

Suicide Prevention Toolkit for District Health Boards

February 2015

Disclaimer

The resources and examples included in this Toolkit support and encourage cross-DHB and intersectoral collaboration. District health boards need to consider these resources against their own knowledge of their community and available evidence of what is safe and effective.

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Contents

Introduction	1
Developing the toolkit	2
How to use the Toolkit	4
Continuous improvement	5
Feedback	5
Submission of new resources	5
Suicide Prevention Toolkit for DHBs	8
Introduction	8
Summary of guidance topics	9
Engaging	10
Analysing	17
Planning	29
Delivering	41
Learning and improvement	43
Bibliography	48
Appendix 1: Further information on implementing goal 6 of the <i>New Zealand Suicide Prevention Strategy</i>	53
Appendix 2: Suicide prevention and postvention plan 2015–2017	59
Appendix 3: Suicide prevention planning flow chart	63
Appendix 4: Tools and templates to help with planning	64
Appendix 5: Coronial Suspected Suicide Data Sharing Service (CDS) Explanatory Notes	69
Appendix 6: Coronial Suspected Suicide Data Sharing Service (CDS) – Privacy Impact Assessment	72
List of figures	
Figure 1: Pathways to suicidal behaviour	18

Introduction

Every week on average, 10 people die in New Zealand by suicide. Many more are treated in hospital after a suicide attempt, having seriously harmed themselves. Suicide is devastating for those personally affected and a tragedy for our society as a whole. In 2011, the suicide rates were almost 30 percent lower than at their peak in 1998, but they are still far too high. Sadly, New Zealand has some of the highest youth suicide rates in the developed world, and suicide rates for Māori are 54 percent higher than they are for non-Māori.

Suicide is preventable, and there is still much more we as a society can do to lower suicide rates.

Suicide prevention is complex, and there is no quick fix. People who take their own lives usually do so as a result of a range of factors. For this reason, actions to prevent suicide need to have multiple components and work both at an individual level and across the population.

While suicide prevention requires sustained activity across a number of sectors, the health sector plays a pivotal role. With their regional focus, district health boards (DHBs) are well placed to facilitate a comprehensive and intersectoral response within their own regions to address the spectrum of suicidal behaviour.

The suicide prevention work that DHBs are already doing, and will do in the future, is an integral part of a much bigger picture. Suicide prevention requires multi-level, multi-faceted, sustained commitment. DHBs will identify different approaches depending on their populations – it's not 'one size fits all'. A range of programmes and services is available to support DHBs in suicide prevention and postvention. Everyone has a role in preventing suicide.

The Ministry of Health has developed this Suicide Prevention Toolkit to support DHBs to implement suicide prevention and postvention activities within their regions.

The Toolkit outlines some of the key services areas involved, and discusses the issues that DHBs need to consider when planning how to address suicide. There is no expectation that DHBs will use all the tools, resources, ideas and guidance this Toolkit presents. District health boards know their communities best; they will need to design an approach that best meets the needs of their individual communities.

The Toolkit should be read alongside the following key documents:

- the Ministry of Health's New Zealand Suicide Prevention Strategy 2006–2016
- the Ministry of Health's New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action
- the Ministry of Health's New Zealand Suicide Prevention Action Plan 2013–2016
- Ministry of Health *Suicide Facts: Deaths and intentional self-harm hospitalisations 2011*
- Ministry of Health *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*
- Te Rau Matatini *Te Whakauruora – Restoration of health: Māori suicide prevention resource*.

As this is a planning tool, this Toolkit does not provide clinical guidance on how to recognise and respond to people at risk of suicide, or detail about specific interventions.

Developing the toolkit

The National Service Coverage Schedule sets out the Ministry of Health's expectations of DHBs in relation to suicide prevention and postvention from 1 July 2014. It states:

DHBs are expected to co-ordinate suicide prevention activities. This includes implementing a district suicide prevention plan, facilitating and enhancing cross-agency collaboration in respect of suicide prevention, and when necessary, implementing a suicide postvention plan and a coordinated response to suicide clusters/contagion. Activities will support implementation of the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016, and any other guidance/toolkits provided by the Ministry.

The development of this Toolkit is part of action 2.2 of the *New Zealand Suicide Prevention Action Plan 2013–2016*, which commits the Ministry of Health to 'develop and disseminate a toolkit for district health boards with guidance about best practice for preventing suicide and responding to suicide clusters or contagion'.

This Toolkit builds on the previous *Suicide Prevention Toolkit for DHBs* published by the Ministry of Health in 2001, and aims to:

- clarify DHBs' roles and responsibilities in suicide prevention and postvention
- assist DHBs to meet their suicide prevention and postvention responsibilities
- guide DHBs in developing a district-wide plan
- outline a range of best practice and evidence-informed approaches for suicide prevention that can be implemented at a district level
- provide local, national and international examples of how others have explored this complex issue
- provide a mechanism for sharing good practice and disseminating resources over time.

Sources and partnerships

Development of this Toolkit drew largely on DHBs' practical experiences and knowledge of their districts and communities. The material for the postvention section (both framework and content) was primarily drawn from Clinical Advisory Services Aotearoa (CASA)'s Community Postvention Response Service resources and knowledge. The authors greatly appreciate the generous contribution of time and expertise.

Evidence base

Where possible, the Toolkit is evidence-informed, and based on international and national research. In particular, it draws on existing suicide prevention initiatives in New Zealand and internationally with a strong evidence base, and others that are currently helping to build that base.

Development principles

The Toolkit was developed using a co-design approach – stakeholders were actively involved in its design and content. Another key principle was continuous quality improvement – the Toolkit will be improved over time as new evidence and experience becomes available.

Principles for suicide prevention activities

The Toolkit is in accordance with the [New Zealand Suicide Prevention Strategy 2006–2016](#), which states that all activities undertaken as part of this strategy should:

- be evidence-informed
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a coordinated multisectoral approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

How to use the Toolkit

Each section of the Toolkit presents guidance to assist DHBs and provides some examples from the sector and some supporting resources and templates.

The web format will guide users to relevant information, through:

- links to places within the Toolkit
- links to information on the internet
- links to supporting Word documents and PDFs that can be downloaded and printed.

Some information is presented in a text box to highlight its importance.

Developing a suicide prevention and postvention plan

The DHB Suicide Prevention and Postvention plan template is a guide to help DHBs develop their own plan (see Appendix 2).

Use the resources in this toolkit to help complete each section of the template.

Continuous improvement

Over time, learning about suicide prevention will increase, and new tools and examples of best practice for DHBs will be identified.

To ensure this Toolkit remains relevant and up-to-date, the Ministry of Health will periodically review the Toolkit and liaise with DHBs to ensure it is meeting their needs.

Feedback

We would like to hear from you. Please tell us how the Toolkit is working for you, which elements are the most useful and the areas in which it could be improved. If you would like to provide feedback please email us at DHBsuicidepreventiontoolkit@moh.govt.nz

Submission of new resources

This Toolkit contains links to a range of resources. New information and evidence on suicide prevention is being generated all the time. If you know of a new resource or best practice example that might be useful to DHBs, and should be considered for inclusion in this Toolkit, please let us know.

The criteria for possible inclusion of a resource are:

- Is it relevant to other DHBs?
- Is it based on /informed by evidence?
- Has it been evaluated, or are there plans in place to evaluate it?

Please consider whether this resource can stand alone and is self-explanatory. Are acronyms or terminology used that need explanation or accompanying narrative text to ensure understanding by other audiences? If so, please also include this explanation as part of your submission.

To submit a resource for consideration, please complete the submission form on the web page and email it and the resource to DHBsuicidepreventiontoolkit@moh.govt.nz.

Submitted resources

Submitted resources will be reviewed by a group comprising Ministry staff, clinical leads from DHBs, academics and other suicide prevention agencies (when appropriate).

Depending on the volume lodged, materials will be reviewed approximately six-monthly. Resources will be evaluated against the criteria for inclusion and checked for clinical safety. The Ministry reserves the right to decide whether a resource will be uploaded onto the Toolkit.

Any DHB resources that are posted on the Toolkit will be acknowledged. Any updated versions of resources need to be sent to the Ministry via the Toolkit email address to ensure the Toolkit is as up to date as possible.

Glossary of terms

Definitions of terms commonly used in the area of suicide and suicide prevention vary between countries. The following definitions fit the NZ environment and/or international best practice.

1X calls: Police code for 111 calls relating to threatened or attempted suicide.

Attempted suicide: a range of actions where people make attempts at suicide that are non-fatal.

Bereaved by suicide: those close to a person who has died by suicide, needing specific support and who can be at greater risk of complicated grief or suicide themselves.

Best practice: the use of methods (often evidence-based) that achieve improvements and/or optimal outcomes.

Clinical governance: the system through which health and disability services are accountable and responsible for continuously improving the quality of their services and safeguarding high standards of care, by creating an environment in which clinical excellence will flourish. Clinical governance is the system. Leadership by clinicians and others, is a component of that system.

Community of practice: a group of people who share a concern or a passion for something they do, and learn how to do it better as they interact regularly.

Data (Suicide): statistics that inform on specific aspects of suicide, such as rates and trends of suicide and suicide attempts. Data collection can also be a means of monitoring service arrangements, such as post-discharge follow-up or outcomes.

Deliberate self-harm: a range of behaviours that may or may not result in serious injury, but are not intentionally fatal.

Evaluation: The continuous process of asking questions, reflecting on the answers to these questions and reviewing ongoing strategy and action.

Evidence-based: approaches that use and are based on clear evidence from existing literature.

Evidence-informed practice: ensuring that health practice is guided by the best research and information available.

Gatekeeper: adults of influence in the community who, in their day-to-day work or lives, are in contact with people experiencing emotional distress and who are well placed to respond in the event of imminent suicide risk, for example, kaumātua, teachers.

Intervention: in suicide prevention it refers to any action taken to improve a person's health and wellbeing or to change the course of or treat suicidal behaviour.

Mental disorder: a recognised, medically diagnosable illness or disorder that results in significant impairment of an individual's thinking and emotional abilities and may require intervention.

Mental health and wellbeing: a social, mental and emotional state in which a person can fully contribute to community life and achieve their potential.

Multi-disciplinary approach: approaches that involve professionals, agencies, organisations, and persons providing coordinated client service that draws on expertise from a range of disciplines.

Primary care: the care system that forms the first point of contact for those in the community seeking assistance. It includes community-based care from generalist services such as general practitioners, Māori health services, school counsellors and community-based health and welfare services.

Protective factors: factors such as biological, psychological, social and cultural agents that are associated with suicide/ suicide ideation and **decrease** their probability.

Resilience: a person's capacity to cope with adversity, seek help when it's needed and protect against factors that might increase their risk of suicide.

Risk factors: factors such as biological, psychological, social and cultural agents that are associated with suicide/ suicide ideation and **increase** their probability. Risk factors can be defined as either distal factors, such as genetic or neurochemical factors, or proximal factors, such as life events or the availability of lethal means – factors which can trigger a suicide or suicidal behaviour.

