BOPDHB Suicide Prevention Postvention Action Plan 2018 - 2021

BAY OF PLENTY
DISTRICT HEALTH BOARD
HAUORA A TOI

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Introduction

This three year Bay of Plenty DHB (BOPDHB) Suicide Prevention Postvention (SPP) Action Plan replaces the DHB Suicide Prevention Postvention Plan dated 2015-2017. The later was guided by the NZ Suicide Prevention Strategy 2006- 2016, the NZ Suicide Prevention Action Plan 2013 – 2016 and the Ministry of Health (MoH) DHB Toolkit 2015 (Currently under review). This renewed plan updates initial actions and brings them into line with other BOPDHB strategic intentions.

In the absence of a current National Suicide Prevention Strategy this plan has been developed using BOPDHB population statistics, coronial suspected suicides data and other local intelligence to inform prevention and postvention activities. However, it must be noted that the BOPDHB SPP Action Plan is a living document which is open to review and re-editing as guidance/directives become available from the Ministry of Health, stated actions of the plan are achieved, and new initiatives or needs in the BOPDHB region are identified.

We already know through research that there are multiple risk factors that contribute to suicide, and protective factors that can counteract this risk[1]. For any suicide prevention initiative to be effective it has to be sustainable and occur within a multi-level intervention framework that expands across communities and sectors. This BOPDHB SPP Action Plan works towards achieving this.

The BOPDHB SPP Action Plan 2018 - 2021 is now linked to other BOPDHB strategic and MOH documents including;

BOP Strategic Health Services Plan: *see Section 4*

http://www.bopdhb.govt.nz/media/57182/hepouorangatangatawhenua.pdf

http://www.bopdhb.govt.nz/media/61157/good-to-great-maori-health-strategy.pdf

BOPDHB Annual Plan (Draft) 18/19:

SLM: Youth access to and utilisation of youth appropriate health services

To expand further, the BOPDHB Strategic Health Services Plan is a 10 year plan that sets out what the DHB is going to focus on to support people in communities to live healthy lives. This includes strengthening focus on providing integrated health services, bringing health services closer to the service

[1] See *Appendix 3* for further information on Risk and Protective factors

user, and providing the right mix of health supports in the right place. There are five priority populations identified in the BOPDHB Strategic Health Services Plan: Māori, young children (the first 1000 days of life), vulnerable children and youth, vulnerable older people and people with severe long-term mental health needs and/or addiction issues.

Purpose (what we are aiming to achieve)

Suicide is a significant public health issue in New Zealand, and is one of the 10 leading causes of death across all ages and the leading cause of death in young people aged less than 25 years. The latest annual provisional coronial suspected suicide data for the period 1 July 2016 to 30 June 2017 reported a national total of 606 deaths, the highest number of suspected suicides since the coroner's annual provisional suicide statistics were first reported in 2007/08. The suicide rate per 100,000 people was 12.64, up from 12.33 the previous year, but similar to the number recorded in 2010/11 of 12.65. Despite efforts, suicide rates have not fallen substantially, and international trends suggest suicide rates are increasing.

While suicides occur across the lifespan, some groups are disproportionately affected. Men account for 75% of all suicides annually with those of working age (20-65 years) accounting for more than half and those aged 20-39 years for at least 25%. As with men, Māori are also highly over represented in annual suspected suicide statistics, with rates well above the national average and that of other ethnicities in every year since coronial data was reported.

For the period 1 July 2016 to 30 June 2017 there was a total of 41 suspected suicides in the BOPDHB area, the highest number of deaths since 2009/10. Like national trends men and Māori are over represented annually in our regional statistics. Māori youth aged 15-24 years made up almost half of all Māori suicides, and just over 71% of all youth suicides in the ten year period July 2007/08 to June 2016/17. The remaining Māori suicides were almost exclusively committed by adults aged 25-64 years, with numbers reasonably similar between each five year age cohort. More detailed analysis of our regional data follows in this document and can also be reviewed in the appendices.

The overarching aim of this BOPDHB SPP Plan is to reduce, if not eliminate, the number of suicides that occur in our communities. We aim to do this, by focusing on the promotion of mental health wellbeing and resiliency, improving support and intervention for individuals experiencing mental health distress and/or suicidal behaviour and supporting those affected by suicidal loss. To work towards this the BOPDHB SPP Action Plan will:

- Continue to build a suicide continuum (prevention, intervention and postvention) model across the BOPDHB area which will meet the needs of individuals, family/whānau/hapū/iwi and communities.
- Continue to identify and build on existing suicide continuum planning and activity within the BOPDHB area.

- Formalise relationships of systems and processes between the BOPDHB and other agencies, services and communities to respond to the suicide continuum.
- Ensure appropriate governance and monitoring mechanisms are in place both at a BOPDHB district and community level.
- Increase education and training opportunities to all, including workforce, communities, iwi, hapū and family/whānau.

Our Geography and Population

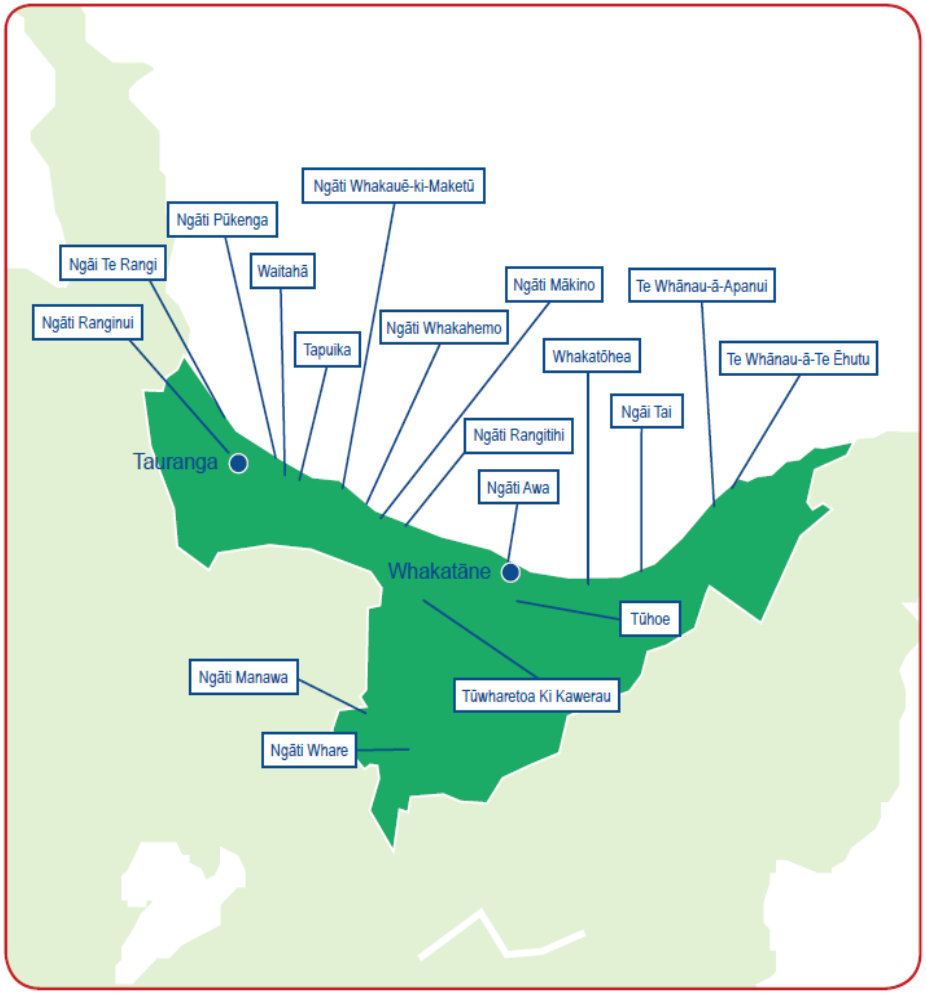
The BOPDHB covers 9,666 square kilometres and serves a population of 225,320. It stretches from Waihi Beach in the north-west to Whangaparaoa on the East Cape and inland to the Urewera, Kaimai and Mamaku ranges. These boundaries take in the major population centres of Tauranga, Katikati, Te Puke, Whakatāne, Kawerau and Opotiki.

77% of the BOPDHB population, or 173,290 people, reside in the Western Bay of Plenty. 18% of the Western Bay's population is Māori.

The Eastern Bay of Plenty spans a large geography and is one of the poorest and most deprived rural areas of New Zealand. Nearly half of the population lives in areas of high deprivation (deprivation areas 9 or 10[2]). Approximately 48% identify as Māori, many of whom experience poor access to health and social services and issues related to geographic isolation.

The geographical map identifies the 18 iwi located within the BOPDHB area.

BOPDHB has a low proportion of the population identifying as Asian (6%) or Pacific peoples (2%)[3]. Deaths by suicide amongst Pacific peoples are low, with three confirmed suicides in the last ten years and two confirmed deaths by suicide recorded for Asian peoples during this period.



[2] NZDep2013 is an index of socioeconomic deprivation. NZDep2013 combines census data relating to income, home ownership, employment, qualifications, family structure, housing, access to transport and communications. NZDep2013 provides a deprivation score for each mesh block in New Zealand. Mesh blocks are the smallest geographical area defined by Statistics New Zealand, with a population of around 60–110 people.
NZDep2013 group's deprivation scores into deciles, where 1 represents the areas with the least deprived scores and 10 the areas with the most deprived scores. A value of 10 therefore indicates that a mesh block is in the most deprived 10% of areas in New Zealand.

[3] Source: Bay of Plenty Health and Service Profile 2016, Bay of Plenty District Health Board

BOPDHB Suicide Statistics

On reviewing Coronial Suspected Suicide Data from 1 July 2007 to 30 June 2017 numbers of deaths by suicide in the BOPDHB area have ranged from 20 – 41 annually, the average number being 30 over the ten year period.

