Interim Southern District Suicide Prevention Action Plan 2018– 2019

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Executive Summary:

Suicide is a tragedy. Not only is it a tragedy for those who have lost a loved one, but it is also a tragedy for those families and communities impacted by the death, as each suicide can increase the risks of suicide for those who are vulnerable.

This interim document has been developed to provide the Southern District Health Board (DHB) and the wider Southern community, guidance for action over the next six months (May to November 2018) to reduce suicide in the District and enhance postvention processes. This action plan as an interim document, will be substantially revised and developed further through a co-design process during this interim period. It is anticipated that it will be able to incorporate some of the preliminary outcomes from the Mental Health Inquiry.

The objectives in this draft document reflect the actions proposed in the Ministry of Health's **"A Strategy to Prevent Suicide in New Zealand 2017" as well as additional guidance from the Ministry of Health to DHBs, entitled "DHB Suicide Prevention /Postvention Coordinators Hui 12-13 March 2018**

The proposed actions found in this interim document are also partially derived from feedback received from consultation and analysis of the Southern DHB's Suicide Prevention Action Plan (2018-2019)[3] as well as data and issues collated over the past 3 years both in the Southern District and nationally, including international best practice and research. Once approved by the Southern DHB and Ministry of Health, this document will be the guiding document for not only the DHB but also community postvention groups, suicide prevention agencies, Maori community supports and the wider Southern community. It focuses on the priorities for the next year with the aim of reducing the impact of suicide in our communities.

Some of the key proposals found in the Interim Action Plan are:

- (Engage 'targeted' groups)Target high risk groups identified by Southern suicide events over the past eighteen months- including rangatahi tane (young Maori men), tertiary education students, corrections clients, and smaller town communities.
- Enhance resources available for supporting those bereaved by suicide.
- Encourage and facilitate best practice suicide risk management in all services working with people with mental health distress across the district.
- Develop a regional suicide prevention advisory group which includes the key statutory agencies to advise and respond to Southern suicide risk issues.
- Facilitate the development of effective trauma services in the Southern district.
- Develop full coverage in the southern district for community oversight of postvention in collaboration with the district Suicide Prevention Coordinator.

The Consultation Process for the 2019-2020 Southern Suicide Prevention Action Plan:

Over the last several years the Southern DHB have adopted a consultative approach to the development of the district wide suicide prevention and postvention plan. This approach has generally worked reasonably well. However, given the growing interest in finding solutions to New Zealand's high level of completed suicides, it seems appropriate to consider a more inclusive and community focussed approach to finding a solution. Co-design provides this option as it's a flexible and inclusive approach to developing a new plan for the district.

The co-design approach we are looking to use will be facilitated by Dr Jeff Foote from the University of Otago. Jeff has extensive experience in organisational planning and co-design and has just completed three two day workshops across the district for co-design and mental health services.

We are intending to organise three one day workshops across the district in Eastern Otago, Central Lakes, and Invercargill to facilitate the development of the 2 year Southern Suicide Prevention Action Plan 2019-2020. These will focus on co-designing the new suicide prevention and postvention plan for the district. These workshops will start at the end of August and be completed in early September this year. Following the workshops a draft plan will be prepared that incorporates all the ideas and which will be further developed interactively with the stakeholders and finalised.

An outline of co-design, is provided below, including a diagram of a typical co-design process.

Co-Design is a different and more inclusive process. It has four main phases and starts off by looking at what is already in place, the "what is" phase. We will be doing this at a series of large workshop events with all the key stakeholders attending and participating to map out the current responses and plans for suicide prevention and postvention. All previous plans will help inform this work, alongside other research data, and a broad range of stakeholders will then participate in a series of exercises and discussions as representatives of their communities to sketch out a whole of community response.

At these same large workshops, we move into the next phase of co-design, the "what if" phase. In this phase we avoid coming up with solutions to the problems that we may have identified earlier, these go on the back burner. Instead what we try to do here is focus on an ideal situation where we map out interventions, activities, and interactions that support the achievement of outcomes that we want our community to develop in response to suicide and which should be included in our plan.