Selective intervention: activities that target population or community groups at higher risk for a particular problem, rather than the whole population or particular individuals. This might include working with the families of those bereaved through suicide or, for instance children who have been traumatised or abused over time.

Social connectedness – refers to the relationships people have with others and the benefits these relationships can bring to the individual as well as to society.

Suicide: the act of intentionally killing oneself as determined by coronial ruling.

Suicidal behaviour/s: encompasses suicide, attempted suicide, deliberate self-harm and suicidal ideation.

Suicide cluster: multiple suicides or suicide attempts, or both, occurring closer together in time, geography, or through social connections than would normally be expected for a given community.

Suicide contagion: where the original suicide influences others to attempt or complete suicide.

Suicidal ideation: thoughts of suicide.

Suicide postvention: the wide range of activities undertaken directly after a suicide in a community due to the potentially harmful effect a suicide may have on others.

Suicide prevention: the wide range of activities focusing on increasing protective factors and reducing risk factors and associated with suicidal behaviour.

Support: to assist with the burden or the weight of an issue, problem or adversity. Support can take many forms, including information provision, services and face-to-face counselling.

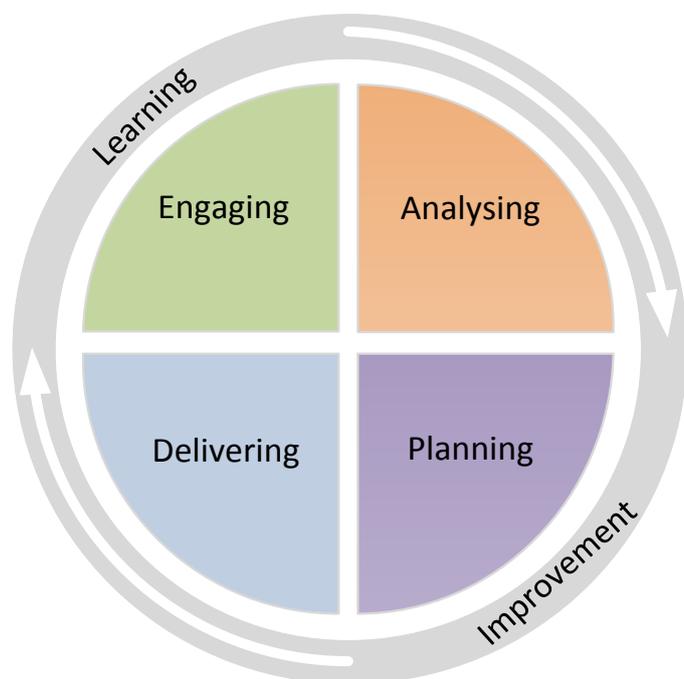
Sustainability: the ability of a programme to function over the long-term through adequate funding and the appropriate use of resources.

Warning signs: behaviours that indicate a possible increased risk of suicide, such as giving away possessions, talking about suicide or the withdrawal from family, friends and normal activities.

Suicide Prevention Toolkit for DHBs

Introduction

This Toolkit is structured around four areas, embedded within a learning and improvement process.



This Toolkit defines the four central terms as follows.

- **Engaging:** Developing relationships and partnerships with the community and across agencies to share ideas about, build understanding of, and take action concerning suicide.
- **Analysing:** Building an understanding of factors that influence suicide and opportunities for prevention, making use of local information to prioritise strategies, set goals and target resources.
- **Planning:** Developing a robust suicide prevention plan that reflects evidence and is tailored to local needs and resources.
- **Delivering:** Implementing and monitoring the delivery of suicide prevention and postvention activities.

The purpose of the 'learning and improvement' process that underpins these four areas in the conceptual model is to ensure that collective action is making a positive difference and that activity is supported by continuous quality improvement.

Summary of guidance topics

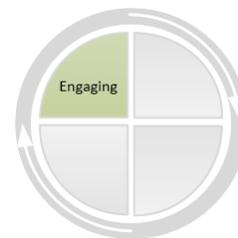
The summary table below provides a guide to the information this Toolkit presents. Relevant sections of the Toolkit provide links to the examples and resources.

Toolkit area	Guidance topics
Analysing	Understanding the causal pathways of suicide Understanding high-risk populations Evidence on the most effective interventions Understanding suicide in your local area Undertaking an environmental scan of capacity Information sources
Planning	Developing a programme logic model to support planning and learning Planning to ensure responsiveness to Māori Setting a plan with clear goals and actions
Delivering	Activating agency partnerships coordinating local networks
Learning and improvement	Measuring the impact of suicide prevention Creating communities of practice to share learning Building in continuous quality improvement The Plan Do Study Act cycle

Engaging

Suicide prevention and postvention activities rely on established relationships with the community and across a range of agencies and organisations. These relationships enable:

- integrated action
- the best use of resources
- joint priority setting
- sharing of information and learning
- a coordinated and timely postvention response.



Relationships require ongoing maintenance to ensure they can be activated when needed, particularly in a crisis.

This section provides guidance to help DHBs engage under the following topic headings:

- Identifying stakeholders
- Establishing relationships and networks
- Engaging with Māori
- Engaging with diverse communities.

Some examples from the sector

The following initiatives/publications provide examples of effective engagement.

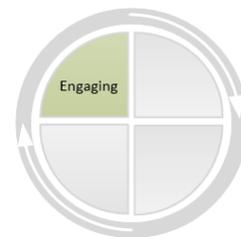
- Engaging with Māori: A guide for staff of the Bay of Plenty Regional Council
- Hawke's Bay DHB Fusion Group Terms of Reference (Coordination Group) (available on the Suicide Prevention Toolkit webpage)
- Northland DHB Social Wellbeing Governance Group Structure and Terms of Reference

Supporting resources

- Affinity Services *Rainbow Health: The Public Health Needs of LGBTTI Communities in Aotearoa New Zealand with Policy Recommendations.*
- Centre for Clinical Excellence (Health Navigator New Zealand) 'Cultural Competence'.
- LeVa Advice on engagement with Pasifika communities.
- Living is for Everyone Fact Sheet 15: 'Working with communities (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government).
- Ministry of Health *Equity of Health Care for Māori: A framework.*
- Ministry of Health *He Korowai Oranga: The Māori Health Strategy.*
- Office for the Community and Voluntary Sector *Ready Reference Engagement Guide: Supporting government agencies to engage effectively with citizens and communities.*
- Stakeholder Analysis Tool (see Appendix 4).
- Stakeholder Mapping Tool (see Appendix 4).
- Te Pou *Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report.*
- Te Rau Matatini *Te Whakauruora – Restoration of health: Māori Suicide Prevention Resource.*
- Waka Hourua *National Suicide Prevention Programme for Māori and Pasifika Communities.*

Identifying stakeholders

The first step towards effective community engagement is to get to know key stakeholders – people who are interested in or have a role in suicide prevention. Resources (including dedicated expertise, funding, training and tools) for suicide prevention are spread across many agencies. Service providers can make the most of these resources by consolidating their efforts, reducing service gaps and duplication.



Fostering strong and trusting relationships within the community is important in order to:

- draw on the wisdom of a wider group of people
- develop a common understanding and knowledge of roles
- enhance a shared understanding of the needs and views of the community
- build the trust needed to work collaboratively
- ensure networks are in place when complex situations arise.

DHBs may wish to consider initiating a coordinating network group of key stakeholders, to guide the development and implementation of a district suicide prevention plan.

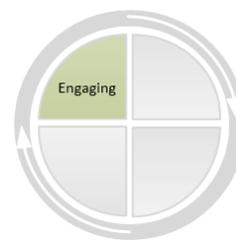
Key stakeholders in the development of a DHB suicide prevention plan may include:

- DHB personnel from public health, Māori health, mental health and addiction services and emergency departments
- non-government organisation (NGO) mental health and addiction providers
- NGO specialist suicide prevention/postvention services
- primary health organisation (PHO) clinical leadership
- government agencies such as the Ministries of Social Development (including Child, Youth and Family (CYF)), Police and Justice (including local coroners) and the Department of Corrections, and the education sector (including the Special Education Traumatic Incident service, school counsellors, principals and tertiary education counselling services)
- Kia Piki te Ora Māori suicide prevention providers (if available)
- other Māori organisations and service providers, including community leaders, hapū, iwi and hapori Māori
- Pasifika organisations and services providers, and community leaders
- other relevant health or social service providers
- charitable organisations with an interest in suicide prevention
- mental health and addiction consumer advisors
- local researchers and academics with an interest in suicide prevention
- advocates or representatives from high-risk population groups.

Establishing relationships and networks

Suicide prevention and postvention activity requires action across DHBs, services, organisations and agencies who can jointly:

- provide a district ‘network infrastructure’ that enables collective action
- coordinate governance and operations
- provide data-informed intelligence across the network as a whole.



Networks are particularly important for recognising the need for, and managing, postvention responses.

DHBs have a key role in establishing networks, as follows.

Supporting system leadership

Activities include engaging cross-agency stakeholders with leadership roles to:

- set priorities
- establish the platform of expectations for collaboration and partnership
- provide structures for ongoing leadership.

Some DHBs have already established suicide-specific governance groups (see Hawke’s Bay Fusion Group Terms of Reference). Others are engaging with existing cross-agency and community leadership forums that keep suicide prevention on the collective leadership agenda (see Northland DHB Social Wellbeing Governance Group Structure and Terms of Reference).

Supporting operational coordination

An effective suicide postvention response requires collective planning and action. It requires partners to establish clear roles, and agree on protocols for working together.

Much of a DHB’s work may involve liaison with, and mobilisation of, other sectors. This may require supporting others to modify their services to contribute to suicide prevention more effectively, or collaborating on particular projects.

In a suicide postvention response, the DHB’s coordinating role might include oversight and surveillance of emerging contagion risks and instigating the response. Ideally, the postvention planning group will have already established the agreed protocols and communication channels required to mobilise each agency’s local response rapidly.

Some DHBs support operational coordination by developing formal networks across agencies, which may include any of the stakeholders listed in ‘Identifying stakeholders’ above.

Networks may also play a surveillance role, to identify patterns of concern (eg, where intelligence from emergency departments, schools or CYF indicates an increase in suicidal behaviour).

Supporting community engagement, linkages and networks

Strong community linkages and networks provide support for postvention responses. DHBs may find it useful to run a practice exercise aimed at quickly calling together the necessary elements of the local response network, testing readiness and familiarising individual stakeholders with their roles.

Some DHBs are already:

- forging active links with the community
- involving the community in suicide prevention governance structures
- co-designing suicide prevention plans and interventions with community members
- undertaking surveillance of community wellbeing, risk and resiliency.