It is difficult to gain a totally accurate picture on local BOPDHB statistics due to the relative small numbers of suicides when broken down into specific demographics. However, analysis of BOPDHB provisional suicide data taken over a ten year period from 1 July 2007 to 30 June 2017 and applying linear trend lines to the various demographic graphs, we are able to explain in part, how suicides are trending for various population groups[4].

By gender, clearly there are more male suicides than female suicides per annum in the BOPDHB region, with both trending upwards.

By ethnicity, non- Māori and Māori suicides were compared, as other ethnic groups are minimal and make trending difficult. Although non- Māori suicide numbers are higher than for Māori per annum in the BOPDHB region, when looking at the difference in suicide rates per 100,000 population, Māori have been consistently higher. Both non-Māori and Māori suicides are trending upwards.

By age, youth (mainly 15-24yrs) make up approximately 25% of suicides in the BOPDHB region. Adults primarily in their twenties and forties make up around 60% and our elderly population approximately 10%. In all age groups except youth (10-24yrs) suicides are trending upwards, particularly the 25-44 cohort.

Youth suicides are in slight decline but have remained largely unchanged in the past six years. Youth statistics for the BOPDHB region are also higher than the national average. Analysis of provisional suicide data over the last ten years shows that Māori youth suicide rates are higher than for non- Māori youth in all years, being at least two times higher, except for the 2015/16 period[5].

Review of the BOPDHB coronial notification database of suspected suicides from 1 July 2014 to current has identified that in the past year there has been a marked increase in deaths of those over the age of 65 years. Numbers of elderly suicides in the last ten years have usually fluctuated from 2 - 5 deaths per annum, but in the last annual coronial provisional suspected suicide period of 2016/17 a total of 9 deaths were reported.

Another population of concern identified on reviewing the BOPDHB coronial notification database are suicides of individuals who have been current or recent to BOPDHB Mental Health and Addiction Services (DHB MH&AS). Out of a total of 104 suspected suicides in the BOPDHB region for the three year

[4] Demographic information highlighted in Appendix 1

[5] See Appendix 2 for Youth statistics

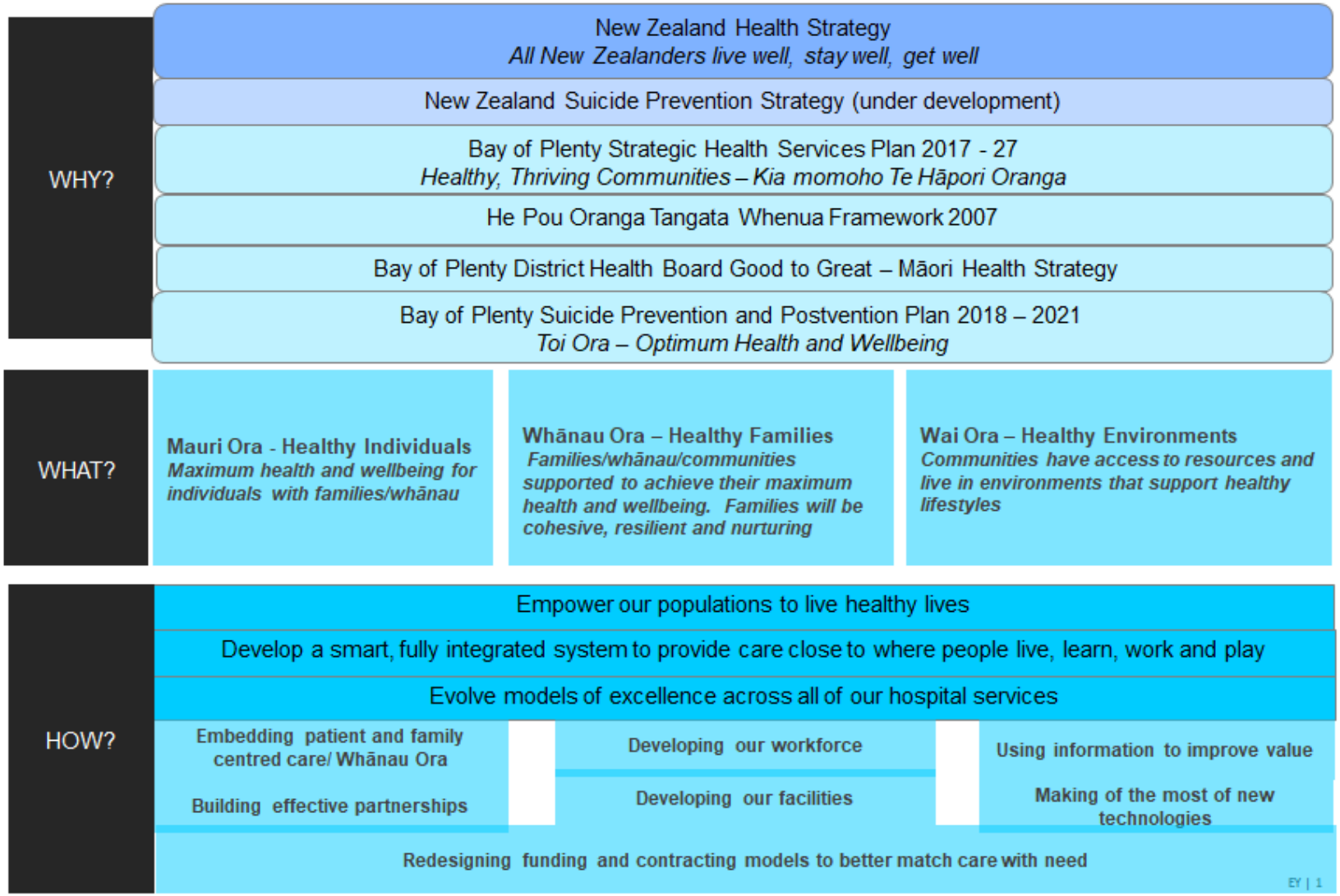
period of 1 July 2014 to 30 June 2017 there have been 27 deaths of individual's current to DHB MH&AS. A further 15 suspected suicides of those who had been recent to DHB MH&AS i.e. less than one year from discharge. The majority of these deaths occurred less than six months from discharge, with 5 occurring within one month from discharge. Overall individuals current or discharged within a year from DHB MH&AS accounted for 40.5% of all suspected suicide deaths in the period 1 July 2014 to 30 June 2017

From analysis of BOPDHB suicide statistics over the 10 year period and review of the BOPDHB coronial suspected suicide database we have been able to identify five populations of concern where focused actions are required and have been included in this BOPDHB SPP Plan.

These population groups are:

- **Māori**
- **Youth, particularly Māori**
- **Men**
- **Elderly**
- **People who present or are current to DHB MH&AS with suicidal behaviour**

Bay of Plenty Strategic Direction for Suicide Prevention



Toi Ora – Optimum Health and Wellbeing

The vision has been guided and influenced by He Pou Oranga Tangata Whenua (2007) framework, developed by the BOPDHB Māori Health Rūnanga[6] and He Korowai Oranga: Māori Health Strategy (2014), Ministry of Health's health strategy for Māori.

He Korowai Oranga continues to guide the implementation of health strategy for all Māori, by expanding on the aims of He Korowai Oranga (2002) from Whānau Ora to Pae Ora – healthy futures. Pae Ora has three elements: Mauri Ora – healthy individuals; Whānau Ora – healthy families; and Wai Ora – healthy environments. All three elements are interconnected and are mutually enforcing.

Across the BOPDHB district, the concept of Pae Ora is known as Toi Ora - optimum health and wellbeing, inherent within the He Pou Oranga Tangata Whenua (2007) framework. The concepts are the same, in being based on fundamental Tangata Whenua values, knowledge and practices.

This Plan adopts the overall vision of Toi Ora, but utilises the elements of Pae Ora to describe the outcomes sought in relation to suicide prevention. Together, they provide a framework in which to build our personal and public health interventions to respond to suicide. The vision sits comfortably with the BOPDHB' vision;

Kia momoho te hāpori oranga - Healthy, Thriving Communities

[6] Governance partner to the BOPDHB Board, consisting of 18 mandated iwi representatives.

Themes

From previous and recent engagements with sector/community stakeholders four key themes have been identified for achieving a meaningful impact on reducing suicide in BOPDHB communities.

These themes reflect the vision of Toi Ora and provide the foundation for this Plan.

1. Workforce development for agencies/services working with at risk individuals.
2. A focus on family/whanau education and intervention.
3. Leadership within communities, and community-led solutions.
4. Multiple agency collaboration in suicide prevention initiatives.

Principles

The following eight principles from *He Pou Oranga Tangata Whenua* will guide the implementation of the BOPDHB Suicide Prevention Postvention Action Plan 2018 – 2021.

- **Wairuatanga** Understanding and engaging in a spiritual existence.
- **Rangatiratanga** Positive leadership and self-empowerment.
- **Manaakitanga** Show of respect or kindness, and support.
- **Kotahitanga** Maintaining unity of purpose and direction.
- **Ūkaipōtanga** Place of belonging, purpose and importance.
- **Kaitiakitanga** Guardianship and stewardship over people, land and resource.
- **Whānaungatanga** Being part of and contributing collectively.
- **Pūkengatanga** Teaching, preserving and creating knowledge.

Overview of BOPDHB Suicide Prevention Postvention Action Plan 2018 - 2021

The previous BOPDHB Suicide Prevention Postvention Action Plan 2015 -2017 was based solely on a Community Action Model, which looked to support communities in the development of their own suicide prevention postvention (SPP) plans to meet the local needs of their people. Progress has been slow using this approach. To date Kawerau continues to institute their local SPP plan and the communities of Murupara and Ruatahuna are at varying stages of their plan development. Community readiness, leadership and relationships are critical to the success of this model.

