective 4: Improve services and support for people at high risk of suicide who are receiving Government services					
Area of Activity	**Action**	**Milestones**	**Lead/Support**	**Expected Outcomes**	**Timeframe**
Risk Management	Development of screening (for risk and need) tools to aid early identification and intervention.	Audit of existing screening tools that are used in individual agencies. An integrated risk assessment tool is developed. Agencies are trained and educated in risk assessment processes and multi-agency tools.	Taranaki District Health Board	Integrated screening tools and methodology is implemented. Professional agencies can - Identify the signs. - Understand the risks. - Know the referral pathways.	December 2015

Early response	Coordinated responsive services are offered and available following incidents of self-harm and attempted suicides.	Referral and support pathways are in place (Refer to infrastructure outcome).	Taranaki Suicide Prevention and Postvention Governance Group	Agencies understand the signs and triggers to avoid crisis referrals. Information is shared amongst agencies. Referral pathways are known. Agencies are connected and coordinated. Services and supports are appropriate to the person and their need.	March 2016

Monitoring, Evaluation and Risk Management

Results Based Accountability Evaluation Framework

A Results Based Accountability (RBA) framework will be developed to assess whether the Taranaki community population is 'better off' as a result of the region's suicide prevention and postvention strategy and plans. Taranaki DHB has been working locally to include RBA in Kaupapa Māori contracts.

Two forms of accountability will be used to consider the effectiveness of the region's work and efforts in the area of suicide prevention and postvention.

1. Population accountability is about quality of life in a specific population i.e. prevalence of suicide/self-harm in the community.
2. Performance accountability is about how well the services were delivered, and whether they are making a difference to the people who receive them.

RBA identifies the most important measures for each service that is delivered and the results achieved. Performance accountability will be based on answers to three questions:

1. How much did we do? (Volumes)
2. How well did we do it? (Effectiveness)
3. Is anyone better off? (Outcomes and Impact)

The Suicide Prevention and Postvention Advisory Group has begun to identify a suite of indicators (Appendix A) that provide the foundation for the RBA plan. This will be refined and built upon as part of the RBA development process.

Risk Management

The Taranaki Suicide Prevention and Postvention Plan 2015- 2017 represents a new approach to suicide prevention and postvention planning and delivery in the region. The Plan will challenge some of the existing practices and operations and will require greater leadership and resource commitment from across the community. The Plan approach offers considerable potential to make a positive difference and achieve the vision to eliminate suicide and self-harm in the region. With this new approach there are risks that could thwart the progress of the Plan.

As part of the Plan implementation, the Advisory Group have identified the need to undertake a thorough assessment of risk.

Risks have been identified across the following areas:

- Resources
- Community
- Service Delivery
- Governance
- Capacity and Capability
- Communication

Appendix B presents the risks and the mitigation and prevention strategies that have been identified by the Advisory Group as part of the Plan development process. The Governance Group will continue to develop their approach to managing risk.

Appendix A

RBA Outcomes and Indicators

Population Outcome	Taranaki Outcome	Performance Indicators
A society where all people feel: they are valued and nurtured, value their own life, they are supported and strengthened if they experience difficulties, and do not want to take their lives or harm themselves (NZ Suicide Prevention Strategy 2006-2016).	Taranaki will promote wellbeing to eliminate suicide.	1. Suicide Attempts 2. Completed Suicides 3. Incidence of Self Harm Data to be disaggregated and cross tabulated by population groups, geography/location, repeat attempts.
Government Objectives	**Programme Outcomes**	**Programmes Indicators**
Objective 1: Strengthen the infrastructure for suicide prevention	Infrastructure Outcome: Agencies collaborate and are resourced to embed sustainable coordinated responses to support community wellness.	Regional governance structures are in place. Taranaki is resourced to implement the Plan (including the appointment of a Suicide Prevention and Postvention Coordinator). Communication and Community Awareness Strategy is developed. Community Education and Training Strategy is developed. Number of people who have received suicide prevention and postvention training (community, professionals, works places and schools). Information repository/portal is developed. Reduced admissions to secondary services because of increased community and primary health support. Cluster Prevention Strategy and Response Team is established. Multi-disciplinary Teams are established for high risk people and vulnerable groups.