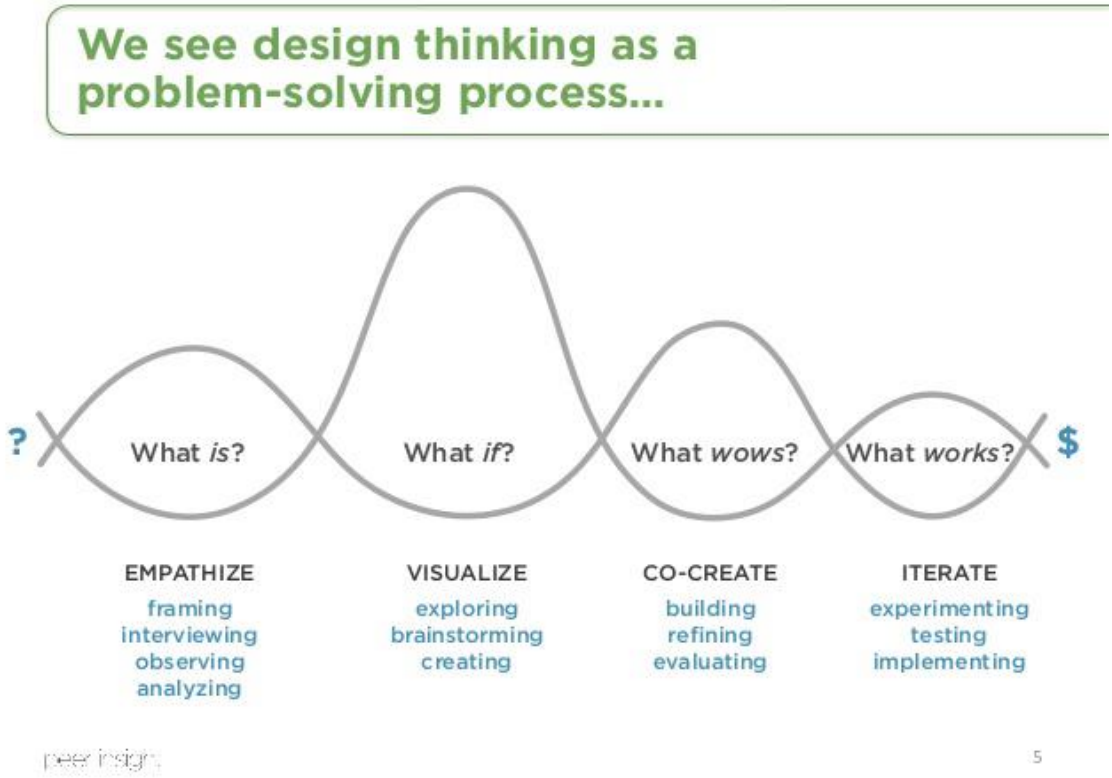
The third phase involves the matching of the different 'ideal' designs with all the different constraints and limitations. The design group, which can be the large meeting or a smaller group, are tasked with taking the best of the different designs, which will have been identified in the "what if" phase, and weaving them together into a prototype or working model that is influenced and informed by the various constraints in the system; this may involve financial constraints, geography, and workforce amongst

others. In this third phase, the “what wows” phase, the prototype that the design group construct can be modelled through visualisation (comic strips or storyboards), through narrative, through pathways and journeys, and sometimes physical enactment (role play or work through).

The design group’s prototype is then presented to the larger group, so that it can be explored and discussed. At this stage what’s sought is modification and correction of the design but not a reworking of the service model. The design group collect all the feedback, corrections, commentary, and thoughts and integrate them into a final prototype.

This final prototype is then shared again with the stakeholders for any final commentary, which may be incorporated or held for later consideration. Then in the final stage, the “what works” phase, we move into preparing a detailed plan for suicide prevention and postvention.

Here’s a model of how the process might work:



Introduction:

Each year approximately 600 people take their own lives in New Zealand[4], on average 50 of these people resided in the Southern District. While the numbers of people dying by suicide nationally have increased steadily over the past few years as population increases, the rate of deaths per 100,000 has stayed relatively constant. While it is difficult to make assumptions from relatively small numbers, it would appear that Southern's suicide rate has been increasing over the past few years, particularly in Southland. It should however be noted that annual suicide numbers in the south can be significantly impacted by relatively small suicide clusters.

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, but other risk factors include exposure to adverse childhood events, trauma, personal experience of suicide, a lack of social support, and difficult economic circumstances.[1]Individual family and whanau, local communities and local and state agencies do much to address these issues through multiple mechanisms; many of which do not directly have a focus on suicide prevention.

This draft Southern District Suicide Prevention Action Plan 2018-2019 takes a population health and community development approach to suicide prevention, and highlights priority actions for suicide prevention and postvention in the Southern District, (the South Island, south of the Waitaki River excluding the West Coast*).* A population health approach aims to improve the health of whole populations and requires all sectors and communities to contribute. Therefore, no one sector of a community is 'responsible' for suicide prevention; understanding that southern suicide prevention is a community wide approach which supports local initiatives based on evidence based practice. It aims to reflect current strategic directions, acknowledge national actions being delivered, while responding to local community needs and priorities. Emphasis has been placed on ensuring outcomes are realistic within identified timeframes. The action plan below notes specific work needing to be undertaken alongside targeted groups in the Southern community including rangatahi tane (young Maori men), those who live in small rural communities, people involved in the Justice system, and young people engaged in tertiary education services.