The BOPDHB will continue to support communities in the development of their own plans to meet the needs of their people: whānau, hapū and iwi, by providing specialist advice and contracting appropriate health care providers to support community SPP plan development. Suicide data, information/resources and relevant trainings will also continue to be made available to these communities so that they can identify their vulnerable populations and develop SPP initiatives which will support those people and their overall community.

As previously mentioned, in order for suicide prevention to be effective, a multilevel approach across systems with long term commitment and sustainability is required. However, we also know that suicide does not solely exist within the health sector as a "mental health" issue. That in reality, the social determinants of health and the inequity of such, can often lead an individual to experience mental distress and suicidal behaviour. Social issues such as poverty, inadequate housing, unemployment, a lack of educational opportunities, interface with the justice system and experience of discrimination are but a few of the known risk factors to suicide. This BOPDHB SPP Action Plan will evolve towards adopting an integrated health care approach in working collaboratively with other government sectors and communities to address these risk factors.

In addition to the community action model and working towards an integrated healthcare approach this BOPDHB SPP Action Plan now expands to include evidence based suicide prevention postvention actions that are: **Universal** (whole of population), **Targeted** for our identified populations of concern, and **Indicated** for those already at risk.

Lastly, it is estimated that anywhere between 4 – 60 people can be affected per suicide. However, if we were to consider social media forums and memorial sites this number could multiple into the hundreds. Also, not all suspected suicides for a DHB region are officially captured. Although Provisional Coronial Suspected Suicide Statistics record those deaths which have occurred within a DHB region they do not account for those which occur outside of the area but return home for Tangi and burial. Therefore the full impact of suicidal loss for a community can be easily under estimated. This BOPDHB SPP Action Plan will work towards creating better support options for those affected by suicidal loss, with a particular focus on developing more responsive support for Māori.

Governance and Leadership

The BOPDHB is currently reviewing what governance and leadership structure is required to oversee and implement this plan. Previously the BOPDHB only had a designated Suicide Prevention Postvention Governance Group however, it may be more appropriate to consider establishing an 'actions based accountability group' to oversee and progress the actions of the plan and to utilise a pre-existing DHB governance group. Whatever future governance and leadership arrangements are confirmed it is important that Māori leaders are represented in these forums to provide a distinct voice for Tangata Whenua.

Clinical Leadership

A key role within respective governance and leadership arrangements is the provision of clinical oversight. This will ensure planned activities are evidence-based and best practice, potential risks are identified, and mitigation strategies are put in place. To achieve this, the BOPDHB appointed a Suicide Prevention Postvention Coordinator (SPC) in October 2016.

The role of the SPC Coordinator in addition to leading and coordinating the implementation of the BOPDHB SPP Plan is to identify and support clinical lead agencies/providers to promote suicide prevention initiatives and postvention response in their communities. The SPC Coordinator will also support the establishment of evidence based protocols and clinical pathways to govern practice within these services, including BOPDHB MH&AS.

Monitoring and Evaluation

The BOPDHB SPP Action Plan overall will be monitored by providing monthly reports to the General Manager Planning, Funding & Population Health, and the General Manager Māori Health Gains and Development, with quarterly reports to the BOPDHB Governance Group (TBC) and the Ministry of Health. Evaluation will occur through reviewing measures of success and surveys completed by workforce, service users and family/whanau/significant others as stipulated in the plan.

Monitoring and evaluation of youth initiatives in the BOPDHB SPP Action Plan will occur through the Youth Mental Health section of the System Level Measures (SLM) Framework. Progress against these measures will be reported to the Bay of Plenty Alliance Leadership Team (BOPALT) and the Ministry of Health on a quarterly basis. The specific measures include: 1/ Age Standardised youth self-harm hospitalisation rates and 2/ Number of Youth Suicides per annum.

Action Plan

The following Action Plan template sets out the actions to achieve our vision of Toi Ora – optimum health and wellbeing. The three elements of Pae Ora have been expanded on, to provide the outcomes that have focused both our short and longer term actions.

Using quality improvement methodology the Action Plan outlines the aims, actions/ideas of change, measures of success, and timeframes within which we estimate actions will be completed, as well as who will provide lead and support of these actions.

Please note that the timeframes for actions outlined in this Plan are broad and do not account for work plans that will develop out of this high level strategy. Such work plans will include more defined timeframes for process and outcome measures leading to completion of an action.

1. Outcome: Mauri Ora – Healthy Individuals

Maximum health and wellbeing for individuals with families/whanau.

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
Vulnerable rangatahi/youth are able to identify and have access to community resources that promote wellbeing and resiliency. **Themes 3 & 4** Leadership within communities, and community-led solutions. Multi-agency collaboration in suicide prevention.	Collaborate with existing rangatahi/youth groups within priority communities, to develop their own initiatives to promote wellbeing and resiliency.	**Outcome Measures** 1. Age Standardised youth self-harm hospitalisations are reduced for those priority communities. 2. Number of suspected rangatahi/youth suicides is reduced in those priority communities. 3. Rangatahi/youth experience survey/feedback. **Process Measures** 1. At least two priority communities are identified. 2. Working group is established with appropriate engagement and representation from community and youth sector. 3. Engagement and collaboration with rangatahi/youth groups is established in priority communities. 4. Rangatahi/youth designed community initiatives are developed and implemented. **Balancing Measures** 1. Increase in referral volumes and wait times for Youth Mental Health and Addiction Services (Primary & Secondary).	**Rangatahi/youth Groups** Established working group Iwi Providers SPC Coordinator Kia Piki te Ora Tauranga Youth Development Trust Priority One	July 2018 – June 2020

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
To improve the knowledge and skill of those working with vulnerable rangatahi/youth to be able to identify mental health and addiction issues, support and refer to appropriate services as required. **Themes 1 & 4** Workforce development for agencies/services working with at risk individuals. Multi-agency collaboration in suicide prevention.	Identify or develop a workforce training programme to deliver to the youth sector which is evidence based and responsive to Te Ao Māori.	**Outcome Measures** 1. Workforce has improved knowledge of rangatahi /youth mental health issues, Te Ao Māori wellbeing and suicide prevention as evidenced by pre and post participant surveys. 2. Age standardised Youth self harm hospitalisations are reduced, especially for rangatahi. 3. Increase in referral volumes for rangatahi/youth to primary and specialist Mental Health and/or Addiction Services (MH&AS). **Process Measures** 1. BOPDHB System levels Measures (SLM) Mental Health Youth working group is established with appropriate interagency representation. 2. Work plan outlining actions is completed. 3. Workforce training programme is identified or developed and delivered across youth sector in BOPDHB region. **Balancing Measures** 1. Increase in referral volumes and wait times for Youth Mental Health and Addiction Services (Primary & Specialist).	**BOPDHB SLM Mental Health Youth Working Group** BOPALT (Bay of Plenty Alliance Leadership Team) MOE Ministry of Justice MSD Māori Workforce Development	July 2018 – June 2019
To promote wellbeing and resiliency in vulnerable men.	Explore ways of working with men to increase resilience and wellbeing, and await Mental Health & Addiction Inquiry	**Outcome Measures** TBC.	**SPC Coordinator**	July 2018 – June 2021

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
	recommendations.	**Process Measures** 1. Complete a stocktake on existing local and national men's programmes.		
To improve the quality of care for those who present or are current to DHB MH&AS that experience suicidal behaviour. **Theme 1** Workforce development for agencies/services working with at risk individuals.	Establish an evidenced based, Te Ao Māori responsive treatment model within DHB MH&AS for supporting individuals with suicidal behaviour.	**Outcome Measures** 1. Service user/whanāu/family and staff satisfaction surveys demonstrate positive outcomes in treatment/care delivery. 2. Self-harm hospitalisations are reduced. 3. Numbers of suspected suicides while under the care of DHB MH&AS or discharged within six months are reduced. **Process Measures** 1. Working group is established with appropriate representation. 2. A work plan is developed. 3. Evidence based, Te Ao Māori responsive model of treatment is identified and implemented across DHB MH&AS. 4. Evaluation of treatment model is completed post implementation.	**DHB MH&AS Working group** Core Clinical Group Māori Workforce Development DHB Emergency Departments SPC Coordinator TTHW Planning & Funding MH Portfolio Managers	July 2018 – June 2021
To improve the knowledge and skill of those working with elderly (65+) to be able to identify depression and/or suicidal behaviour, support and	Develop An evidence informed workforce training programme to deliver to the elderly sector.	**Outcome Measures** 1. Workforce has improved knowledge of elderly depression, suicide, and support strategies as evidenced by pre and post participant surveys. 2. 65+ self harm hospitalisations are reduced. 3. Suspected suicides of those 65+ are reduced.	**MHSOP (Mental Health for Older People)** SPC Coordinator DHB MH&AS Nurse Educator	July 2018 – June 2020

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
refer to appropriate services as required. **Themes 1 & 4** Workforce development for agencies/services working with at risk individuals. Multi-agency collaboration in suicide prevention.		**Process Measures** 1. An evidence based workforce training programme is developed and delivered across the BOPDHB region. **Balancing Measures** 2. Increase in referral volumes and/or wait times for older peoples Mental Health and Addiction Services.	TTHW Planning & Funding Healthy Aging Portfolio Managers	
Improve bereavement support options for Family/whānau and others affected by suicidal loss. **Themes 1, 2 & 3** Workforce development for agencies/services working with at risk individuals. A focus on family/whanau education and intervention.	Services to support families/whānau and others bereaved by suicide are identified, coordinated and made available as a routine part of suicide postvention activities.	**Outcome Measures** 1. Families/whānau and others bereaved by suicide feel supported by appropriate services as evidenced by service user satisfaction surveys. 2. Contagion suicide is non evident in communities. **Process Measures** 1. Stocktake of existing service provision across the BOPDHB area is undertaken. 2. Engagements with those affected by suicide across communities is undertaken to identify needs and gaps in service delivery. 3. Appropriate resource and trainings are made available to build capacity and capability in communities to support those affected by suicide.	**SPC Coordinator** Grief Support Services Eastern Bay Public Health Alliance Anamata Growing Through Grief TTHW Planning & Funding MH Portfolio Managers	July 2018 – June 2020

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
Leadership within communities, and community-led solutions.				