		Information sharing protocol is in place. Improved surveillance systems are established. Data and information is shared. Fewer complaints are received. Increased satisfaction from clients and community groups.
Objective 2: Support families, whānau, hapu, iwi and communities to prevent suicide	Prevention Outcome: Everyone in Taranaki is aware of the impact of suicide and knows how to access and navigate appropriate effective pathways for help	Levels of participation in training programmes (professionals, community). Community support team locations. Numbers of people allied to a community support team. Number of peer support groups. Levels of participation in peer-to-peer support groups. Community feedback (all high risk and identified vulnerable community groups). Types and numbers of community education and campaigns. Impact evaluation. Increased level of information and access to information and services. Referral pathways are effective for community and professionals. Increased access to and availability of services. Youth support systems in place. Number of schools with access to consult liaison. Number of multi-agency treatment plans for young people. Number of peer-to-peer support systems in schools. Levels of participation in training programmes. Number of 'whole of family plans'. Numbers of rural support teams. Location to GP/nurse mental health leaders in rural communities. Crisis team response times. Suicide Prevention and Postvention programmes in place to support Māori, men, youth,

		elderly, rural. Levels of participation in programmes. Impact evaluation of programme and service.
Objective 3: Support families, whānau, hapu, iwi and communities after a suicide	Postvention Outcome: Everyone affected by suicide has access to the right help and support at the right time.	Number of families with a multi agency postvention support plan. Postvention programmes and services. Levels of participation in postvention support systems and groups. Contagion and cluster occurrences.
Objective 4: Improve services and support for people at high risk of suicide who are receiving government services.	High Risk Outcome: Frontline staff are trained and mobilised to consistently, cohesively and appropriately recognise and respond to a suicide risk.	Number of agencies using screening methodology. Effectiveness of screening information sharing. Intervention and response times to those displaying a high risk of suicide.

Appendix B

Risk Areas

Risk	Mitigation and Prevention
Resources Lack of resources to deliver the changes that are required. Inability to employ a Coordinator to drive the project and maintain momentum.	Early signalling to all agencies that a shared resource is needed to allow allocations in planning and budgets. Agency commitment to ensure alignment and coordination of resources and efforts. Ring-fencing of funding for suicide prevention and postvention. Securing community (grant) investment.
Community Lack of community buy-in to a whole of community approach. Unrealistic awareness and support expectations on the community.	On-going support and commitment from agencies to work alongside community. Resourcing to ensure that community has capacity to deliver. On-going training and support from agencies.
Service Delivery Capacity and Capability Gatekeeping – unwillingness to change or innovate. Lack of commitment from agencies/change fatigue. Lack of connectivity amongst agencies and organisations, lack of integration. Lack of a whānau ora approach/cultural awareness. The demands are too high and progress and action becomes limited. Initiative overload and competing priorities and resources.	Strong infrastructure in place. Leadership and multi-agency commitment. Resourcing to deliver plan priorities. Clear pathways developed. Quality communications and information. Representation from Māori. Programmes, training and information are culturally responsive.

Risk	Mitigation and Prevention
Governance Lack of a committed governance structure to maintain momentum **Leadership** Poor strategic planning leads to a lack of focus. Narrow representation of interests at the governance level resulting in key groups who are not part of the decision making structure. Lack of DHB buy-in – ability to keep momentum up internally.	Governance group to comprise of a balanced membership drawn from clinical leaders, agencies and organisations and community interest groups (comprised on priority population groups). Governance is supported by strong representative suicide prevention and postvention structures. Governance has a mandate and authority to lead and innovate. Demonstration of high level management support demonstrated for the plan along with appropriate communication and resourcing.
Communication Miscommunication amongst services and agencies. Poor communication with the community.	Development of a multi-agency Communications Strategy

Notes

[i] Includes all people who stated each ethnic group, whether as their only ethnic group or as one of several. Where a person reported more than one ethnic group, they were counted in each applicable group. Middle Eastern, Latin American, and African was introduced as a new category for the 2006 Census. Previously Middle Eastern, Latin American, and African responses were allocated to the 'other ethnicity' category (Statistics NZ).

[ii] Ministry of Health (2015) Suicide Facts: Deaths and intentional self harm hospitalisations, 2012.

[iii] Taranaki Police, Suicide Attempt Call Out Data between January 2014 and April 2015.