Purpose of this document:

The purpose of this document is to inform the Ministry of Health of the work being undertaken in the Southern DHB District while implementing the national Suicide Prevention Strategy and Action Plan. It also provides guidance to the DHB on suicide prevention and postvention actions recommended to be undertaken over the next year. It will also assist the wider public, government and non-government agencies in the region to collaborate effectively, with the aim of reducing suicides, attempted suicides and suicide ideation in the District.

Responding to He Korowai Oranga in the planning and in meeting statutory objectives and functions for Maori suicide prevention and Postvention is fundamental for this Action Plan. The key elements of He Korowai Oranga will assist in providing direction at a strategic level, improving Maori health status and realising pae ora – healthy futures for all.

This document identifies a number of community projects and initiatives in the District. While not always specifically mentioning suicide, many of these indirectly reduce suicide risk through the development of a secure cultural identity, sense of purpose and hope, access to support and help, and whanau and community support or connectedness.

This strategy also acknowledges the key role that Southern communities and individuals outside of the formal support agencies have in reducing suicide risk. Examples of this support include: reducing trauma and abuse of young people, increasing social wellbeing, increasing resilience and connectedness and also supporting those at risk; and may include marae communities and Maori groups, neighbours, whānau, schools, faith based groups, sports groups, youth groups, rural communities, local authorities, neighbourhood groups, older person's groups, LGBTTi community groups, etc.

The action plan has been developed taking into account current fiscal constraints by the Southern DHB and other agencies. Should further resources become available, adjustments to targets may be possible.

While the plan emphasises that developing effective responses to suicide risk is a whole of community response, the Southern DHB acknowledges it is also one of the key agents in our Southern District.

Suicide Statistics in the Southern District:

There are two main sources of data for completed suicides nationally. One is the Ministry of Health's data[8] which is published annually and refers to suicides up to 3 years before the date of publication; the second is the coronial data[9]released annually by the Chief Coroner, which includes "provisional" suicides (i.e. not finally confirmed by the coroner as a suicide), but which is able to be broken down by council area.

The latest Ministry of Health data notes that in 2015 the national rate of suicide was 11.1 deaths per 100,000. From 2006-2010 the suicide rates in Otago were 12.1 deaths per 100,000 and in Southland 16.4 deaths per 100,000. This data identifies that Southland had a suicide rate significantly higher than the national average over that period, although the specific reasons for this higher Southland rate are unknown.

In the Southern District one in 10 people who die by suicide are Māori. Within this there are regional variations; one in 16 people who die by suicide in Otago are Māori and one in 7 who die by suicide in Southland are Māori.[8] These averages are below the national average that reports one in five people who died by suicide are Māori.[8]Nonetheless the lower proportion of Māori to total population in the Southern District compared to the national population may indicate a comparable death rate of Māori by suicide in the Southern District to that observed in more northern populations.

Nationally Māori youth suicide rates are two and a half times higher when compared to non-Māori youth suicide rates.[1]