Ensuring services are well coordinated, and implementing best practice

As well as engaging with external partners, DHBs must ensure that their own services reflect best practice and coordinated action, including by:

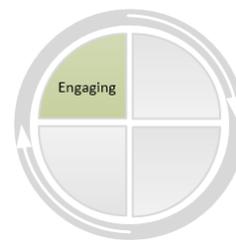
- supporting mental health services to implement best-practice approaches towards people at high risk of suicide
- supporting emergency department clinicians to implement best-practice approaches towards people presenting to emergency services following a suicide attempt
- supporting public health and community health services to deliver best-practice suicide prevention strategies
- supporting primary care services to better recognise and respond to people with mental health problems and others at high risk of suicide.

Clinical governance in DHB services

Strong clinical governance in mental health and addiction services can improve suicide prevention and postvention activities both within DHBs and across agencies. Governance structures for suicide prevention and postvention may benefit from a multi-disciplinary approach, involving clinicians and managers from within mental health and addiction services as well as those from other key services, such as public health, paediatrics and emergency departments. Strong clinical governance supports quick decision making and allocation of resources in situations where suicide clusters are suspected. It can also foster productive discussion and action towards broader suicide prevention strategies.

Engaging with Māori

In order to recognise and respect the principles of the Treaty of Waitangi, the New Zealand Public Health and Disability Act 2000 outlines mechanisms by which health providers may effectively engage with Māori; DHBs need to bear these in mind in planning strategies to reduce the rate of Māori suicide and suicide attempts.



DHBs already have well-developed networks and processes in place to engage with Māori. In terms of suicide prevention, DHBs will need to apply the principles on which these processes are based as follows:

- **Partnership:** working together with iwi, hapū and Māori communities to develop strategy for reducing the rate of Māori suicide and suicide attempts
- **Participation:** involving Māori at all levels in planning, development and delivery of health and disability services to reduce the rate of suicide and suicide attempts
- **Protection:** ensuring Māori rates of suicide and suicide attempts are lowered to at least the same level as those of non-Māori while safeguarding Māori cultural concepts, values and practices.

The Act recognises the need for service delivery that positively reduces disparities and is targeted at population-related initiatives.

All DHB staff play a key role in achieving the best outcomes for Māori. When developing Māori health policy or strategies relating to suicide prevention, DHBs should first engage with their own staff.

Given the high rate of Māori suicide, it is essential that DHBs design approaches with active engagement with Māori; confirm these approaches with local Māori leadership; take into account the unique features of the whānau, hapū, iwi, hapori Māori and communities in the region; and make use of strategies and approaches that have proven to be effective.

The Ministry of Health's *He Korowai Oranga: The Māori Health Strategy* sets an overarching framework to guide the Government and the health and disability sector to achieve the best health outcomes for Māori, improving Māori health and realising pae ora – healthy futures. DHBs should consider *He Korowai Oranga* in their planning, and in meeting their statutory objectives and functions for Māori health. *He Korowai Oranga* also assists Māori health providers and communities when planning their own strategic development.

The four pathways of *He Korowai Oranga* guide providers in implementing the strategy. These pathways are:

- supporting whānau, hapū, iwi and community development
- supporting Māori participation at all levels of the health and disability sector
- ensuring effective health service delivery
- working across sectors.

Te Rau Matatini created *Te Whakauruora – Restoration of health: Māori Suicide Prevention Resource* to assist hapū, iwi, hapori Māori and communities to provide safe and effective suicide prevention responses.

The resource uses a rarangahia te taurawhiri tangata (weaving people together) approach, encouraging the coordination of people, skills and resources and, most importantly, the mobilising of communities. It promotes:

- use of He Kaupapa Whakahaere: Mā Māori Mō Māori framework to work with and for Māori to strengthen their whānau ora
- ensuring Māori aspirations and needs are at the centre of suicide prevention initiatives
- recognising the diversity of Māori communities and lifestyles.

Another useful tool is the Ministry of Health's *Equity of Health Care for Māori: A framework*, which the Ministry developed to guide the health sector to achieve equitable health care for Māori. This can guide both Māori-specific and mainstream prevention approaches in working towards better outcomes for Māori.

Three values support the Equity of Health Care for Māori framework:

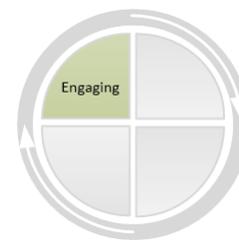
- **leadership:** championing the provision of high-quality health care that delivers equitable health outcomes for Māori
- **knowledge:** developing a knowledge base about high-quality health care for Māori
- **commitment:** committing to provision of high-quality health care that meets the health care needs and aspirations of Māori.

The framework is based upon current literature in the field of quality improvement and research on improving access to health services for Māori, indigenous peoples and minority ethnic groups.

Kia Piki te Ora Māori suicide prevention initiatives are in place in eight DHB regions (Northland, Counties Manukau, Bay of Plenty, Lakes, Hawke's Bay, Whanganui, Canterbury and Southland). The Ministry of Health encourages DHBs to work in partnership with Kia Piki te Ora providers to address suicide among Māori.

Engaging with diverse communities

New Zealand is an increasingly diverse nation. Developers of suicide prevention initiatives should recognise this, and aim to achieve equitable outcomes and equitable access to services for all populations.



Engagement with communities in terms of suicide prevention needs to be handled sensitively, and in a way that takes into account the needs, values and beliefs of different cultural, religious, social and ethnic groups.

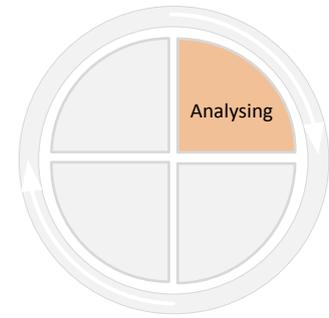
The *New Zealand Suicide Prevention Strategy 2006–2016* outlines key population groups that planners of suicide prevention or postvention initiatives should specifically consider. These include Māori; Pasifika people; Asian people; refugees; migrants; lesbian, gay, bisexual, transgender and intersex people (LGBTI); older people; young people; people with disabilities; and people in rural communities.

DHBs know their communities, and will already have agreed ways to ensure they engage with these groups in ways that are respectful and meaningful. The following resources and agencies may provide additional guidance:

- Affinity Services *Rainbow Health: The Public Health Needs of LGBTTI Communities in Aotearoa New Zealand with Policy Recommendations*
- Centre for Clinical Excellence (Health Navigator New Zealand) ‘Cultural Competence’
- ‘Living is for Everyone Fact Sheets 16–20: ‘Information on some at risk groups‘ (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)
- J Tiatia *Pacific Cultural Competencies: A Literature Review* (information and resources on how to engage with Pacific communities produced by LeVa)
- Nga Hou E Wha (a group within Midland DHB that provides an informed and strategic voice for people with experience of mental health issues and/or addiction on local, regional and national services and issues)
- Office for the Community and Voluntary Sector *Ready Reference Engagement Guide: Supporting government agencies to engage effectively with citizens and communities*
- OUTline and RainbowYOUTH (providing support for LGBTTI people)
- Te Pou *Mental health promotion and prevention services to gay, lesbian, bisexual, transgender and intersex populations in New Zealand: Needs assessment report*
- Waitemata DHB *Toolkit for Staff Working in a Culturally and Linguistically Diverse Health Environment*.

Analysing

To develop suicide prevention plans based on the best available evidence and that reflect the needs of the community, DHBs need to gather and analyse a range of information.



In terms of suicide prevention, there are five levels to this process:

1. **Contributors to suicide** – understanding the causal pathways of suicidal behaviour, including the risk and protective factors
2. **High-risk populations** – understanding population groups identified as having a higher risk of suicide and/or suicide attempts
3. **Evidence of most effective interventions** – understanding the available evidence on the most effective, evidence-informed or promising interventions for suicide prevention
4. **Suicidal behaviour in the district** – understanding suicide deaths and self-harm hospitalisation data (eg, numbers, rates, trends, demographic profiles and comparisons with national data; interactions with other health services and other agencies; prevalence of and relative level of exposure to key risk and protective factors)
5. **Capacity to respond** – understanding the capacity of the DHB region to undertake suicide prevention and postvention activities.

This section provides guidance to help DHBs analyse information under the following topic headings:

- Understanding the causal pathways of suicide
- Understanding high-risk populations
- Evidence on the most effective interventions
- Understanding suicide in your local area
- Undertaking an environmental scan of capacity
- Information sources.

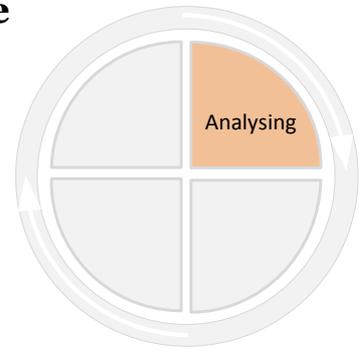
Some examples from the sector

The following initiatives/publications provide examples of effective engagement.

- Police provide daily information on incidents of death by suicide, suicide threats and attempts by young people under 25 years; some DHBs use this data to identify high-risk individuals.
- University of Auckland Faculty of Medical and Health Sciences Youth 2000 publications.

Understanding the causal pathways for suicide

The foundation of any suicide prevention approach is robust understanding of contributing factors.

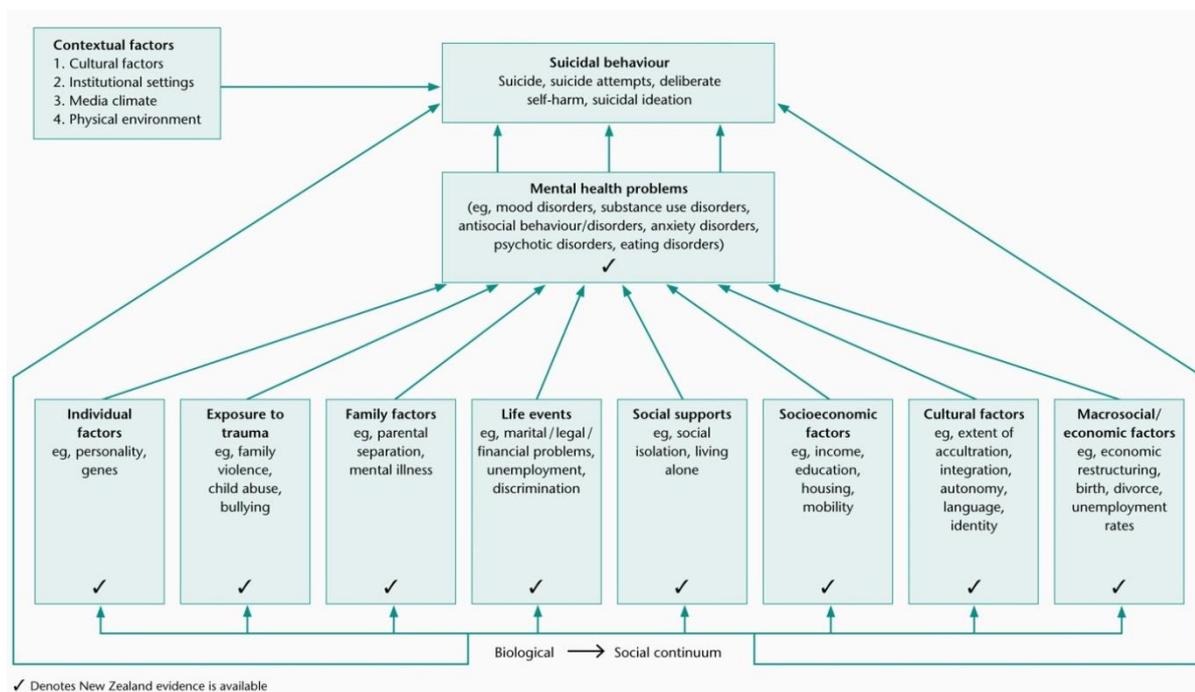


A wide body of research has found that the pathway to suicide typically involves a combination of biological, psychological, social, environmental and cultural factors. Suicide prevention requires tackling as many of the known underlying factors as possible, basing strategies, wherever possible, on evidence for effectiveness (K Skegg ‘Youth Suicide’ in P Gluckman and H Hayne *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*).