2. Outcome: Whānau Ora – Healthy Families

Families/whanau/communities supported to achieve their maximum health and wellbeing. Families/whanau will be cohesive, resilient and nurturing.

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
Build the capacity of whānau, hapū, iwi and communities to prevent suicide. **Themes 1, 2, 3 & 4** Workforce development for agencies/services working with at risk individuals. A focus on family/whanau education and intervention. Leadership within communities, and community-led solutions. Multi-agency collaboration in suicide prevention	Support the inclusion of SPP activities in community, iwi and hapū plans.	**Outcome Measures** 1. There is evidence of suicide prevention and/or postvention activities reflected in community, iwi and hapū plans. 2. Community, iwi and hapū reported experience of DHB support. **Process Measures** 1. Whānau/community champions and/or services are identified to lead community engagements. 2. Community engagements are undertaken and supported by agencies and services where appropriate. 3. DHB contracted health providers within communities are identified to provide clinical leadership and support of community plan development and action. 4. Community suicide prevention and postvention activities are planned and implemented.	**Community Level Governance** Kia Piki te Ora SPC Coordinator BOPDHB TTHW Planning & Funding	July 2018 – June 2021

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
EBOP and outlying WBOP communities will have access to timely and appropriate support following a suspected suicide. **Themes 1, 2, 3 & 4** Workforce development for agencies/services working with at risk individuals. A focus on family/whanau education and intervention. Leadership within communities, and community-led solutions. Multi-agency collaboration in suicide prevention.	Communities are supported to establish their own Intervention Response Teams (IRTs) to local suspected suicides.	**Outcome Measures** 1. Communities in EBOP and outlying WBOP areas have operational IRTs that provide postvention support in their communities. 2. Contagion suicide is not evident in communities with established IRTs. **Process Measures** 1. Lead Community Health Provider is identified to engage whānau/community champions and other services in the development of the local IRT. 2. Local IRT has access to appropriate trainings and resources to build capability and capacity. 3. Lead Community Health Provider routinely works with SPC Coordinator and District SIRT in planning community postvention response after a suspected suicide.	**Lead Community Health Provider** **SPC Coordinator** Kia Piki te Ora TTHW Planning & Funding MH Portfolio Managers	July 2018 – June 2021

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
Workforce, communities, iwi, hapū and family/whānau have access to training and educational opportunities in mental health wellbeing and suicide prevention. **Themes 1, 2 & 4** Workforce development for agencies/services working with at risk individuals. A focus on family/ whanau education and intervention. Interagency collaboration in suicide prevention.	Training and educational opportunities for BOPDHB communities are actively sourced and promoted.	**Outcome measures** 1. Workforce, communities, iwi, hapū, family/whānau have increased knowledge of mental health wellbeing and suicide prevention as evidenced by course/Wānanga participant evaluation forms. **Process Measures** 1. Evidence based Gate Keeper Suicide Prevention and relevant mental health trainings/educational opportunities are promoted to BOPDHB communities. i.e. Le Va Life keepers, QPR, MH1O1 and ASSIST. 2. SPC Coordinator delivers education/training on suicide prevention on request. 3. Whanau Champion Training is promoted and made available to communities, whānau Hapū and iwi on request. 4. Anamata Level 6 National Certificate in Suicide Intervention is promoted and delivered. 5. Training events and attendance numbers are recorded and reported on.	**SPC Coordinator** Kia Piki te Ora Tuwharetoa Ki Kawerau Health, Education & Social Services Anamata Māori Health Planning & Funding MH Portfolio Manager	Ongoing

Aim	Change idea / Action	Measures of Success	Lead/Support	Timeframe
Improve information and support to family/whanāu and/or significant others of those who have self harmed or attempted suicide. **Theme 2** Focus on family/ whanau education and intervention.	Develop an information pack for family/whānau and/or significant others that can be customised.	**Outcome Measures** 1. Families/whānau, significant others, caregivers have increased understanding on self harm and/or suicidal behaviour and feel more able to support those affected as evidenced by annual survey responses. **Process Measures** 2. A resource pack which can be customised is developed. 3. Resource packs are made readily available at DHB MH&AS, Family Link, Pou Whakaaro, Kia Piki te Ora and are provided to family/whanau and/or significant others/caregivers at time of first contact.	**SPC Coordinator** DHB MH&AS FamilyLink Pou Whakaaro Ki Piki te Ora Marae TTHW Planning & Funding	July 2019 –June 2020

3. Outcome: Wai Ora – Healthy Environments

Communities have access to resources and live in environments that support healthy lifestyles.

Aim	Idea of Change/Actions	Measures of Success	Lead/Support	Timeframe
BOPDHB population has improved access to local, regional and national mental health wellbeing, suicide prevention, intervention and postvention information, resources and initiatives. **Themes 1, 2, 3 & 4** Workforce development for agencies/services working with at risk individuals. A focus on family/whanau education and intervention. leadership within communities, and community-led solutions. Multi-agency collaboration in suicide prevention.	Develop a multi media strategy to promote information, resources and initiatives on mental health well being, suicide prevention, intervention and postvention. Establish a Suicide Prevention Postvention webpage on the BOPDHB website.	**Outcome measures** 1. Consumer, provider experience survey/feedback on awareness of resources. **Process Measures** 1. Hit rates for BOPDHB website and other social media apps utilised to promote information is monitored.	**SPC Coordinator** Toi Te Ora BOPDHB Comms Local councils DHB contracted MH&AS providers Kia Piki te Ora TTHW Planning & Funding	July 2018 – June 2020 Ongoing.

Aim	Idea of Change/Actions	Measures of Success	Lead/Support	Timeframe
Increase district level postvention response to include suspected suicides of all ages. **Themes 3 & 4** Leadership within communities, and community led solutions. Multi agency collaboration in suicide prevention.	Expand existing District Level Youth Suicide Intervention Response Teams (SIRTs) in WBOP and EBOP to include postvention response for suspected suicides of all ages.	**Outcome Measures** 1. District All age SIRTs are operational in the EBOP and WBOP. 2. Suicide contagion is non evident in BOP communities. **Process Measures** 1. Interagency members of all age SIRT are confirmed. 2. Postvention protocol is developed and implemented in line with Clinical Advisory Service Aotearoa (CASA) guidelines. 3. District SIRT collaborates with local community Intervention Response Teams (IRTs) to provide postvention support and monitoring. 4. District SIRT collaborates with CASA and local community if contagion or cluster suicide is suspected.	**SPC Coordinator** District SIRT members CASA	July 2018 – June 2019

Appendices

Appendix 1: Overview of BOPDHB Suicide Data 1 July 2007 to 30 June 2017

Total population

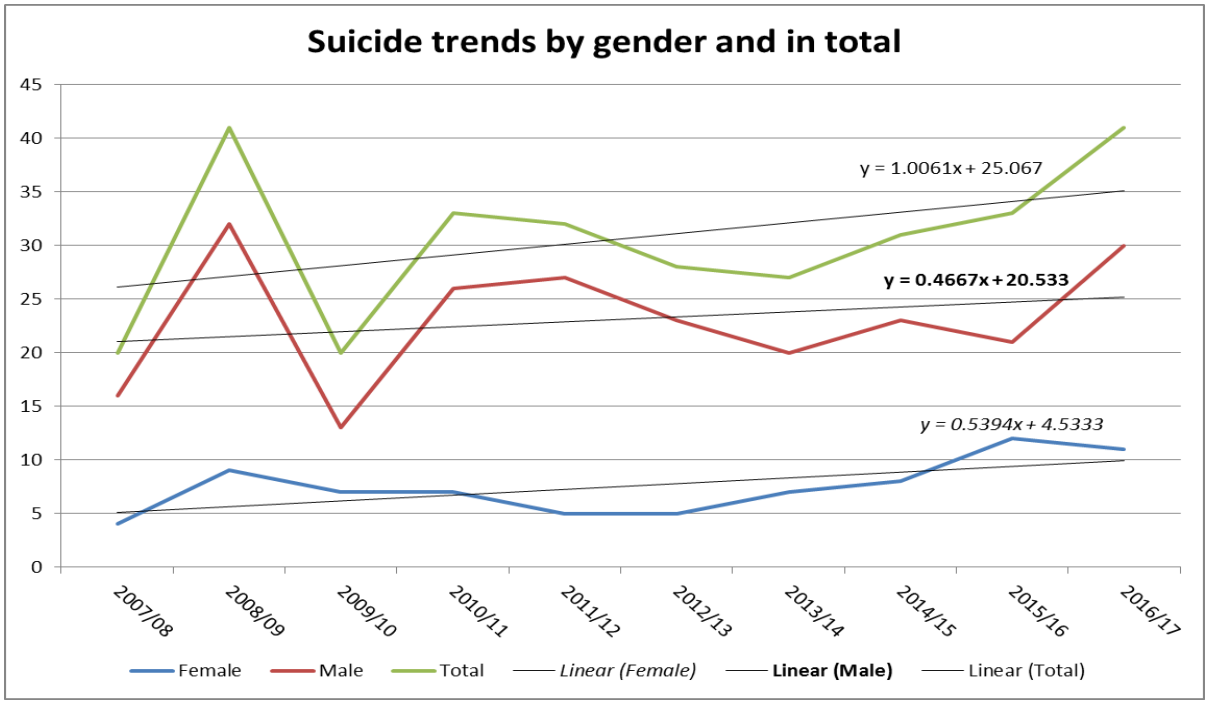


Image 1: Suicide Trends by gender for total population

Image 1 above shows simple linear trending for total population suicide for the ten year reporting period, and separate trending by gender. The graph clearly shows there are more male than female suicides per annum, and that suicides have trended upwards for both males and females over the reporting period. Interestingly, suicides are trending upwards faster for females than males, but not substantively. For both males and females there is approximately one additional suicide every two years, or, in other words, there is an additional suicide in Bay of Plenty each year on average. An increasing population in BOPDHB might mitigate some of this increase in actual suicides when considering suicide rates.