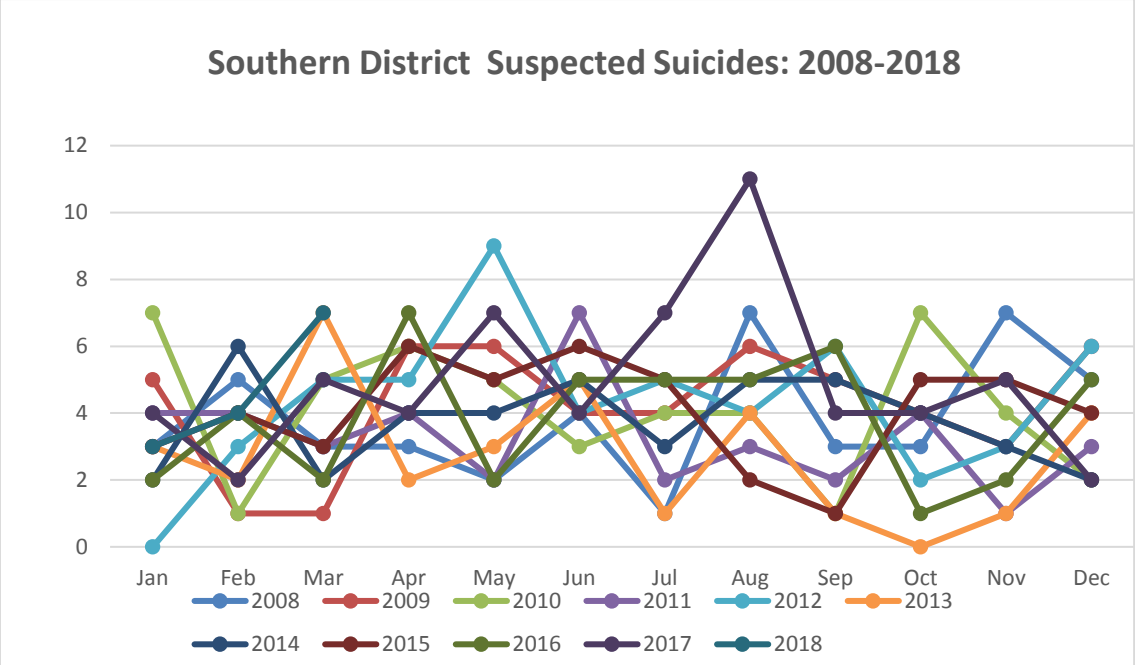


Figure 1

Figure 1 above shows the number of suspected suicides (including some recent deaths not confirmed by an inquest) occurring per month in the Southern district from January 2008 to June 2018. The table illustrates the apparent randomness of suicide numbers in the south per month, within a fairly narrow data range.

Southern District comparisons of youth suicide rates are not available due to the sample size being too small to draw statistically robust conclusions. Ministry of Health data[8] notes that for the period 2006-2010 Otago had a rate of youth suicide of 15.8 per 100,000, with Southland having a rate of 34.3 and the national average being 18.1, indicating a significant concern with Southland youth suicides at that time. However we know that of the 54 reported suspected deaths by suicide between July 2016 and end of June 2017 in Otago/Southland, 15 of those were under the age of 24, or just over 28%. In 2011 nationally, there were 127 deaths by suicide by people under 24, out of a total of 478 deaths, or 26%. As younger people are more at risk from the contagion of suicide, the proportion of younger people completing suicide in the district can change significantly year by year, when suicide clusters occur.

Current Suicide Prevention and Postvention Groups in the Southern District

The Southern District currently has eight community led suicide prevention groups in operation with formal linkages to the suicide prevention coordinator's role. These are based in Invercargill, Gore, Queenstown, Alexandra, Dunedin and Oamaru Each group operates differently; some have a sole focus on postvention, others are focussed on general suicide prevention while others take a more global approach to suicide issues. Four of the groups have signed up to a CASA approved Postvention Plan process [18], which was initially developed by both the Otago and Southland DHBs and after May 2010, the Southern DHB, with the guidance of the national Clinical Advisory Services Aotearoa (CASA) which is funded by the Ministry of Health. CASA's Community Postvention Response Service (CPRS) assists communities experiencing suicidal contagion or suicide clusters. A suicide cluster may be defined as[10]

> "*A group of suicides or suicide attempts, or both, that occur closer together in time and space than would normally be expected in a given community."*

The CASA team can help a community assess if there is a cluster emerging or occurring and how best to respond to the situation. The development of each community postvention group uses a strong community development approach to ensure community ownership and engagement with the process.

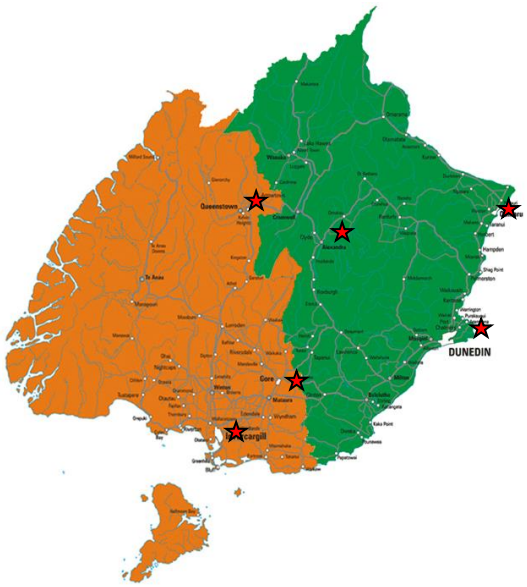
The four postvention community groups have adapted a template jointly developed by the Southern DHB and CASA which formalises their role and the key community agencies involved with the postvention process in their community. This community agreement is thus linked to the DHB signed Memorandum of Understanding on the sharing of coronial and CASA information to reduce further risk after a suicide

The Southern district also has a number of other community based suicide prevention community groups- including the Dunedin based 'Life Matters Suicide Prevention Trust and the Alexandra based 'Otago Suicide Prevention Trust'.

Ministry of Health Suicide Prevention objectives have previously required the DHB to develop a response to 'intentional self-harm'. Hospital data currently records those who self-harm, but the data does not identify intent; i.e. it is unknown how many of those who "self-harm" are actually attempting suicide. International research suggests that most people who self-harm will not go on to attempt suicide, although a small proportion will make an attempt or complete suicide, and those who self-harm are a high risk group for suicide ideation.

In contrast to suicide deaths, the true number of people who attempt suicide each year in the Southern District is currently unknown, but estimates from people accessing emergency departments and emergency psychiatric services for suicide attempts have been recorded by services as being just over 200 per year. The actual number of attempted suicides is likely to be substantially higher, possibly in the vicinity of 1200 attempts per year across the south (based on estimated Police 'X1' callouts).