Risk factors

Risk factors for suicide can include individual factors (eg, genes or personality), life events (eg, a relationship break-up or a job loss) and wider social/economic factors (eg, economic recession), all of which can lead directly or indirectly to suicidal behaviour. Most often, several risk factors act cumulatively to increase an individual’s vulnerability to suicidal behaviour, but often just one or two factors trigger a person into making a suicide plan or an attempt on their life. The model below illustrates this process.

Figure 1: Pathways to suicidal behaviour



Source: *New Zealand Suicide Prevention Strategy 2006–2016*

Because suicidal behaviour is difficult to predict at an individual level, planners of suicide prevention strategies should target all people with these risk profiles.

Protective factors

Protective factors are often described as either positive configurations of risk factors or factors that act to mitigate, compensate or protect individuals from the effects of exposure to risk factors. Noting that the research is limited, the following protective factors have been suggested:

- good problem solving skills
- strong family and community social supports
- connectedness (eg, to family, peer group, school or community)
- secure cultural identity
- cultural, religious and personal beliefs that discourage suicide
- skills in managing interpersonal conflicts and disputes.

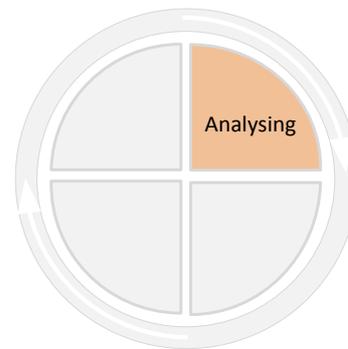
Supporting resources

- AL Beautrais, SCD Collings, P Ehrhardt *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*
- Living is for Everyone (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)
- Ministry of Health *New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action*
- Ministry of Health. *New Zealand Suicide Prevention Action Plan 2013–2016*
- S Collings, A Beautrais *Suicide Prevention in New Zealand: A contemporary perspective*
- S Collings (ed) *Social Explanations of Suicide in New Zealand* (a suite of six reports that explore the range of possible social explanations, analyses and evidence about New Zealand's suicide trends, including P Hirini, S Collings *Whakamomori: He whakaaro, he kōrero noa: A collection of contemporary views on Māori and suicide*).

Understanding high-risk populations

Knowing which population groups have a higher risk of suicide will guide interventions.

In New Zealand, suicide rates appear to be affected by gender, age, ethnicity and deprivation.



There also seems to be higher risk of suicide for people who:

- have a mental health disorder; in particular depression, anxiety, alcohol dependence or drug dependence
- have long-term/chronic health conditions or disabilities
- intentionally self-harm
- have made a previous suicide attempt
- have been exposed to trauma (eg, family violence, child abuse, sexual or physical assault or bullying)
- have experienced a major disappointment, or a humiliating or shameful event
- have experienced loss of a loved one, job, status or relationship
- have a family member or friend who has died by suicide
- are experiencing conflict in a relationship
- are socially isolated
- have easy access to means of suicide
- are exposed to unsafe media reports on suicide (eg, coverage that is repetitive, provides 'how-to' descriptions, normalises suicide or oversimplifies the reasons behind it)
- have an unstable family environment (eg, a lack of care, lack of boundaries, parental relationship conflict, parental history of substance abuse or offending, or family moving frequently)
- have experienced loss of cultural identity, language or land
- have a non-heterosexual orientation
- are transgender or intersex
- live in a deprived area or are significantly financially disadvantaged
- live in an institutional setting (eg, a prison or mental health facility)
- live in a society characterised by poverty, inequality, inequity, discrimination, rapid urbanisation, economic restructuring or high unemployment rates (see AL Beautrais, SCD Collings, P Ehrhardt, et al 2005).

Additional factors that may contribute to suicidal thoughts and self-harming behaviour include feelings of disempowerment (feeling out of control or overpowered by circumstances), migration and refugee experiences, geographical isolation and challenges with aging.

These risk factors may contribute to suicidal behaviours directly or indirectly by influencing individual susceptibility to mental health disorders (AL Beautrais, SCD Collings, P Ehrhardt, et al 2005).

Specific high-risk populations

Māori have higher rates of suicide than non-Māori. Explanations for suicidal behaviour among Māori often confirm recognised risk factors but suggest that these factors need to be placed in a wider social, cultural and historical context that recognises the compounding effects of colonisation, social and institutional bias and intergenerational disadvantage.

While males have higher rates of suicide, females have higher rates of non-fatal suicidal behaviours, such as suicidal ideation, having a suicide plan and making a suicide attempt. In New Zealand twice as many females as males are hospitalised for intentional self-harm.

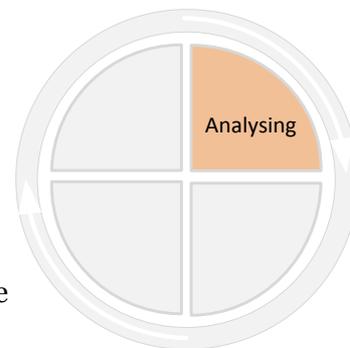
Having a mental disorder is one of the strongest risk factors for suicide. Approximately 40 percent of those who died by suicide or undetermined intent (among those aged 10–64 years) in 2011 were mental health service users. Of 185 service users who died by suicide, 24 percent were female and 76 percent were male (Office of the Director of Mental Health *Annual Report 2013*).

Supporting resources

- AL Beutrais, SCD Collings, P Ehrhardt, et al *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*
- Lawson, Te Aho *A review of evidence : a background document to support Kia Piki te Ora o te Taitamariki*
- Mental Health Foundation of New Zealand *Responding to People at Risk of Suicide: How can you and your organisation help?*
- Ministry of Health *New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action*
- Office of the Director of Mental Health *Annual Report 2013*
- P Hirini, S Collings *Whakamomori: He whakaaro, he kōrero noa: A collection of contemporary views on Māori and suicide* (part of the report below)
- S Collings (ed) *Social Explanations of Suicide in New Zealand* (a suite of six reports that explore the range of possible social explanations, analyses and evidence about New Zealand's suicide trends).

Evidence on the most effective interventions

A comprehensive approach to suicide prevention addresses a range of risk and protective factors, and is informed by evidence.



Based on the available evidence and shaped by the New Zealand context, the goals of the *New Zealand Suicide Prevention Strategy 2006–2016* set out the key points of intervention in a comprehensive approach to suicide prevention. The Strategy is consistent with international evidence on suicide prevention. It comprises seven goals.

1. Promote mental health and wellbeing, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour by the media.
6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about rates, causes and effective interventions.

Key components of suicide prevention

These goals provide a framework to guide prevention efforts and to ensure they are comprehensive and intersectoral; that is, that they:

- address multiple risk and protective factors
- involve sustained action over a long period
- take local, regional and national action
- formulate interventions at a range of levels, including the environment, the whole population, specific population groups (eg, Māori, youth, Pasifika, rural males) and individuals at risk (preferably in the context of their family/whānau)
- include a focus on improving data, research and evaluation.

Safety

Planners and developers of suicide prevention efforts must ensure they do no unintended harm. They should ensure safety is promoted by:

- informing actions with the best available evidence
- piloting new initiatives before wider roll-out wherever feasible
- appropriately training individuals involved in service delivery, and clearly defining their roles
- implementing safety protocols for people involved in service delivery (eg, peer support, supervision or counselling)
- implementing mechanisms to audit programme safety
- factoring in evaluation as a key component of the programme at the outset.

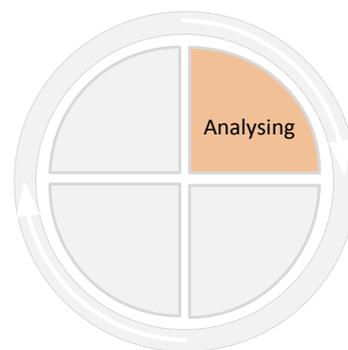
Supporting resources

- Living is for Everyone (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)
- Ministry of Health *New Zealand Suicide Prevention Action Plan 2008–2012: The Evidence for Action*
- Ministry of Health *Suicide Prevention: A review of evidence of risk and protective factors, and points of effective intervention*
- Office of the Surgeon General and National Action Alliance for Suicide Prevention (United States) *2012 National Strategy for Suicide Prevention: Goals and Objectives for Action*
- Te Pou *Updated evidence and guidance supporting suicide prevention activity in New Zealand Schools 2003–2012*
- World Health Organization *For which strategies of suicide prevention is there evidence of effectiveness?*
- World Health Organization *Preventing Suicide: A global imperative*
- World Health Organization *Public Health Action for the Prevention of Suicide: A framework*

Understanding suicide in your local area

Local suicide prevention planning needs to be guided by an understanding of the nature and extent of suicide in the region.

Data shows variations across DHBs in levels and patterns of suicidal behaviour. The following steps are important strategies for analysing the local situation in relation to suicide:



1. Gathering information on suicidal behaviour in the region

Such regional information can include:

- data on the incidence and prevalence of suicide, suicide attempts and intentional self-harm, and demographic analyses of data, to identify population groups at high risk
- data on frequently used methods of suicide
- an understanding of 'hot spots' (eg, bridges, cliffs, parks, buildings) associated with suicide
- information on previous suicide clusters
- consideration of the extent to which media reporting of local suicides reflects good practice.

When looking at patterns of suicidal behaviour regionally, it is advisable for DHBs to compare local data with that of other similar DHBs and against national data to get a clear understanding of local patterns.

Caution is advised when interpreting suicide data, because small actual numbers can result in large variations in rates.