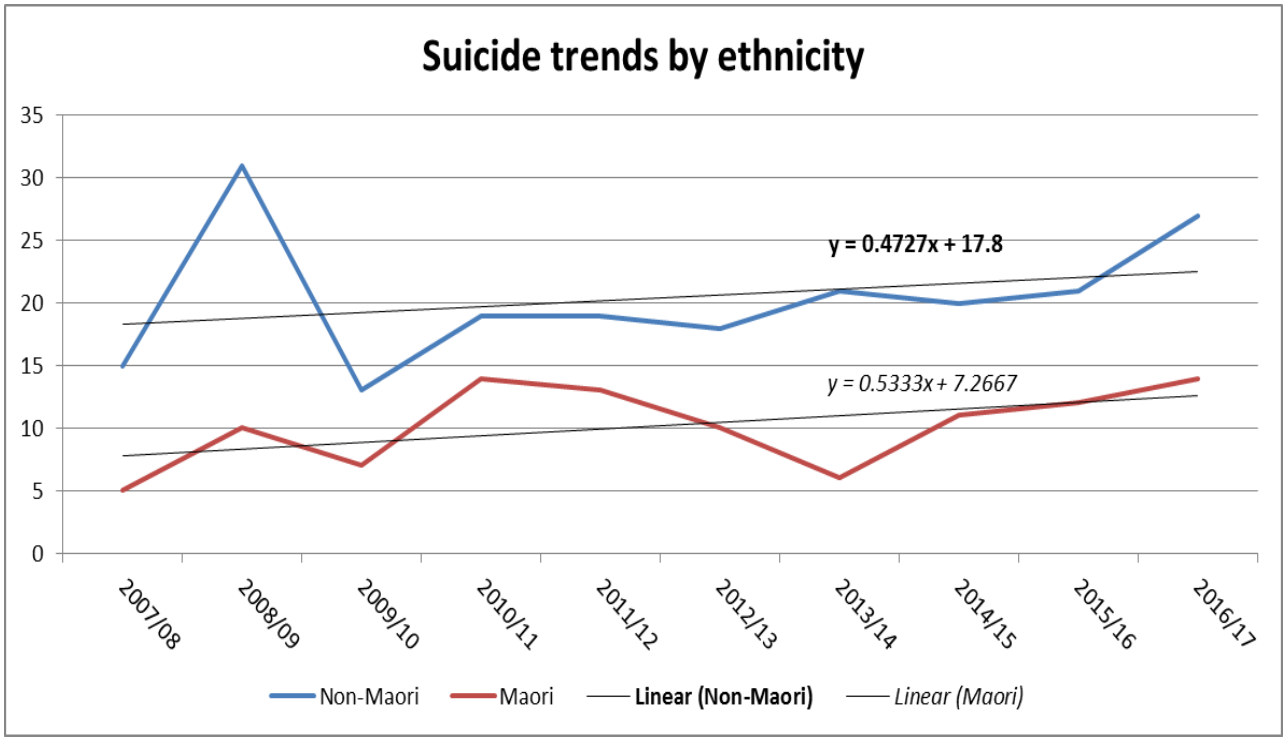


Image 2: Suicide Trends by ethnicity for total population

Image 2 above shows suicide trends by ethnicity for the ten year reporting period. The focus has been on Māori and non-Māori groups only, as the number of suicides for other ethnic groups are minimal, which makes trending difficult. The graph shows that non-Māori suicides are higher than Māori suicides in each of the last ten years (in terms of number of suicides), while suicide rates for Māori are always higher than for non-Māori.

Suicides are trending upwards for both Māori and non-Māori populations, though slightly faster for Māori. As with males and females, for both Māori and non-Māori there is approximately one additional suicide every two years based on the reporting period.

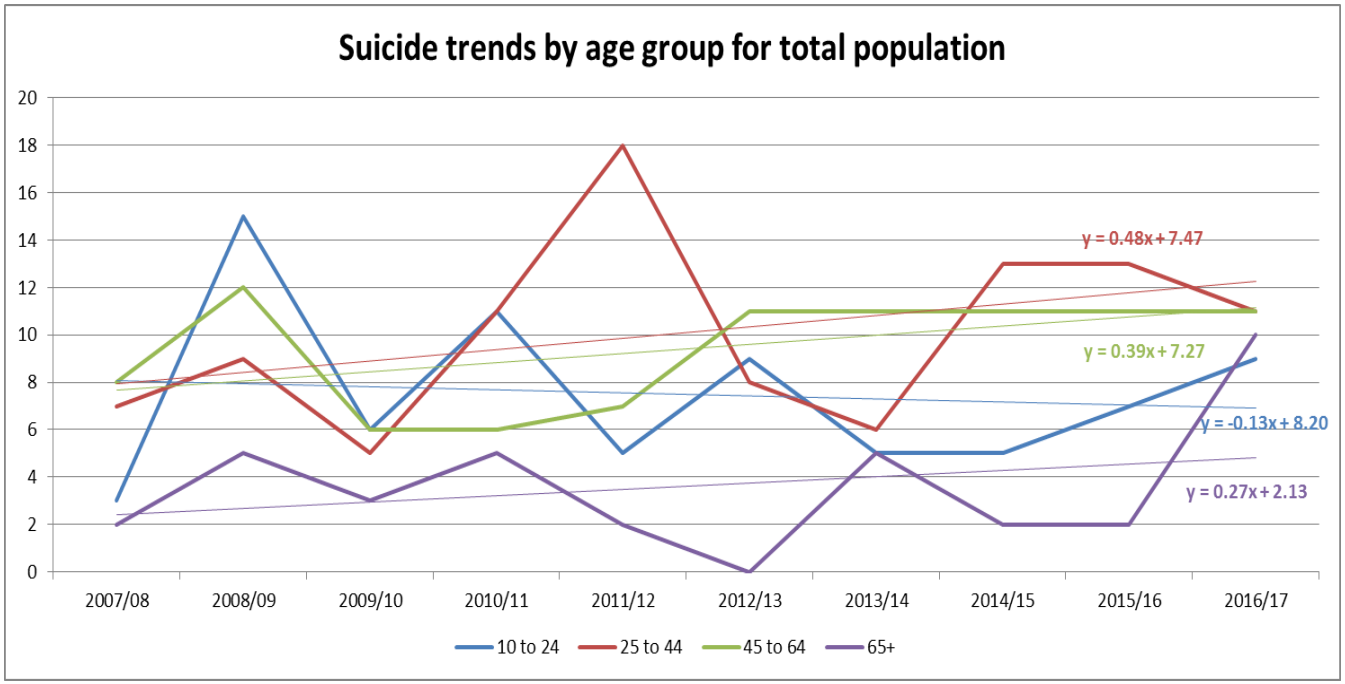


Image 3: Suicide Trends by age group for total population

Due to small numbers, the number of suicides per annum for each age can differ substantially from year on year. Image 3 above applies linear trend lines in order to provide a high-level indication as to how suicides are changing over time for each age group. However, a dramatic rise or fall in suicides from one year to the next in a particular age group can have a profound impact on this trending.

The graph indicates that child/youth (10-24) suicides are falling, on average, at a rate of 1 suicide every 7.5 years (0.13 suicides per year). However, over the last six years, suicides in this age group are largely unchanged (based on a linear trend). Suicides are trending upwards for all other groups based on suicide data for the period 2007/08 to 2016/17 (noting that 2016/17 data is provisional). There is a particularly strong increase for the 25-44 age groups, where a linear trend indicates there is, on average, an additional suicide in this age group every two years.

The trend in elderly suicides has been substantially influenced by the high result in 2016/17. Without this data point, suicides in this age group have been on the decline. The fact the latest data point has reversed has reversed this trend, i.e. there is an increase of 0.27 suicides per annum, on average, shows the substantive influence the number of suicides in any given year can have on trending.