Figure 2: Southern DHB catchment and current community postvention locations



The Southern District (Otago/Southland) Suicide Prevention Coordinator role is based at WellSouth PHO in Dunedin, and takes a "population health" and community development approach to suicide prevention. The Suicide Prevention Coordinator's role is to implement the DHB objectives arising from the Southern DHB's Suicide Prevention Action Plan 2018-2019.

Each of the current eight Southern community suicide prevention groups has followed a different journey since their inception. Most groups were established following a suicide event within a community. As the frequency of suicides in each community inevitably decreases after the initial case/cluster, the perceived need to maintain regular meetings naturally tends to drop away. There also tends to be a transition of focus away from postvention towards suicide prevention, and this shift often results in a change of participants at meetings.

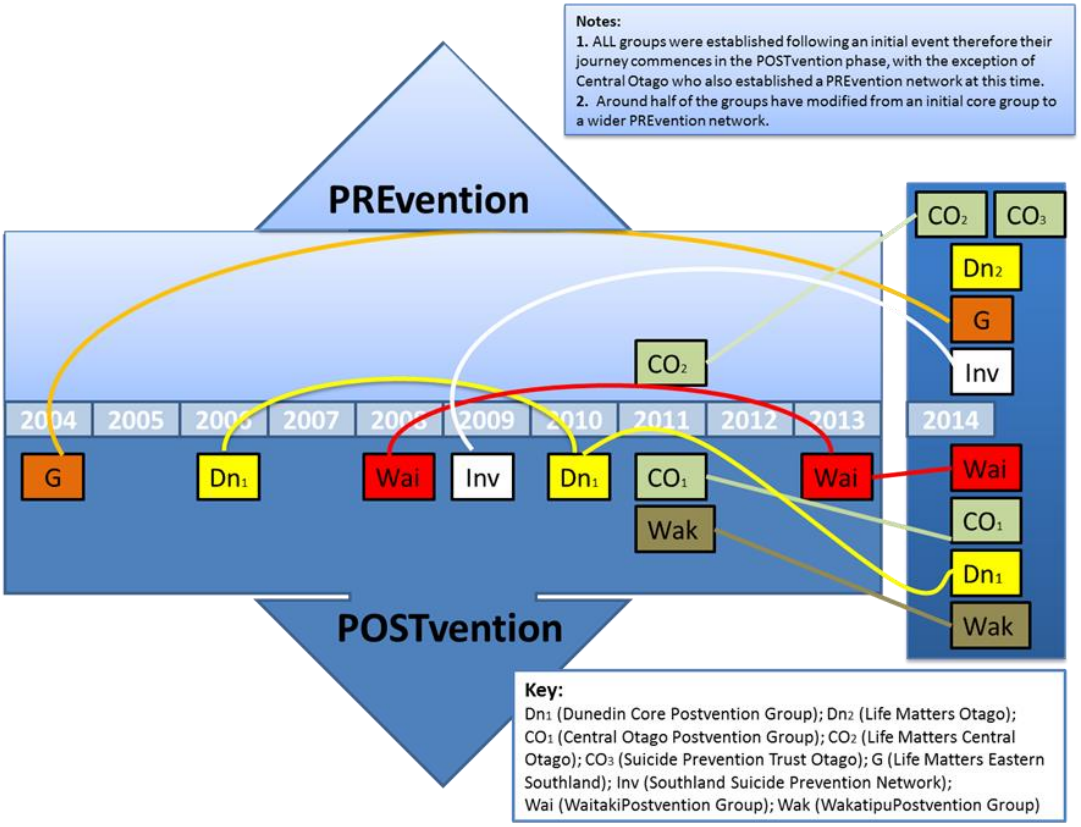
Community postvention and prevention groups within the Southern District are neither funded by the Southern DHB, nor from any other explicit suicide prevention source. Any work undertaken is done so under the auspices of employee's roles or by volunteers, and typically utilises existing resources. Given the infrequency of suicide events in smaller communities, maintaining a group that retains the skills and knowledge of previous suicide community responses, even when no suicides are occurring, is considered essential.

Regional or national engagement

The Southern Suicide Prevention Coordinator facilitates and participates in monthly teleconferences with other District suicide prevention coordination roles across the country, and attends national meetings on suicide prevention coordinated by the Ministry of Health where appropriate. Regular teleconferences with Southern postvention chairs are also held.

In addition the Ministry of Health's revision of the "DHB Toolkit" will assist with a best practice approach to suicide prevention.