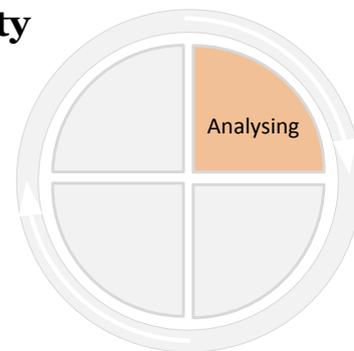
2. Gathering information on patterns of specific risk and protective factors for suicidal behaviour in your region

Research has shown that risk factors for suicidal behaviour show strong similarity across cultures and countries. However, contextual factors can influence patterns of suicidal behaviour and shape prevention approaches. An understanding of particular local factors can inform local prevention efforts. Such factors may include:

- the significant loss of a major employer or industry
- a natural disaster
- a previous suicide cluster
- high levels of social isolation and poor access to support
- high levels of family violence, child abuse or alcohol/drug misuse
- high levels of unemployment or financial stress affecting a sector of the population
- high levels of discrimination or social exclusion
- greater access to a particular means of suicide (eg, high numbers of firearms, access to pesticides).

Undertaking an environmental scan of capacity

‘Capacity’ refers to the availability of, and access to, human and financial resources able to be harnessed for the prevention of suicide.



As well as gathering and analysing regional data on suicidal behaviour, it is important for planners of suicide prevention initiatives to also develop a picture of the range and uptake of existing suicide prevention-related services.

An environmental scan of capacity will answer the following key questions.

- What are the currently available resources (people, knowledge, community, money)?
- What are the gaps, and how can they be met (or not)?
- Are there issues with coordination across services?
- How can existing suicide prevention and postvention resources most effectively be used?
- How satisfied is the community with current suicide prevention activity/response to suicides?
- What are the human and financial resources required to formulate and implement a district-wide suicide prevention plan?

It may be useful to undertake a simple assessment of key people and services in the district with a current role in suicide prevention, such as:

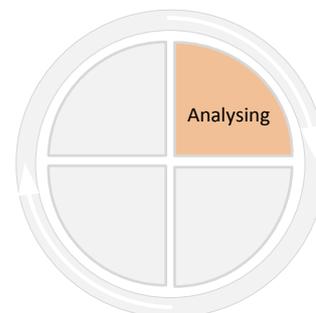
- health promotion, primary care, mental health and addiction, and emergency department workers
- other community-based health and social service workers
- counsellors, social workers and nurses in schools, communities, workplaces and corrections services
- first-line responders, including ambulance, police and fire services
- key leaders from communities and community organisations
- Māori service providers
- Pasifika and other cultural service providers.

Supporting resource

- *Living is for Everyone* (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government).

Information sources

Gathering information to build local knowledge of patterns of suicide.



The following table outlines some sources of data DHBs might access to get a better understanding of rates of suicide. Note: take care when interpreting data on suicide deaths at district level; suicide is a relatively rare occurrence, so rates in a smaller subgroup can fluctuate considerably across years.

Information	Definition	Where to access
Population information sources specific to suicide		
Suicide deaths and intentional self-harm hospitalisations	Each year the Ministry of Health publishes information on deaths determined to be suicides after a completed coronial process. This publication also includes information on intentional self-harm hospitalisations. It breaks down suicide information by gender, age, ethnicity, deprivation, DHBs and urban/rural location.	Suicide Facts: Deaths and intentional self-harm hospitalisations
Specific regional data extracted from the National Mortality Collection	Detailed data from the National Mortality Collection can be obtained on request. For smaller subgroups, data is generally provided for a five-year period.	Contact the Ministry of Health's National Collections and Reporting team: data-enquiries@moh.govt.nz
Provisional coronial data	Each financial year, the Chief Coroner publishes a provisional count of all possibly self-inflicted deaths referred to the coronial system.	Provisional Suicide Statistics
DHB data sources		
Demographic data on the DHB population	A range of social determinants influence protective and risk factors for suicidal behaviour including age, gender, socio-economic factors, sexual identity, ethnicity, social and physical isolation.	DHB data analysis team
Critical incident review information	This information will be collected in all cases of the death of a person in the care of the DHB.	DHB quality and risk team
Post-discharge community care information (KPI 19)	DHBs are required to collect data on the post-discharge community care of people who have contact with specialist mental health services as part of the Key Performance Indicator Framework for New Zealand Mental Health and Addiction Services	DHB data analysis team
Information from the Coronial Data Sharing Service	The Coronial Data Sharing Service (CDS) notifies relevant DHBs of suspected self-inflicted deaths. The service provides very brief demographic details only, primarily so that DHBs can undertake a timely and appropriate response if necessary.	This information is only accessible to a small number of DHB employees with authorised access.
Atlas of Healthcare Variation: Suicide	As part of its range of Atlases presenting easy-to-use maps, graphs, tables and commentaries on specific health services and outcomes, the Health Quality and Safety Commission has collated anonymised data on confirmed suicides from a range of sources, including the National Mortality Collection and the Specialist Mental Health and Addictions Outcome and Activity Collection (through the Programme for the Integration of Mental Health Data (PRIMHD)).	DHB data analysis team General information on the Atlas The Atlas of Healthcare Variation: Suicide is available to DHBs. To access the Atlas, contact info@hqsc.govt.nz

Information	Definition	Where to access
National surveys and relevant New Zealand publications		
The Youth2000 national youth health survey series	This series samples New Zealand secondary school students every five years.	University of Auckland Youth 2000 series
New Zealand Health Survey	The Ministry of Health's annual Health Survey reports annually on health behaviours and risk factors, health conditions and access to health services among New Zealanders.	New Zealand Health Survey
Te Rau Hinengaro – New Zealand Mental Health Survey	The Ministry of Health's Te Rau Hinengaro Survey collected information in 2003/04 on the prevalence, severity, impairment and treatment of major mental health disorders among New Zealanders.	Te Rau Hinengaro
New Zealand publications on suicide	The Ministry of Health maintains a directory of publications on suicide on its website.	Suicide prevention publications
Te Pou's suicide prevention research fund publications	This is a suite of research reports examining suicide and its prevention in New Zealand.	Suicide prevention research fund
International resources		
Living is for Everyone (LIFE)	LIFE provides a comprehensive Australian resource that covers all aspects of suicide prevention and postvention, including an excellent bibliography.	Living is for Everyone
<i>Preventing Suicide: A global imperative</i>	WHO published this document in October 2014 to contribute to the global knowledge base on suicide and suicide attempts and outline actionable steps for countries still to develop comprehensive suicide prevention strategies.	First WHO World Suicide Report
Suicide Prevention Australia	This is the central body for the suicide prevention sector in Australia; it currently provides policy advice to governments, raises community awareness and develops public education programme. It is playing an increased involvement in research and in leading Australia's engagement internationally.	Suicide Prevention Australia
Mindframe National Media Initiative (Australia)	The Mindframe project has developed various resources on suicide, including information about appropriate reporting of suicide and mental illness for media professionals.	Mindframe
Suicide prevention strategy for England	This strategy represents a cross-government outcomes effort to save lives.	Suicide prevention report
<i>Scottish Government: Suicide Prevention Strategy 2013–2016</i>	The Scottish Government's suicide prevention strategy sets out key areas of work to continue to reduce the number of suicides in Scotland.	<i>Scottish Government: Suicide Prevention Strategy 2013–2016</i>
Centre for Suicide Prevention (Canada)	The Canadian suicide prevention centre supports research and provides information and training related to suicide prevention.	Centre for Suicide Prevention
Suicide Prevention Resource Center (United States)	This agency provides prevention support, training, and resources to assist organisations and individuals in the United States to develop suicide prevention programmes, interventions and policies.	Suicide Prevention Resource Center
International Association for Suicide Prevention	This Association is dedicated to preventing suicidal behaviour, alleviating its effects and providing a forum for academics, mental health professionals, crisis workers, volunteers and suicide survivors.	International Association for Suicide Prevention
American Association of Suicidology	This Association is an education and resource organisation that works for the advancement of suicide prevention through research, education and training; the development of standards and resources; and survivor support services.	American Association of Suicidology

Information	Definition	Where to access
<i>2012 National Strategy for Suicide Prevention: Goals and Objectives for Action (United States)</i>	This National Strategy is the result of a joint effort by the Office of the United States Surgeon General and the National Action Alliance for Suicide Prevention.	<i>2012 National Strategy for Suicide Prevention: Goals and Objectives for Action</i>
<i>For which strategies of suicide prevention is their evidence of effectiveness?</i>	This World Health Organization report synthesises research findings from systematic reviews to address two questions: <ul style="list-style-type: none"> • What types of suicide preventive intervention have been evaluated in the published research? • Which suicide preventive interventions have good-quality evidence to support them? 	<i>For which strategies of suicide prevention is their evidence of effectiveness?</i>
<i>Reflections on Expert Recommendations for US Research Priorities in Suicide Prevention</i>	This article represents the collective thinking of international suicide prevention experts about where research efforts might best be invested to address suicide.	<i>Reflections on Expert Recommendations for US Research Priorities in Suicide Prevention</i>
Research Prioritisation Task Force	This task force is an initiative of the United States National Action Alliance for Suicide Prevention.	Research Prioritisation Task Force

Planning

Developing a robust suicide prevention plan that reflects evidence and is tailored to local needs and resources.

The National Service Coverage Schedule requires every DHB to develop a suicide prevention plan that describes the sustained action the DHB will take to address suicide in their local communities. While they are not solely responsible for addressing suicide, DHBs are well placed to lead this planning.



This section provides guidance to help DHBs develop suicide prevention plans and interventions under the following topic headings:

- Developing a programme logic model to support planning and learning
- Planning to ensure responsiveness to Māori
- Setting a plan with clear goals and actions.

Some examples from the sector

The following initiatives/publications provide examples of effective planning.

- *South Canterbury Suicide Prevention Action Plan 2013–2016*
- *Auckland District Health Board Suicide Prevention Annual Plan: July 2011 to June 2012*
- *Kawerau Suicide Prevention Action Plan – Te Kupenga mo Kawerau (the Kawerau Support Net) 2013–2016.*

Supporting resources

- Living is for Everyone ‘About LIFE Communications’ (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)
- Living is for Everyone Fact Sheets 10–14: ‘Designing and implementing prevention activities’
- Suicide prevention plan template (see Appendix 2)
- World Health Organization Suicide Prevention Planning Flow Chart (see Appendix 3).

Developing a programme logic model to support planning and learning

A logic model is a planning tool that can show connections between a problem to be addressed, activities to be implemented and expected outcomes or results.

Logic models may be useful to DHBs in developing a district suicide prevention plan.



Strategy

To ensure plans are comprehensive and address the spectrum of intervention, it is useful to use a suicide prevention framework, such as the seven goals of the *New Zealand Suicide Prevention Strategy 2006–2016*.

Supporting resources

- Logic model template (see Appendix 4)
- Logic models – a tool for demonstrating and understanding results
- Ministry of Health *A Guide to Developing Public Health Programmes: a generic programme logic model*.

Planning to ensure responsiveness to Māori

Suicide prevention for Māori should address the spectrum of prevention, and acknowledge the needs of whānau and the importance of identity, cultural heritage, whakapapa and access to cultural resources.



District health boards are encouraged to work in partnership with whānau, hapū, iwi and Māori communities to ensure suicide prevention programmes and services are responsive to Māori, culturally appropriate and effective.