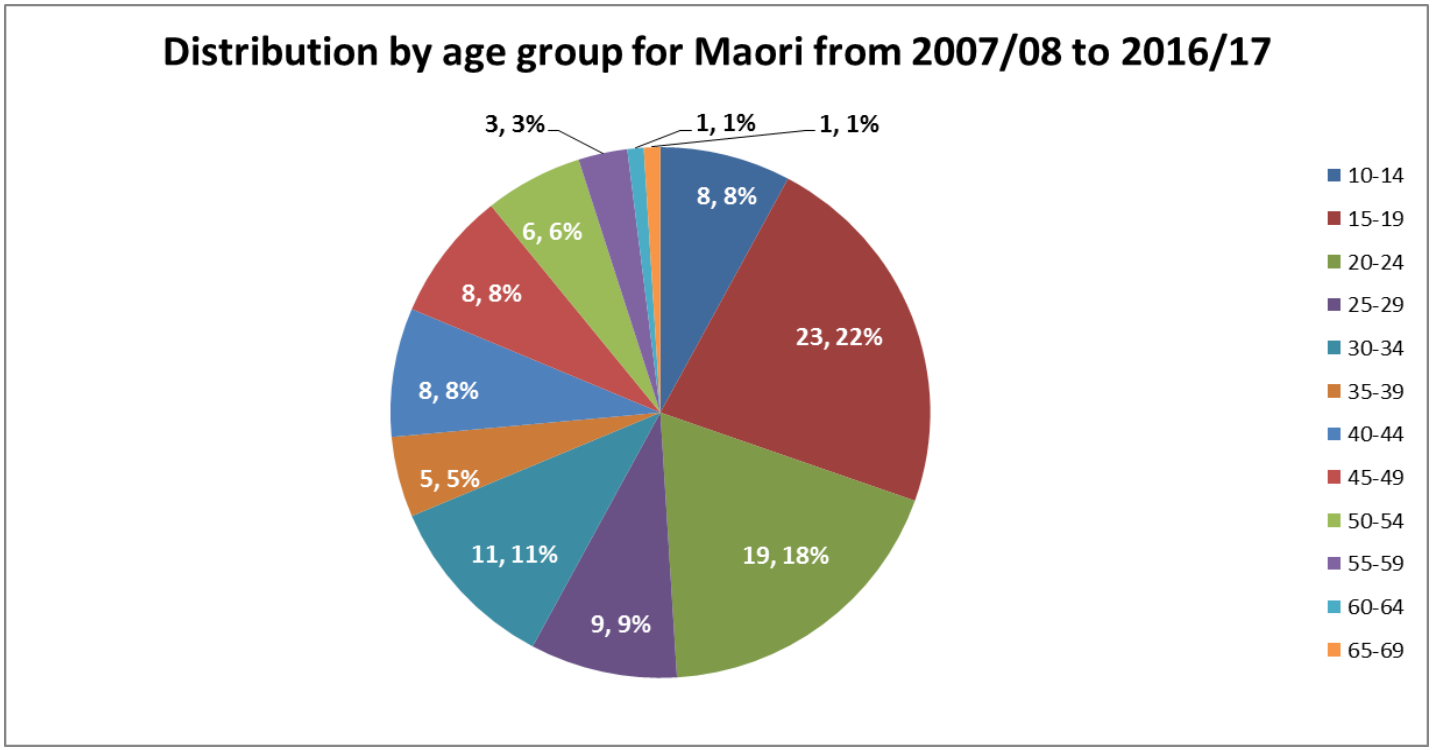


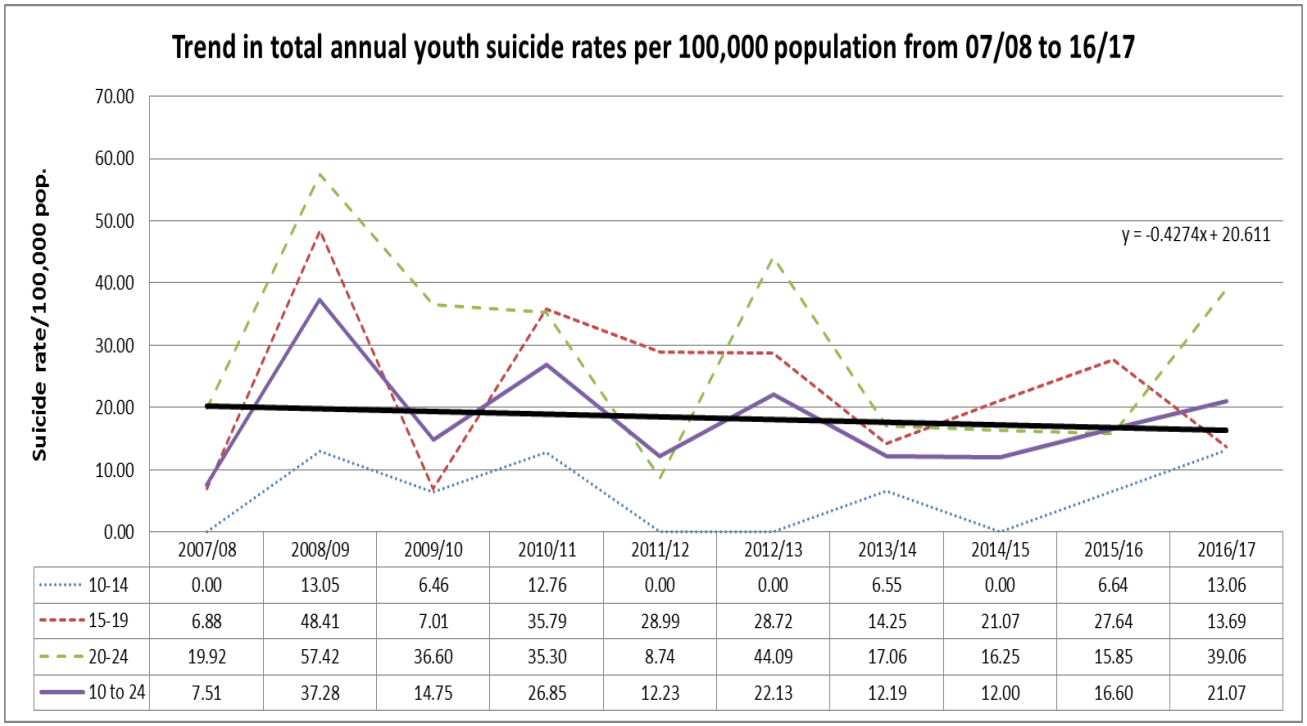
Image 4: Distribution of suicides by age group for Māori

The distribution of suicides by age group for Māori over the ten year reporting period is different from what is observed in the total population trends. Almost half of all Māori suicides are committed by youth, primarily in the 15-24 age range, i.e. there are twice as many Māori suicides in the 15-19 and 20-24 age groups than for any other age cohort. However, within the total population, which includes Māori suicides, only 25% of suicides are committed by youth. This is a clear indication that a significant portion of youth suicide is attributable to Māori. In numerical terms, Māori represented 50 of the 75 youth suicides in the last ten years

The remaining Māori suicides are (almost exclusively) committed by adults, with numbers reasonably similar by age group. Over the last ten years there has been only one Māori suicide over the age of 65 years, while there have been 36 suicides in this age group overall.

Appendix 2: BOPDHB Youth Suicide Data from 1 July 2007 to 30 June 2017

Total population



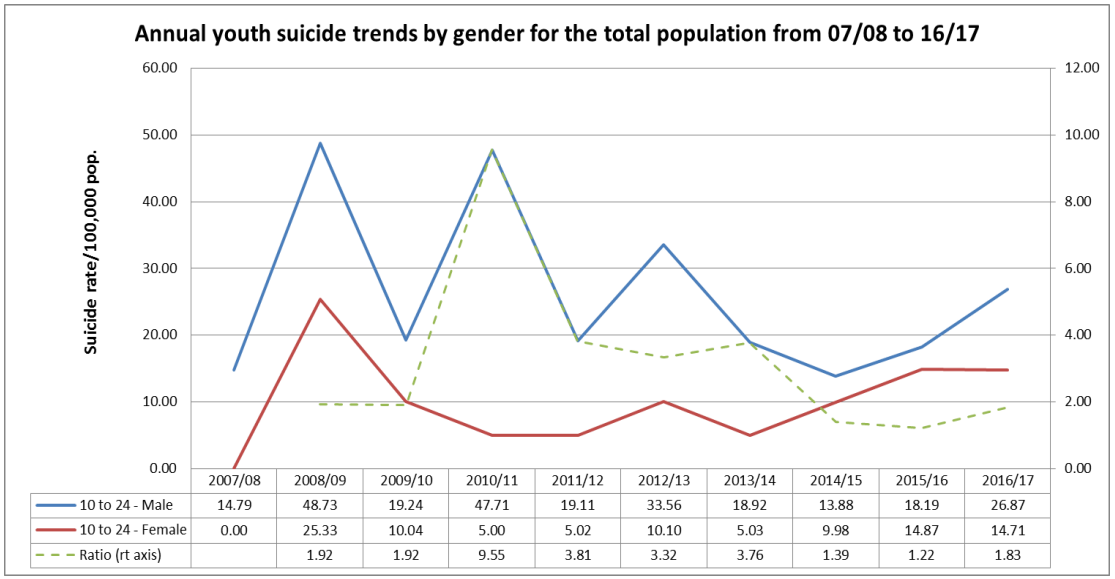
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10-14	0.00	13.05	6.46	12.76	0.00	0.00	6.55	0.00	6.64	13.06
15-19	6.88	48.41	7.01	35.79	28.99	28.72	14.25	21.07	27.64	13.69
20-24	19.92	57.42	36.60	35.30	8.74	44.09	17.06	16.25	15.85	39.06
10 to 24	7.51	37.28	14.75	26.85	12.23	22.13	12.19	12.00	16.60	21.07

Image 1: Trend in youth suicide rates from 2007/08 to 2016/17

Image 1 illustrates trends in youth suicide rates per 100,000 in Bay of Plenty over the last ten years. Trends are provided for the wider youth age group (10-24) and for three five-year sub age groups over this period. Populations are based on Statistics New Zealand population estimates with the 2013 census population as the base. Image 1 shows that suicide rates in the youngest five year age group (10-14) are much lower than for the other five year age groups, with annual suicide rates ranging from 0/100,000 population in multiple years to 13.06/100,000 population in 2016/17. This is compared to suicide rates in the 20s and 30s/100,000 population in the other two age groups.

Substantive variation in annual suicide rates for youth were observed over the past ten years, with rates ranging from 7.51/100,000 population in 2007/08 to 37.28/100,000 population in 2008/09. Due to the relatively small numbers of youth suicides in the Bay of Plenty per annum (generally less than 10), variations in suicide rates are not unexpected. Suicide rates can be influenced heavily by events such as suicide clusters; one such event occurred during 2008/09, which, in part, explains the high youth suicide rate in that year.