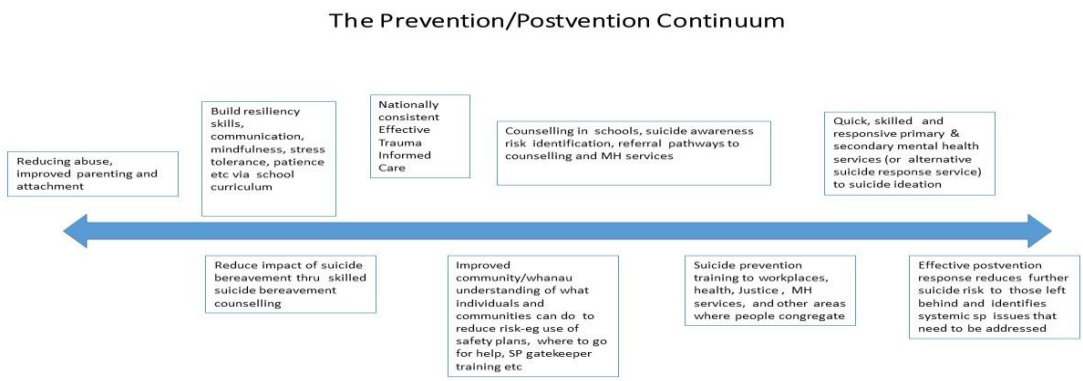
Figure 3: The Southern Postvention journey travelled to date



The Suicide Prevention Continuum

Suicide prevention responses may be seen to be a continuum from early intervention to the postvention responses, which may also inform some of the earlier intervention work, as per Figure 3 below.

Figure 3: The Prevention/Postvention Continuum



The Action Plan Template

The draft Objectives on the following pages are partially based on the previous Southern DHB Suicide Prevention Action Plan 2015-2018[3], which in turn reflects the objectives and required actions of the Ministry of Health's objectives for DHBs in its New Zealand Suicide Prevention Action Plan 2013-16.[1]

The draft Actions and Intended Outcomes are drawn largely from analysis of the coronial suspected suicide data for the district collated by the suicide prevention coordinator, with a focus on the key cluster risk groups over the past few years.

There are limited other resources available from the DHB to implement suicide prevention and postvention in the Southern District. Consequently, delivering effective outcomes to reduce suicide and the impacts of suicide within the Southern District requires a collaborative and community resourced approach to suicide prevention alongside the Southern DHB.

Suicide prevention training has been consistently identified as a priority in community meetings around the District. The various types of suicide prevention training can be categorised as follows:

1. community meetings/hui that 'raise awareness' of suicide generally,
2. gatekeeper training (e.g. Safe TALK and QPR online and latterly LEVA's LifeKeepers and RHAANZ's "SafeHands SafePLans'),
3. more in-depth Community and Public Health approaches to suicide prevention,
4. suicide risk assessment (triaging) and risk response for clinical roles,
5. suicide bereavement training and programmes.

It is important to ensure that all of these five categories of suicide prevention training and awareness-raising are delivered systematically across the district and that training is targeted at the right level to the right audience; e.g. in most cases mental health clinicians require more in-depth training which includes suicide assessment, skills to engage family/whanau in risk management etc rather than entry-level gatekeeper training.

As noted previously, financial constraints by the Southern DHB and other key agencies will limit the amount of training that can be implemented in any one year, but a strong effort will be made to maximise resources for suicide prevention training wherever possible.

The five types of suicide prevention training outlined above, mirror the approach taken by Southern DHB to reduce suicides in the District through:

1. whole population initiatives,
2. providing support to those groups of people who may be at risk statistically, and
3. providing suicide prevention support to specific individuals at risk of suicide.

Abbreviations: Agencies or individuals identified in the tables below

CASA	Clinical Advisory Services Aotearoa	NGO	Non government organisation
CYF	Child Youth and Family	NKMP	Nga Kete Matauranga Pounamu Charitable Trust
DPSM	Department of Preventive and Social Medicine	PHN	Public Health Nursing
ED	Emergency Department	PHS	Public Health Service
HR	Human Resources	SDHB	Southern District Health Board
LGBTI	Lesbian gay bisexual transgender or intersex	SDHB P&F	Southern DHB Planning and Funding
MHAID	Southern DHB Mental Health & Intellectual Disability Services Directorate	SF	Supporting Families
MHF	Mental Health Foundation	SPC	Southern DHB Suicide Prevention Coordinator
MOE	Ministry of Education	U o O	University of Otago
MOH	Ministry of Health	Well South	The Southern Primary Health Organisation (PHO)
MSD	Ministry of Social Development		

During the period of the interim plan we will work towards the following objectives:

Objective 1: Support families, whanau, hapu, iwi and communities to <u>prevent</u> suicide and promote wellbeing				
Action Area	**Intended Outcomes**	**Actions**	**Timing**	**Agencies involved**
1.0 Clinical and community support agencies are able to more effectively support previously identified at risk groups in the Southern district	1.0.1Clinical support for those at risk of suicide is well-coordinated and effective in reducing risk	a) SPC encourages and facilitates clinical suicide prevention training that meets the clinical needs of agencies working in the secondary mental health sector	2018-2019	Secondary mental health services, CASA, Ministry of Health, suicide prevention training agencies
1.1 Suicide Prevention training is widely disseminated across the Southern region agencies and the wider community.	1.1.1 Suicide prevention training is delivered at the right level to the right people to as many agencies, communities and individuals as resources permit, resulting in reduced suicide risk.	a) Deliver suicide prevention training programmes designed for health workers and community individuals using SafeTALK,[11]QPR and QPR Online,[12] "Keeping the Balance"[13] (WellSouth) and/or ASIST training packages.[11]	2018-2019	SPC; national & local training agencies & local trainers; community funders; Southern NGOs; community groups.
	1.1.2 Mental wellbeing and resilience work is coordinated effectively with suicide prevention work throughout the district	a) SPC works alongside key health promotion agencies and individuals in the district to encourage mental wellbeing - particularly for those at risk of suicide.	2018-2019	SPC, NKMP- KPTO Public Health South and WellSouth health promoters and other national and local health promotion agencies
	1.1.3 Build resilience to reduce suicide risk in communities.	a) Work collaboratively with communities, schools and funders to support projects and initiatives that increase community and individual psycho/social wellbeing resiliency, wellbeing and persistence.	2018-2019	NKMP – KPTO PHS, MHF, mental health consumer groups, NGOs, MOE, schools, MSD, local councils, community initiatives.
	1.1.4 Suicide prevention is recognised as a key issue in workplaces and education settings and agencies have effective systems in place to reduce risk.	a) Facilitate southern employers to develop good practice staff mental wellbeing practice and suicide prevention. (e.g.SafeTALK, Mates in Construction, [14] MH101, and 'Keeping the Balance').	2018-2019	PHS, Chamber of Commerce, employers (management and HR), suicide prevention trainers

Objective 2: Support Families, whanau, hapu, iwi and communities <u>after</u> a suicide				
Action Area	**Intended Outcomes**	**Actions**	**Timing**	**Agencies involved**
2.1 Support communities to respond to suicide, especially when there are concerns of suicide clusters and suicide contagion.	2.1.1 The Southern District has best practice, safe and effective community postvention groups that cover the district and meet the needs of their communities.	a) SPC and SDHB support the development of at least two additional community postvention groups in the Southern District –e.g. Invercargill, Balclutha, Invercargill, Central/Western Southland, Fiordland, Eastern Southland and other Southern communities as appropriate.	2018-2019	PHS, community prevention and postvention group, NGOs, government agencies.
		b) All Southern postvention groups operate under the current postvention template co-developed by CASA, the SDHB and their community.	2018-2019	PHS, community postvention groups, CASA, MOH.
		c) Ensure that all parties involved in the postvention processes are aware of back-up contacts over holidays or when key staff are on leave.	Ongoing	SPC, PHS, CASA, Postvention groups. SPC, postvention chairs, SDHB key agents, WellSouth
		d) Support evidence based and safe community initiatives to reduce suicide risk		SPC, southern suicide prevention community groups
		e) SPC and SDHB support the development of a Maori community Postvention network in the Southern area.	2018 - 2019	SPC, NKMP – KPTO, Maori providers, community groups
	2.1.2 Counsellors and clinicians are resourced and trained in the issues of suicide bereavement	a) People bereaved by suicide have effective evidence based suicide bereavement counselling available to them	2018-2019	Counsellors and clinicians trained in suicide bereavement counselling