A local definition of ‘cultural responsiveness’ will be informed by effective consultation with Māori communities, whānau, hapū and Māori DHB staff.

The cultural responsiveness of a particular suicide prevention service or programme will be one aspect of its overall effectiveness. DHBs need to measure effective cultural responsiveness against defined outcomes or goals; the following are examples developed by Professor Sir Mason Durie for Waka Hourua:

- informed, cohesive, and resilient Māori communities
- strong, secure, and nurturing whānau
- safe, confident, and engaged rangatahi.

Supporting resources

- Te Rau Matatini’s *Te Whakauruora – Restoration of health: Māori Suicide Prevention Resource*.
- The Ministry of Health funds *Kia Piki te Ora* providers to provide a Māori-specific approach to suicide prevention. Currently nine providers deliver this programme in eight DHB regions: Northland (two), Christchurch, Whanganui, Hawke’s Bay, Auckland, Bay of Plenty, Rotorua and Southland.
- Te Rau Matatini developed *Māori Suicide Prevention Training* for *Kia Piki te Ora* providers in 2010 through *Te Whakauruora* to inform and strengthen their capability to deliver effective community-based suicide prevention interventions. This programme is now being used in communities including Kawerau and Wairapapa, and throughout Te Taitokerau.
- *Waka Hourua* is a four-year national suicide prevention programme aiming to provide a clear focus for suicide prevention in Māori and Pacifica communities and funded by the Ministry of Health. It is provided by Te Rau Matatini in partnership with *Le Va*. The programme seeks to build leadership and knowledge through education, training and resources. The programme includes a strategic research agenda to build an evidence base of effective practices in suicide prevention and postvention for Māori and Pacifica communities, and a one-off community fund of \$2 million to support community groups to design and implement suicide prevention initiatives for themselves.

Setting a plan with clear goals and actions

A planning framework

The framework for the New Zealand Suicide Prevention Strategy 2006–2016 consists of a vision, purposes, goals and guiding principles. The Strategy provides a useful way to structure prevention interventions that target risk and protective factors and the causal pathways for suicide. This framework reflects the available evidence on the most effective approaches for suicide prevention.



Vision

The vision of the Strategy is a society where all people:

- are valued and nurtured
- value their own life
- are supported and strengthened if they experience difficulties
- do not want to take their lives or harm themselves.

Purposes

The overall purposes of the Strategy are to:

- reduce the rate of suicide and suicidal behaviour
- reduce the harmful effect and impact associated with suicide and suicidal behaviour on families/whānau, friends and the wider community
- reduce inequalities in suicide and suicidal behaviour.

Principles

All activities undertaken as part of the Strategy should be guided by the following principles:

- be evidence-informed
- be safe and effective
- be responsive to Māori
- recognise and respect diversity
- reflect a coordinated multisectoral approach
- demonstrate sustainability and long-term commitment
- acknowledge that everyone has a role in suicide prevention
- have a commitment to reduce inequalities.

Goals

To achieve these purposes, the Strategy sets out seven broad goals covering the spectrum of prevention:

1. Promote mental health and wellbeing, and prevent mental health problems.
2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour.
3. Improve the care of people who make non-fatal suicide attempts.
4. Reduce access to the means of suicide.
5. Promote the safe reporting and portrayal of suicidal behaviour in the media.

6. Support families/whānau, friends and others affected by a suicide or suicide attempt.
7. Expand the evidence about rates, causes and effective interventions.

These goals cover the broad range of possible suicide prevention and postvention activities. DHBs have the opportunity to tailor specific approaches to the needs of their own districts.

This section provides guidance for DHBs in shaping their own plans based on the goals of the Strategy.

1. Promote mental health and wellbeing, and prevent mental health problems

The purpose of this goal is to reduce the population's exposure to the risk factors for suicide and enhance protective factors in the community.

This can be achieved through local initiatives to:

- promote strong, secure and nurturing families
- build connected and cohesive communities
- eliminate community, family and sexual violence
- reduce the harm associated with alcohol and drug use
- reduce stigma and discrimination associated with mental illness and promote social inclusion
- encourage people to seek help for mental health problems
- increase social support for population groups experiencing stress
- eliminate cultural alienation and institutional racism
- eliminate discrimination (eg, towards different ethnic groups, or based on sexual orientation or gender identity) and promote inclusive communities
- reduce social and economic disadvantage
- promote educational achievement among disadvantaged populations
- promote the mental health and wellbeing of children and young people
- support the mental wellbeing of communities after a natural disaster.

Community examples

A number of DHB and community organisations and programmes currently focus on promoting mental health and wellbeing. These include:

- *Handle the Jandal* (a youth-led campaign aimed at improving Pasifika mental health and wellbeing in South Auckland by addressing the issue of handling pressure)
- the *U-Turn Trust* in Flaxmere, Hawke's Bay (an NGO that works towards a more cohesive and unified approach among the various organisations within the community and celebrates successes – with a view to reversing negative social statistics)
- the *Tuilaepa Youth Mentoring Service* in Auckland (addressing employment, education and training gaps for Māori and Pasifika youth)
- *Te Runanga o Ngati Pikiao Trust* (an iwi provider of services to meet the health, education/training and social needs of nga uri o Ngati Pikiao. The Trust runs a *Kia Piki Te Ora* suicide prevention programme, which provides strategic and policy support for all-age suicide prevention and mental health promotion covering Rotorua, Taupō, Turangi and Mangakino)
- *Travellers* (a school-based early intervention programme based on building resilience for students (generally in Year 9) in New Zealand secondary schools, run by Skylight).

Supporting resources

- Te Rau Matatini's Te Whakauruora – Restoration of health: Māori Suicide Prevention Resource (designed as a community development and action-focused resource to primarily assist hapū, iwi, hapori Māori and community groups)
- Mental Health Commission of New South Wales and Suicide Prevention Australia Communities Matter (a toolkit for community-driven suicide prevention (a resource for small towns), designed to turn community interest and concern into grass-roots response)
- school-based education run by RainbowYOUTH in Auckland to explore sexual orientation and gender identity issues, the impact of homophobia and transphobia, and how to create a safer school and work environment for everyone.

Community awareness initiatives

Initiatives such as World Suicide Prevention Day (10 September each year) can be used as an opportunity for engaging key groups with a role in suicide prevention (eg, by organising a seminar on the latest research, launching a district suicide prevention plan or showcasing a local service initiative).

World Mental Health Day (10 October each year) provides an opportunity for community awareness raising and promotion of mental health, help-seeking and social inclusion. The Mental Health Foundation provides resources for communities for Mental Health Awareness Week and advice on activities that DHBs and communities can undertake to support understanding of mental health and wellbeing.

A note about safety

The Ministry of Health discourages broad school-based or community suicide awareness-raising activities, as they risk inadvertently putting vulnerable people at greater risk of suicide.

The Ministry of Education's resource kit for schools *Preventing and responding to suicide* provides guidance about safe resources and activities in school (see in particular sections two and five).

2. Improve the care of people who are experiencing mental disorders associated with suicidal behaviour

Services can develop strategies to improve the recognition, treatment and management of people experiencing mental health problems that contribute to the development of suicidal behaviours.

This can be achieved through local initiatives to:

- improve community understanding of depression/anxiety/addiction problems and encourage help-seeking
- improve the skills of people in the community who come into contact with people experiencing mental health problems on a regular basis (eg, through Applied Suicide Intervention Skills Training (ASIST), QPR New Zealand, Mental Health 101 or Hair4Life)
- improve the skills of primary health care providers (eg, nurses, general practitioners (GPs), midwives or WellChild providers) to recognise and respond to people experiencing mental health problems

- improve the skills of emergency services and specialist mental health services providers to provide optimal care to people experiencing mental health problems
- provide accessible and responsive primary and specialist mental health services for key population groups (eg, young people, older adults, Māori, Pasifika, refugees and people in the criminal justice system).

Mental health and substance-use disorders are known risk factors for suicide. Difficulties in accessing mental health care can leave at-risk individuals unrecognised and/or untreated and thereby more vulnerable. Improving assessment and management and providing responsive follow-up and community support are important elements in reducing the incidence of suicide.

Improving access to mental health and addiction services is one of the key DHB actions in *Rising to the Challenge: The Mental Health and Addiction Service Development Plan 2012–2017*. This Plan notes the need to increase access for at-risk populations; in particular Māori and Pasifika. The Ministry of Health monitors and reports on access to DHB and NGO services. These reports can assist DHBs identify and prioritise their activities to improve access.

DHBs can support organisations, community members and individuals to undertake suicide prevention training. Training programmes currently available in New Zealand include:

- Suicide Intervention Training provided by Lifeline Aotearoa including ASIST and safeTALK for schools and communities
- QPR gatekeeper foundational and advanced training, available online and face-to-face
- another programme, run by Skylight is Travellers – a resilience building intervention programme for students (generally in Year 9) in New Zealand secondary schools.

Te Rau Matatini developed the Te Whakauruora – Māori suicide prevention training for Kia Piki te Ora providers to strengthen their capability to deliver community-based suicide prevention interventions. This programme has since been adapted to respond to the needs of communities in places including Kawerau and Wairarapa, and throughout Te Taitokerau. The training provides an insight into how suicide is viewed by Māori, and the importance of tikanga Māori frameworks in suicide prevention initiatives.

Some examples from the sector

- Hawke’s Bay DHB has further developed the capacity of youth one-stop shops to provide prolonged community support to youth at risk. It has also supported foster care parent suicide awareness training.
- Counties Manukau DHB is supporting parenting programmes designed to give parents skills and confidence to engage with their children in relation to suicide and mental health.

Supporting resources

- The National Depression Initiative
- The Lowdown (resources for tackling depression in youth)
- SPARX (a computer programme that helps young people learn skills to deal with feeling down, depressed or stressed)
- Coping with suicidal thoughts
- Suicide: worried about someone?

3. Improve the care of people who make non-fatal suicide attempts

The aim of this goal is to develop policies, strategy and services that lead to better treatment and management of those who make suicide attempts. Here ‘care’ refers to both acute and long-term support.

This can be achieved through local initiatives to:

- improve the care and coordination of primary care, Māori health, mental health and emergency services for people who have made a suicide attempt
- involve and support family/whānau and support people in the assessment, treatment, discharge planning and ongoing management of people who have made a suicide attempt
- improve protocols for care of people who have made a suicide attempt in key settings (eg, prisons, schools and CYF services)
- improve the longer-term management of people who have made a suicide attempt, including through follow-up support and psychosocial interventions.