To provide a simple indication of how youth suicide rates have trended over the last ten years, a linear trend line was applied to the youth suicide rate (10-24). This trend line indicates youth suicide rates have been declining by 0.43 suicides per annum per 100,000 populations in Bay of Plenty. In other words, based on our current youth population of just over 40,000, we would expect one less youth suicide every six years on average. However, it is worth noting one or two years of higher suicide rates would significantly impact on this trend.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10 to 24 - Male	14.79	48.73	19.24	47.71	19.11	33.56	18.92	13.88	18.19	26.87
10 to 24 - Female	0.00	25.33	10.04	5.00	5.02	10.10	5.03	9.98	14.87	14.71
Ratio (rt axis)		1.92	1.92	9.55	3.81	3.32	3.76	1.39	1.22	1.83

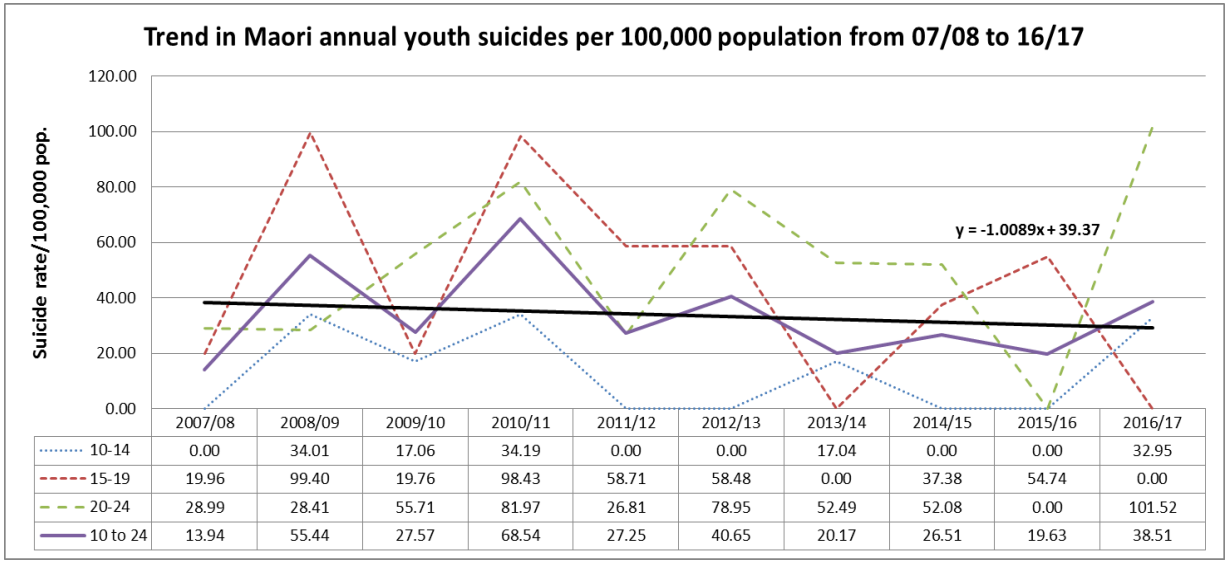
Image 2: Comparison of youth suicide rates by gender

Image 2 shows a breakdown of youth suicide rates by gender, including (on the right axis) a ratio of male to female youth suicide rates. This gender breakdown shows that male youth suicide rates have exceeded female youth suicide rates in all of the last ten financial years, though the difference between the two rates has begun to close, in general, over the last three years.

Male youth suicide rates show substantive variation year on year, but have been trending downwards over the last ten years. Female youth suicide rates demonstrate less volatility, but, unlike for male youth, female youth suicide rates have trended slowly upwards over the last ten years when controlling for the spike in rate in 2008/09.

Male youth suicide rates have ranged from 1.22-9.55 times higher than for females in the last ten years. Over this period, male youth suicide rates per annum were (on average) 2.6 times higher than female youth suicide rates, but have been less than two times higher in each of the last three years. This change is a combination of male youth suicide rates trending downwards and female youth suicide rates trending upwards. If these trends continue, it is expected that in time female youth suicide rates will start to match, and then exceed, male youth suicide rates in Bay of Plenty.

Māori population



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10-14	0.00	34.01	17.06	34.19	0.00	0.00	17.04	0.00	0.00	32.95
15-19	19.96	99.40	19.76	98.43	58.71	58.48	0.00	37.38	54.74	0.00
20-24	28.99	28.41	55.71	81.97	26.81	78.95	52.49	52.08	0.00	101.52
10 to 24	13.94	55.44	27.57	68.54	27.25	40.65	20.17	26.51	19.63	38.51

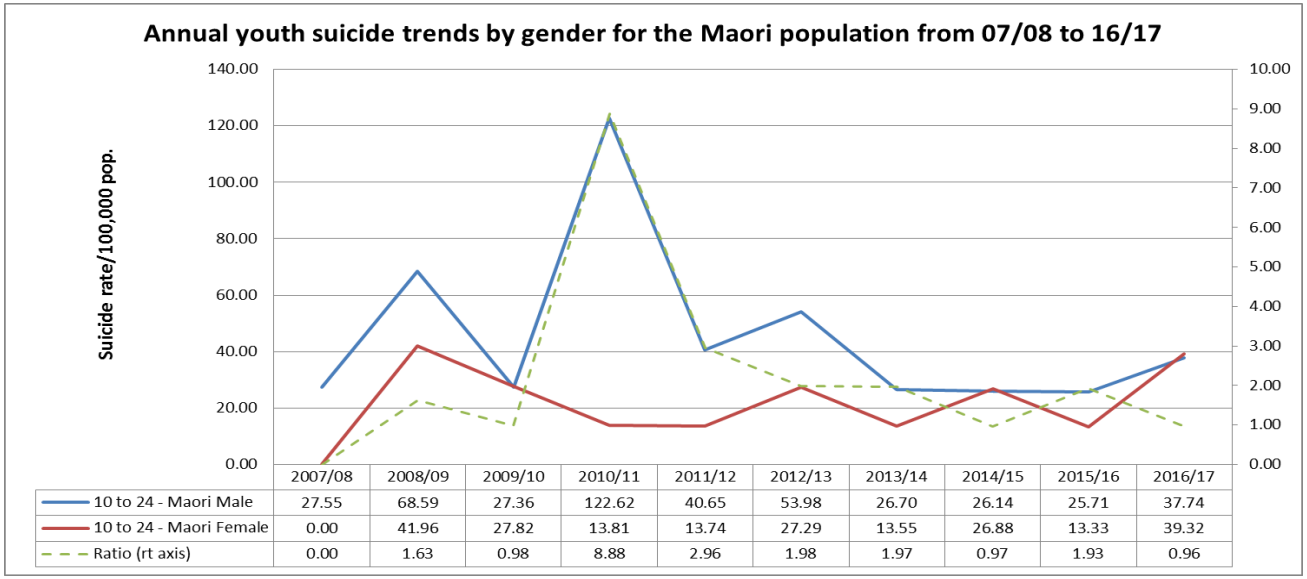
Image 3: Trend in Māori youth suicide rates from 2007/08 to 2016/17

Image 3 illustrates trends in Māori youth suicide rates over the last ten years. As with the total population, trends are provided for the wider youth age group and the three sub age groups within youth. Populations are based on subnational ethnic populations as measured in 2006 and 2013 censuses, with populations in the intervening years being estimates based on these census figures.

Image 3 shows that, as with the total population, the suicide rate for the 10-14 age groups is (generally) lower than the other two age groups in youth. While this is expected, the disappointment is that in 2008/09, 2013/14 and 2016/17 suicide rates in the 10-14 age group actually exceed the rates for one of the other two age groups.

Across all three age groups, and youth in general, for Māori there is significant volatility in annual suicide rates. For Māori youth, annual suicide rates vary from 13.94/100,000 population in 2007/08 to 68.54/100,000 population in 2010/11. This volatility is observed across all three sub age groups within youth, but particularly in the 15-19 and 20-24 age groups where there is a difference in rate of at least 99/100,000 population between the maximum and minimum suicide rates in the last ten years.

This significant volatility makes it challenging to identify trends, but a simple linear trend has been added to the youth suicide line to give an indication of how Māori youth suicide rates have changed over the last ten years. This linear trend line indicates that Māori youth suicide rates in Bay of Plenty have been declining by 1.01 suicides per annum per 100,000 populations. Based on our current Māori youth population of 15,600, this is equivalent to one less Māori youth suicide every six years on average. Taken in conjunction with the findings for the total population, this indicates the downward trend in total youth suicide rates is driven solely by the downward trend in youth suicide rates for Māori.