Objective 3: Improve Services and Support for people at high risk of suicide				
Action Area	**Intended Outcomes**	**Actions**	**Timing**	**Agencies involved**
3.1. Tertiary Students	3.1.1 Supports for tertiary students in the south are well coordinated and effective in reducing risk	3.1.1a) SPC works alongside key services within the southern tertiary sector to improve risk identification and response , suicide prevention training and communication with other agencies involved in suicide prevention and enhance mental wellbeing	2019	University of Otago, SIT, Otago Polytechnic, ComCol, MH services, mental health promotion services, NGOs working with vulnerable students
3.2 People in smaller rural Southern towns	3.2.1Supports for people in southern smaller towns and rural communities are evidence based, well-coordinated and effective in reducing risk	3.2.1a) SPC works alongside key services within the southern rural communities and those agencies who work in rural communities to improve risk identification and response , suicide prevention training and communication with other agencies involved in suicide prevention and enhance mental wellbeing		Otago and Southland Rural Trusts, rural health providers, rural mental health teams, mental health promotion services
3.3 People bereaved by suicide	3.3.1 Supports for people bereaved by suicide are evidence based and assist in reducing their risk	3.3.1a) SPC works alongside bereavement groups, WAVES trainers and other agencies working with people bereaved by to provide best practice bereavement support that reduces suicide risk and enhances mental wellbeing		Skylight, Mental Health Foundation, southern bereavement groups, Life Matters, bereavement counsellors, trainers, mental health promotion services
3.4 Young Maori men	3.4.1 Supports for rangatahi tane (young Maori men) in the south are evidence based, well-coordinated and effective in reducing risk	3.4.1 a) SPC works alongside key Maori health services, local iwi and Nga Kete to improve risk identification and response for Maori , encourage culturally appropriate suicide prevention training and resources and effective bilateral communication with other agencies involved in suicide prevention and enhancing mental wellbeing		Southern Maori Health Providers, Nga Kete Matauranga Pounamu Charitable Trust, local Iwi, Maori tertiary education providers, SDHB Maori services, mental health promotion services
3.5 People in the Justice system	3.5.1 Supports for people in the Justice system are evidence based , well-coordinated and effective in reducing risk	3.5.1a) SPC works alongside key services within the Justice system and to improve risk identification and response , suicide prevention training, postvention support and communication with other agencies involved in suicide prevention and enhance mental wellbeing		Corrections, Prison services, Brief Intervention Service, MH services, mental health promotion services
3.6 People in the mental health service system	3.6.1 Clinical mental health services, primary care and community supports for people in mental distress are evidence based , well-coordinated and effective in reducing risk	3.6.1 a) SPC works alongside key services within the SDHB mental health, NGO and primary care services to improve risk identification and response , suicide prevention training and communication with other agencies involved in suicide prevention and enhance mental wellbeing 3.6.1b) SDHB MHAID reviews and improves identified processes and systems for access to and discharge from mental health and addiction services where patients present with suicidal behaviours in order to reduce risk.		SDHB MHAID, NGOs, WellSouth, Brief Intervention Service, Counsellors, mental health promotion services SDHB MHAID, training providers, SPC, consumers
3.7 People in the Farming sector	3.7. People in rural communities have access to resources and supports that	3.7.1a) Mental wellbeing and mental health service supports are well coordinated and accessible for rural people during rural high risk events		Public Health South mental health promoters, WellSouth health

Objective 3: Improve Services and Support for people at high risk of suicide				
Action Area	**Intended Outcomes**	**Actions**	**Timing**	**Agencies involved**
	promote mental wellbeing during rural high risk events – eg the Myoclasma Bovis outbreak			promoters, Rural Trusts, rural NGOs *and Community networks*

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Objective 4: Strengthen the infrastructure for suicide prevention				
Action Area	**Intended Outcomes**	**Actions**	**Timing**	**Agencies involved**
4.1 Make better use of data related to suicide deaths and self-harm (attempted suicide) incidents.	4.1 Establish effective linkages with the National Suicide Mortality Review Group (SYMRG) for improved data analysis and understanding	4.1.1a) SPC liaises with national suicide prevention coordinators and SYMRG to ensure safe and effective bilateral flow of data and information on suicide prevention issues	2018-2019 and ongoing	National SPCs, Ministry of Health, SYMRG key representatives, CASA
4.2 Develop a systemic response to identified suicide risks and clusters in southern communities	4.2 Systemic responses to suicide risk (eg socio-economic risks) are effective, sustainable and resourced in the southern region .	4.2.1 a) Develop a southern region senior level advisory group for suicide prevention which includes all key statutory agencies and incorporates advice from those with lived experience of suicide.	2018-2019 and thence ongoing	Prisons, Police, Corrections, Tamariki Ora, Work and Income, MoE, local and district councils, Ngai Tahu Trust Board, Southern DHB, People with lived experience of suicide.

Monitoring and evaluation

Actions and outcomes identified in this document will be monitored monthly through WellSouth management review of SPC monthly reports. Each report will describe not only the progress of projects initiated and developed by the Suicide Prevention Coordinator, but also work undertaken and led by other agencies and individuals who work in suicide prevention and postvention within the Southern District. The information from those reports will also be used to populate reports to Southern DHB Planning and Funding and the Ministry of Health's new reporting template.

Identification and mitigation of risk

Where postvention groups or the Suicide Prevention Coordinator identify postvention risks that are not easily managed or have not been confronted before, support is sought from CASA.

The Suicide Prevention Coordinator may also identify more systemic postvention and prevention risk issues in SPC monthly and six monthly reports which are provided to Southern DHB management. Future reports created by the Suicide Prevention Coordinator may use this adopted Action Plan as a template for reporting against ensuring outcomes and risk and opportunities can be identified. The Suicide Prevention Coordinator will also escalate immediate and urgent non clinical risk issues within the Public Health Service, WellSouth

References:

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