Some examples from the sector

- The Ministry of Education’s resource kit for schools *Preventing and responding to suicide* provides guidance for schools following a suicide attempt of a student.
- Clinical Advisory Services Aotearoa currently delivers the *Towards Wellbeing* suicide prevention programme to support Child Youth and Family social workers working with children and young people who are experiencing suicide ideation or have attempted suicide.
- Many DHBs have clear protocols for the assessment, treatment and management of people presenting to emergency departments following a suicide attempt, which includes close liaison with specialist mental health services.
- The suicide prevention response in Northland has focused on intensive child and youth network-based prevention. Alongside the police, education workers, CYF services and NGO services, the DHB is part of a ‘fusion group’ that circulates daily email alerts of high-risk situations, suicides and suicide attempts among young people. Group members check their own systems and feed relevant information back into the central group in order to establish risk and links and make action plans. Each member responds appropriately on their own part, while continuing to share information. If multiple risk flags are identified, the group may hold an additional meeting.
- Some DHBs have implemented a stepped-care model, entailing low-intensity support pathways for lower risk people who have attempted suicide and more intensive strategies as risk increases. In the model, support services include high-quality care aimed at preventing repeat attempts and improving mental health, and follow-up by specialist mental health services. A brief intervention and contact approach has proved effective for reducing suicide mortality among people who have made previous suicide attempts. This approach is uncomplicated and affordable.

Other approaches DHBs are using include:

- joint work with Māori and Pasifika NGO providers on a stepped-care approach to suicide, involving shared training and community education about support options. In this approach, NGO providers are the step-down referral points for post-emergency department support for people who attempt suicide, and either the DHB or an NGO offers step-up care to people with elevated assessed risk

- improving emergency department staff's recognition of self-harm and suicidal behaviour through encouraging them to ask three questions: (1) are you feeling suicidal? (2) do you have a plan? and (3) have you tried before? These questions are based on the suicide risk assessment questions included in a number of publications
- improved assessment and early management of people at risk of suicide in emergency departments and acute psychiatric services according to the New Zealand Guidelines Group guideline *The assessment and management of people at risk of suicide*. The Ministry has contracted Te Pou to develop updated guidance to support this resource
- improved timeliness of assessment and response for those with serious mental health issues, according to an acute/moderate risk 'package' of care that provides some enduring support to people at risk, rather than only a short-term emergency department interaction
- improved follow-through processes for emergency department discharges, including referrals back to GPs to increase patients' connection to primary health
- provision of self-management support (eg, through SPARX or depression.org.nz)
- targeted GP and practice training based on an assessment of patients' patterns of suicide attempts; such training provides particular support to GPs working in areas of high risk
- engagement with PHOs with the aim of assisting primary mental health care services to address modifiable suicide risks, for example through enhanced care for people with depression or addiction
- expanding the role of 'gatekeeper' to work with, for example, family/whānau, NGO supports and schools and 'surround' the environment of people who attempt suicide. DHBs have found training programmes such as ASIST, safeTALK and QPR useful in this context
- taking a chronic care management approach with people who have made a suicide attempt following discharge
- facilitating access to social support, employment and housing among people at high risk of suicide.

These approaches can systematically build a prevention capability over time. They also permit DHBs to design a pragmatic response to the broad issue of suicide, linking their own programmes with the efforts of other organisations, such as police, schools and primary health care.

Use of data relating to suicide attempts

Use of data on suicide attempts is emerging in several DHBs as a key platform on which to build a more targeted response. Not all DHBs will choose to do this – it will depend on an assessment of their capacity and local needs, as well as the extent to which this information is already known.

Uses of data include the following.

- **Tracking data:** software can track the extent to which individuals see GPs or community mental health services following discharge from the emergency department. Follow-up phone calls can substantially lift the rate of follow-up care in the community.
- **An attempts register:** some DHBs have established a suicide attempts register, which collects a suite of information using existing emergency department codes and makes it possible for health care workers to deal with suicidal thoughts and suicidal behaviour as they would a chronic recurring illness. The aim of this register is to share data across services, including primary health.
- **Youth suicide prevention group:** a number of DHBs currently receive daily data about attempted or threatened suicide provided by police '1x' calls. Where there is information to indicate that an individual may be at risk of suicide, DHB services can work with other agencies to provide support and resources.

Supporting resources

- Clinical Advisory Services Aotearoa Towards Wellbeing (a suicide prevention programme to support CYF social workers)
- Ministry of Education Preventing and responding to suicide
- New Zealand Guidelines Group *The Assessment and Management of People at Risk of Suicide*
- Te Pou o Te Whakaaro Nui. The National Centre of Mental Health Research, Information and Workforce Development *Evaluation of the NZGG Self-Harm and Suicide Prevention Collaborative* (research to assist improvements to the care of people at risk of suicide by supporting DHB emergency departments, mental health and Māori health settings to implement best practice)
- Te Pou o Te Whakaaro Nui. The National Centre of Mental Health Research, Information and Workforce Development *Updated evidence and guidance supporting suicide prevention activity in New Zealand Schools 2003–2012*

4. Reduce access to the means of suicide

The purpose of this goal is to reduce people's access to and the lethality of means of suicide.

This can be achieved through local initiatives to:

- ensure the physical environment of key institutional settings, such as prisons, police and court cells, mental health inpatient units and CYF care and protection and youth justice residences have minimised opportunities for self-harm and suicide
- encourage health professionals to routinely ask about guns in homes and access to toxic chemicals and medicines, and to advocate for their removal where people are experiencing emotional distress or mental health problems, or are suicidal
- encourage health professionals to routinely advise family/whānau and others who are caring for people at high risk of suicide to remove potential means of suicide, such as firearms and toxic substances, from their household
- install barriers at favoured suicide jump-sites, such as buildings, cliffs or bridges
- institute regular information campaigns to encourage the return of unused medication.

Examples from the sector

- Installation of barriers on Grafton Bridge in Auckland (see J Pirkis, M Spittal, G Cox, et al 'The effectiveness of structural interventions at suicide hotspots: a meta-analysis' and AL Beautrais 'Effectiveness of barriers at suicide jumping sites: A case study')
- *Closure of Lawyer's Head Road in Dunedin*

Supporting resources

- C Owens, P Aitken, S Lloyd-Tomlins, et al 'Guidance on Actions to be taken at suicide hot spots' (a United Kingdom resource)

5. Promote the safe reporting and portrayal of suicidal behaviour in the media

This goal aims to promote good practice among the media in reporting and portraying suicidal behaviour, in order to minimise the potential for imitation, contagion and normalisation of suicide.

This can be achieved through local initiatives to:

- work with local news media to encourage safe reporting
- promote use of the 2011 media guidelines *Reporting Suicide: A resource for the media*
- work with local other non-print media, such as television, online content providers, film-makers and theatres to minimise the risk of fictional portrayal of suicidal behaviour
- liaise with and seek advice from the Mental Health Foundation (formerly via SPINZ), which has a national responsibility to work with the media on the safe reporting of suicide.

Supporting resources

- *Reporting Suicide: A resource for the media*
- Te Pou *Reporting of Suicide in New Zealand Media – Content and Case Study Analysis*
- Te Pou *Media Influences on Suicidal Behaviour*
- Mindframe National Media Initiative (Australia).

6. Support families/whānau, friends and others affected by a suicide or suicide attempt

The purpose of this goal is to:

- support families/whānau, friends and significant others after a suicide
- support families/whānau, friends and significant others after a suicide attempt
- minimise risks of contagious suicidal behaviour and the development of suicide clusters through a postvention response.

This can be achieved through local initiatives to:

- support the capacity and capability of facilitators of specialist suicide bereavement support programmes (eg, WAVES: see Appendix 1)
- facilitate access to self-help information to people bereaved by suicide
- ensure health professionals address the needs of families/whānau and friends after a suicide attempt
- respond to suicide deaths appropriately where there is a risk of contagion
- identify and manage a potential or confirmed suicide cluster.

Appendix 1 provides guidance for DHBs on this goal, and sets out the role of DHBs and other national service providers in this regard.

Supporting resources

- Living is for Everyone Fact Sheets 22, 23 and 24 (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)
- Living is for Everyone *Research and Evidence in Suicide Prevention* (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government)

7. Expand the evidence about rates, causes and effective interventions

The purpose of this goal is to improve the quality and timeliness of suicide data; expand current knowledge about suicidal behaviour, including effective interventions; and improve the dissemination of research and information about suicide prevention.

This can be achieved through local initiatives to:

- collect, manage and develop protocols to share local suicide data (eg, through a data-sharing agreement between coroners and DHBs)
- formally evaluate the effectiveness of interventions
- use principles of effective programme development and a ‘science to practice’ framework to move knowledge about the nature, correlates and causes of suicide into effective policies and programmes, using international and New Zealand evidence and research
- ensure those working in suicide prevention are staying abreast of new thinking and evidence by networking with colleagues across the country, attending conferences, participating in suicide ‘communities of practice’ and regularly referring to agencies such as the Mental Health Foundation, the International Association for Suicide Prevention and the Suicide Prevention Resource Center.

Supporting resources

- *Waka Hourua* is a strategic research agenda for Māori and Pasifika suicide prevention. The Agenda provides a framework to guide the research fund as part of Waka Hourua and will help to build the evidence base of what works to prevent suicide in Māori whānau, hapū and iwi and Pasifika families and communities.
- Te Pou’s suicide prevention research fund was established to build the body of New Zealand-based research into suicide; it has resulted in a suite of published research.
- *Living is for Everyone (LIFE)* (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government) includes a valuable resource on research and evidence in suicide prevention.

Delivering

Implementing and monitoring the delivery of suicide prevention and postvention activities.

Once DHBs have identified potential interventions and sought agreement on a suicide prevention plan, the next step is for agencies and communities to work together to implement that plan.



This section provides guidance to help DHBs deliver under the following topic heading:

- Activating agency partnerships and coordinating local networks.

Example from the sector

The following initiative provides an example of effective delivery.

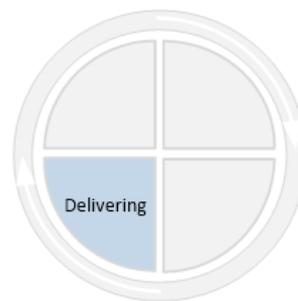
- Canterbury DHB – A learning structure for Zero Suicide.

Supporting resources

- the Ministry of Social Development's *Results Based Accountability* (a simple, common-sense framework to help organisations focus on the results/outcomes of their work with communities, families/whānau and clients)
- *Te Rau Matatini Te Whakauruora – Restoration of Health: Māori Suicide Prevention Resource*
- *Communities Matter* (an Australian toolkit for community-driven suicide prevention (a resource for small towns))
- The Ministry of Education's resource kit for schools *Preventing and responding to suicide* (particularly the section on prevention)
- *Living is for Everyone* (a suicide and self-harm prevention initiative of the Department of Health and Aging, Australian Government). Guidance and links to research and evidence to support safe and effective interventions.

Activating agency partnerships and coordinating local networks

Delivering suicide prevention and postvention services depends to a large extent on developing and investing in agency partnership and network coordination. DHBs' needs and capabilities will vary, but all DHBs should consider these three elements.



1. Network coordination support

Robust delivery requires good connections between services, organisations and communities.

A DHB staff member (or members) with specific responsibility for suicide prevention coordination can play a major part in building relationships, creating common approaches and standards across diverse networks and coordinating support.