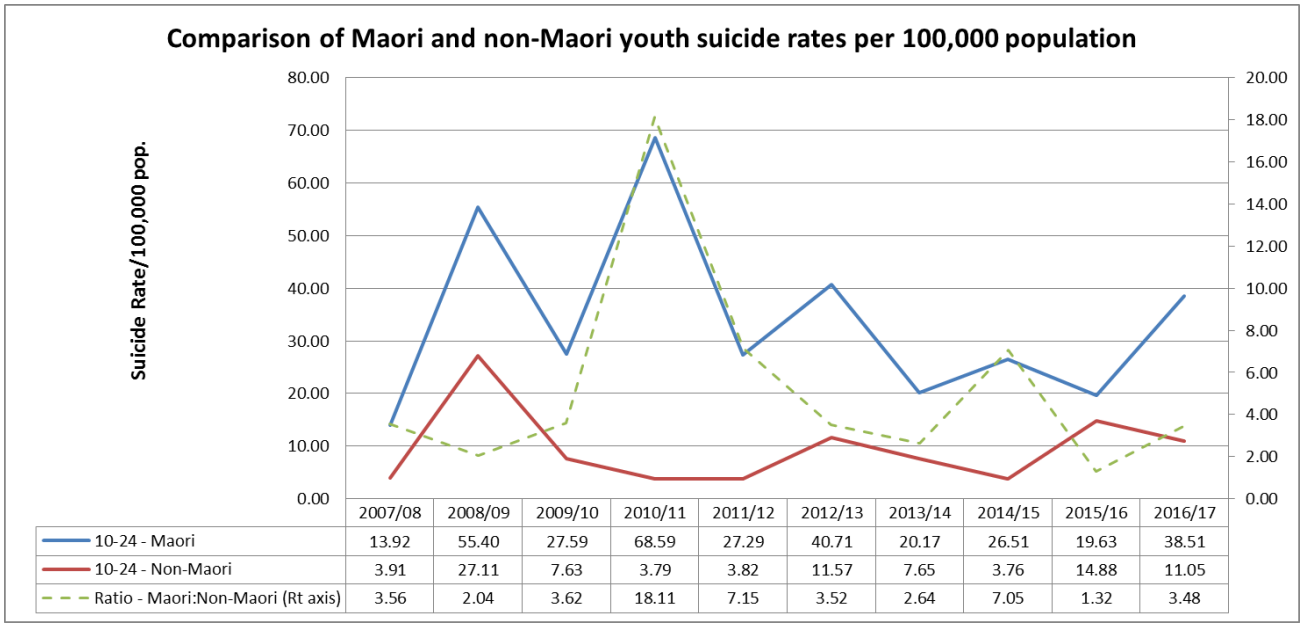
	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10 to 24 - Maori Male	27.55	68.59	27.36	122.62	40.65	53.98	26.70	26.14	25.71	37.74
10 to 24 - Maori Female	0.00	41.96	27.82	13.81	13.74	27.29	13.55	26.88	13.33	39.32
Ratio (rt axis)	0.00	1.63	0.98	8.88	2.96	1.98	1.97	0.97	1.93	0.96

Image 4: Comparison of Māori youth suicide rates by gender

As with the total population, image 4 illustrates that, in general, Māori youth suicide rates are higher for males than females. Over the ten year period, Māori male youth suicides per annum have been (on average) 2.08 times higher than Māori female youth.

However, this has changed noticeably over the last four financial years in particular, where Māori female youth suicides are almost equivalent to, and in some cases exceeding, rates for Māori male youth. Over this period, Māori male youth suicide rates per annum have been (on average) just 1.25 times higher than Māori female youth suicide rates. This is driven primarily by reductions in suicide rates for Māori male youth, as Māori female youth suicide rates have remained reasonably steady in the last ten years.

Comparisons between Māori and non-Māori youth suicide rates

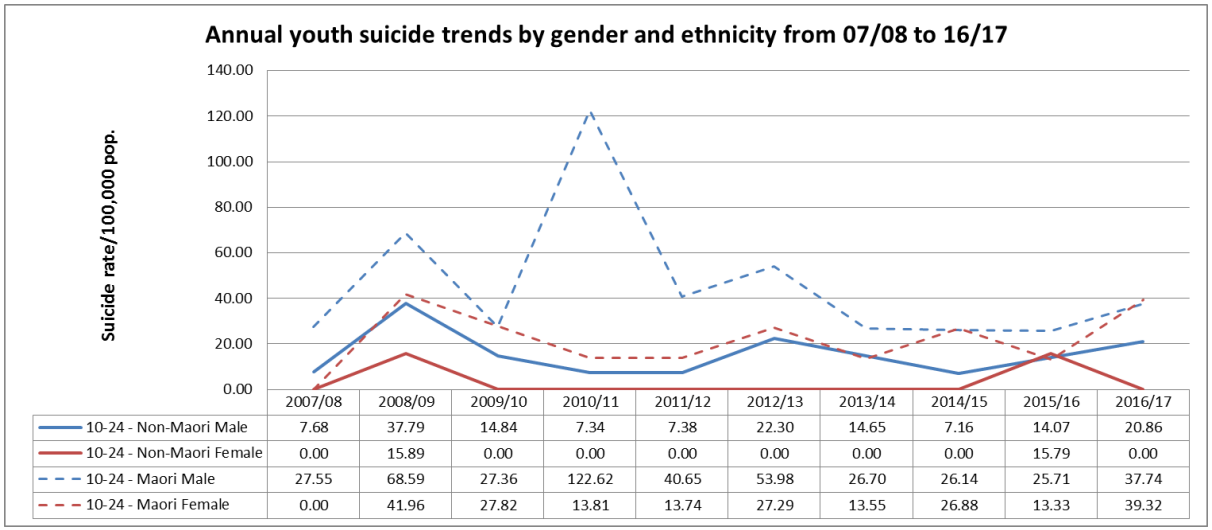


	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10-24 - Maori	13.92	55.40	27.59	68.59	27.29	40.71	20.17	26.51	19.63	38.51
10-24 - Non-Maori	3.91	27.11	7.63	3.79	3.82	11.57	7.65	3.76	14.88	11.05
Ratio - Maori:Non-Maori (Rt axis)	3.56	2.04	3.62	18.11	7.15	3.52	2.64	7.05	1.32	3.48

Image 5: Comparison of Māori and non-Mori youth suicide rates

Image 5 displays a comparison on Māori and non-Māori youth suicide rates over the last ten years. This shows that Māori youth suicide rates are higher than for non-Māori in all of the last ten years and, with the exception if 2015/16, Māori youth suicide rates were at least two times higher than for non-Māori over this period.

On average, over the last ten years Māori youth suicide rates per annum have been 3.55 times greater than non-Māori youth suicide rates, which is a substantive difference. However, over the last five years this difference between Māori and non-Māori youth suicide has started to close slightly, primarily due to a downwards trend in Māori youth suicide (Māori youth suicide 2.81 times greater than for non-Māori per annum over this period). Non-Māori youth suicide rates have remained reasonably steady over the last ten years with the exception of the spike in youth suicide rates in 2008/09.



	2007/08	2008/09	2009/10	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/17
10-24 - Non-Maori Male	7.68	37.79	14.84	7.34	7.38	22.30	14.65	7.16	14.07	20.86
10-24 - Non-Maori Female	0.00	15.89	0.00	0.00	0.00	0.00	0.00	0.00	15.79	0.00
10-24 - Maori Male	27.55	68.59	27.36	122.62	40.65	53.98	26.70	26.14	25.71	37.74
10-24 - Maori Female	0.00	41.96	27.82	13.81	13.74	27.29	13.55	26.88	13.33	39.32

Image 6: Comparison of Māori and non-Māori youth suicide rates by gender

Image 6 illustrates Māori and non-Māori youth suicides over the last ten years by gender. This shows that, in general, male youth suicide rates are higher than female youth suicide rates for both Māori and non-Māori. Image 6 also shows that Māori youth suicide rates are, generally, higher than non-Māori youth suicide rates for males and females.

Over the ten year period, Māori male youth suicide rates per annum were, on average, 2.95 times higher than for non-Māori male youth. For females, this discrepancy widens, with Māori female youth, on average, more than six times more likely than their non-Māori counterparts to commit suicide per annum. This is driven largely by the very low rate of non-Māori female youth suicides. Over the ten year reporting period there were only four non-Māori female youth suicides; there were sixteen Māori female youth suicides over the same period despite their being fewer Māori female youth than non-Māori female youth.

While male youth suicide rates have traditionally been greater than female rates, there is evidence over the last three-four years that this is starting to change – particularly for Māori youth. As previously stated, this appears to be largely driven by a downward trend in Māori male youth suicides over the last few years as opposed to increases in rates of Māori female youth suicide rates.

Appendix 3: Suicide Risk and Protective Factors

Personal risk factors	Personal protective factors
• Presence of poor mental and or physical health • Conflict about cultural identity • Disappointment or humiliation • Alcohol and drug misuse • Breakdown of an important relationship • Loss and grief issues • Negative impact of colonisation • Cultural alienation • Exposure to violence, trauma or abuse • Whānau pressures • Poor parent-to-child relationship • Peer pressure • Conflict about sexual identity • Educational disadvantage • Unemployment • Whakamomori • Breaches of tapu • Problem gambling • Stressful life events and circumstances	• Good self-care • Access to healthcare and social services • Access to support and help • Self-esteem and a sense of belonging • Having a secure identity • Hopefulness • Having a positive outlook on life • Positive relationships and good social support • Supportive whānau, hapū and iwi connections • Positive community support • Skills in problem solving, conflict resolution and positive ways of dealing with disputes and challenges • Having responsibility for others • Cultural/spiritual/religious beliefs that support self-preservation

Cultural protective factors	Clinical protective factors
• Understanding Māori concepts and models of care, e.g. mana atua, mana tupuna, mana whenua, mana tangata and He Pou oranga Tangata Whenua • Strengthening of cultural identity • Access to cultural resources, e.g. tōhunga, kaumātua, rongoā, Pou Oranga, their marae • Re-connect and maintain those connections to whānau, hapū and iwi (whakapapa) • Add Māori perspectives into service delivery • Use outcome measures appropriate to Te Ao Māori (Māori world view) and experiences	• Recognise suicidal behaviours/actions early and support whānau to get help early • Access to services that are culturally relevant and appropriate • Encourage whānau participation and value whānau members' contributions • Therapeutic alliances • Competent assessment processes • Services that value and promote the dignity and safety of the whānau and the whānau member • Evidence-based clinical interventions are effectively applied • Ongoing education programmes are in place for whānau and their whānau member • Chain of Care – services are components in an 'unbroken chain of care'. Every discharge from a service or referral is regarded as a transfer of care to another service, where the discharging/referring service retains responsibility, until the next service has engaged the individual and their whanau.[7]

[7] Child and Youth Mortality Review Committee 5th Report to the Minister of Health