2. Shared leadership, planning and delivery capability

See the Engaging section on page 10 for information on building and maintaining leadership/governance structures and relationships internally, operationally and in the community.

3. Shared intelligence and evaluative learning

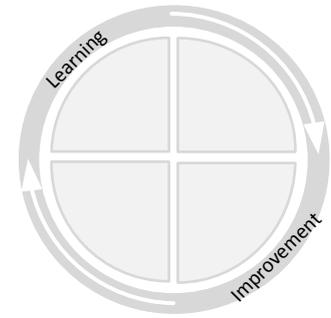
Suicide prevention planners could consider the opportunities for establishing a system for sharing intelligence. Networks with other agencies could involve data analyst support, or the engagement of data interpretation practitioners.

See the Engaging section on page 10 for information on intelligence-sharing networks and processes already in place in some districts.

Learning and improvement

Ensuring collective action is making a positive difference and that activity is supported by continuous quality improvement.

Incorporating learning and improvement processes into health intervention activities is vital. The process involves taking the time to reflect on and review actions, and analysing results. If results do not match expectations, it is worth investigating the reasons and making appropriate adjustments.



Our knowledge of what works to prevent suicide and manage its impact is increasing all the time. Processes to capture, understand and share this learning are important.

This section provides guidance to help DHBs with learning and improvement under the following topic headings:

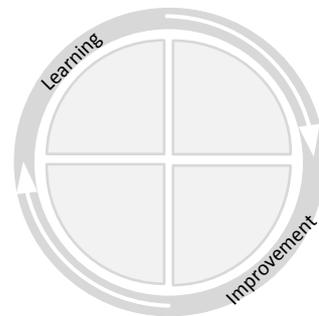
- Measuring the impact of suicide prevention.
- Creating communities of practice to share learning
- Building in continuous quality improvement
- The Plan Do Study Act (PDSA) cycle.

Supporting resources

- E Wenger 'Communities of practice: A brief introduction'
- Improvement plan template (see Appendix 4)
- Plan Do Study Act template (see Appendix 4)
- Te Pou *Evaluation of the NZGG Self-Harm and Suicide Prevention Collaborative*.

Measuring the impact of suicide prevention

Effective evaluation and outcomes frameworks create a clear line of sight between investments made and impacts on the population.



District health boards are encouraged to place a high priority on evaluating their delivery of suicide prevention interventions – particularly when a new programme is being developed, or when the evidence of effectiveness is light. Evaluation in the suicide prevention field requires carefully designed approaches that measure short-term, intermediate and long-term outcomes.

Evaluation has four main purposes:

- to describe the impact of a programme on individuals and population groups
- to ensure fidelity to good practice models and the stated intentions of the programme
- to increase the evidence base to guide future planning and resource allocation
- to provide accountability to funders and the general public for the investment made.

Challenges in evaluating the success of suicide prevention programmes include:

- the multifactorial nature of suicide, and the difficulty of attributing an effect to a particular intervention
- that the effect of ‘upstream’ interventions, such as promoting positive parenting, will not be evident for many years – until the children targeted reach an age of risk for suicide
- that suicide is a statistically rare event, and low absolute numbers make it difficult to be sure whether small rises and falls are significant or just random fluctuations (K Skegg ‘Youth Suicide’ in P Gluckman and H Hayne *Improving the Transition: Reducing Social and Psychological Morbidity During Adolescence*).

Evaluation therefore needs to include proxy measures and short- to intermediate term outcomes.

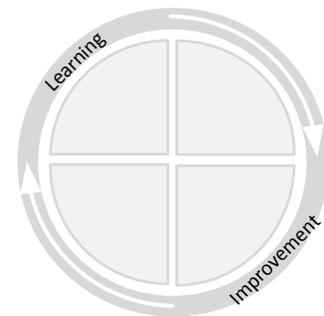
Some examples from the sector

- Canterbury DHB – A learning structure for Zero Suicide
- Epps D Achieving ‘Collective Impact’ with Results-Based Accountability
- Living is for Everyone Fact Sheet 14: ‘Project evaluation’
- Ministry of Social Development *Results Based Accountability: Guidelines and Resources*
- An outcomes framework is being developed for Waka Hourua to enable a clearer picture of what Waka Hourua is achieving and what kind of difference it is making (link to outcomes framework).

Creating communities of practice to share learning

People who share a concern for suicide prevention can learn together about how to do it better.

Learning from others' successes and failures is important. DHBs' collective efforts to prevent suicide will be less successful if each district, team or individual has to create and sustain its own innovation. Each DHB has a unique role to play in ensuring good practice across its own district, its own region and New Zealand as a whole. Shared learning can reveal what is possible and also provide a platform on which to build local innovation and change. One approach some DHBs are currently taking is to establish communities of practice.



Communities of practice are groups of people who share a concern or a passion for something they do and learn how to do it better as they interact regularly (Lave and Wenger 1991).

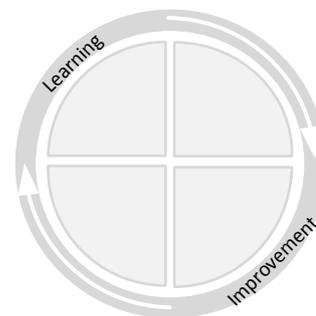
Communities of practice can be sustained in many ways, from regular short teleconferences to all-day workshops. The key principle is to ensure that people from a range of backgrounds spend time together, sharing, listening and learning. It may be possible to establish communities of practice on a regional basis.

Supporting resource

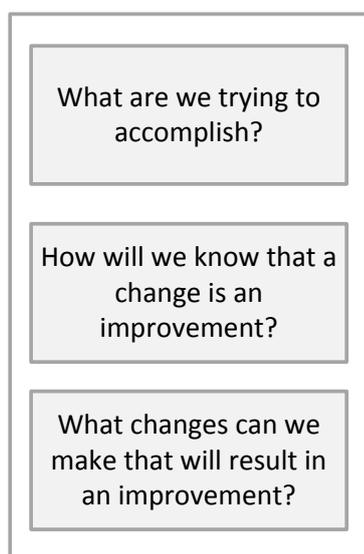
- E Wenger 'Communities of practice: A brief introduction'

Building in continuous quality improvement

Quality improvement frameworks and tools support continuous learning and promote effectiveness.



The Institute for Healthcare Improvement (see also Associates in Process Improvement) promotes a framework that has been adopted widely across the New Zealand health sector to support continuous improvement activities. The framework provides a simple structure to support improvement initiatives, and uses a simple tool, the 'Plan Do Study Act' (PDSA) cycle, to test small, achievable ideas quickly to see if they help towards the improvement desired. The cycle is based on the notion that by taking many small steps towards a bigger goal, the potential for success or failure may be quickly identified. In this way, activity is continuously focused on moving towards success.



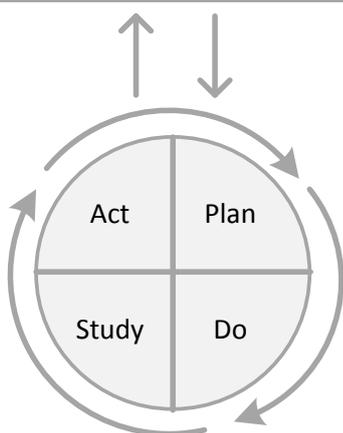
The framework begins with three questions.

Question one is the fundamental 'what are we trying to accomplish?' This question ensures stakeholders gain a clear understanding of the problem they are aiming to solve, and of the desirable aims and objectives.

Question two asks 'how will we know that a change is an improvement?' This ensures stakeholders think about how they will measure processes and outcomes in order to gauge success.

Question three asks 'what changes can we make that will result in an improvement?' This asks stakeholders to generate ideas for achieving the aims of the improvement activity (as identified in question one), based on precedent and evidence.

Answers to these questions form the basis for each PDSA cycle.



The Plan Do Study Act cycle

The PDSA cycle is shorthand for testing a change – by planning it, trying it, observing the results and acting on what is learned. These steps should guide the test of a change. The cycle is a well-tested method of action-oriented learning; many DHBs already use it on a regular basis.

Improvement planners should carry out the cycle as follows.

Plan

- Plan the test or observation, including a plan for collecting data.
- State the objective of the test.
- Make predictions about what will happen and why.
- Develop a plan to test the change. Who? What? When? Where? What data needs to be collected?

Do

- Try out the test on a small scale.
- Carry out the test.
- Document problems and unexpected observations.
- Begin analysis of the data.

Study

- Set aside time to analyse the data and study the results.
- Complete the analysis of the data.
- Compare the data to your predictions.
- Summarise and reflect on what was learned.

Act

- Refine the change, based on what was learned from the test.
- Determine modifications to be made.
- Prepare a plan for the next test.

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Appendix 1: Further information on implementing goal 6 of the *New Zealand Suicide Prevention Strategy*

This appendix provides more details for DHBs on implementing goal 6 of the *New Zealand Suicide Prevention Strategy 2006–2016*: ‘Support families/whānau, friends and others affected by a suicide or suicide attempt’. It sets out the role of DHBs and other national service providers.

Support for people bereaved by suicide

The death of a loved one through suicide can be extremely traumatic, and may even place those who are bereaved, or their associates, at a higher risk of suicidal behaviour themselves. Services for people who are bereaved by suicide need to be accessible, appropriate and responsive to the needs of diverse populations. Support needs to be available in the immediate aftermath of the suicide and in the longer term.

Crisis support

Initial response after a suicide

Victim Support provides a national suicide-specific crisis response service to support families/whānau and friends in the period immediately after a suicide. The *Initial Response Postvention Service* has four primary objectives: to ease trauma, prevent adverse grief reactions/complications, minimise risk of suicidal behaviour in the grieving and encourage coping and resilience. It can provide support for up to six months.

Longer-term support

- **Specialist grief education programmes.** WAVES is an eight-week specialist-facilitated grief education group programme established by Skylight for adults (over 17 years) who are bereaved by suicide. The Ministry of Health funds Skylight to provide facilitator training to appropriate personnel in DHBs and NGOs, and support for organisations delivering the programmes across the country. District health boards are encouraged to lead the provision of these programmes in their district, and support training of facilitators to run programmes.
- **Advice and resources for people bereaved by suicide:** The Ministry of Health contracts the *Mental Health Foundation* to provide guidance and advice for people bereaved by suicide, including resources to help them support each other through peer support networks.

Support for family/whānau and friends after a suicide attempt

Following a suicide attempt, family/whānau and friends are likely to feel high levels of concern, anxiety and responsibility for the person who has made the attempt. It is important to provide them with appropriate information and support about suicide, mental illness, risk recognition and how best to access services.

In treating people who have made a suicide attempt, DHB mental health services should consider and address the needs of family/whānau and significant others in a culturally appropriate way.

Suspected suicide of a mental health and addictions service user

As part of the routine response to a suicide, DHBs should determine whether the deceased was a current mental health service user, and report these deaths to the Health Quality and Safety Commission.

If the service user was being treated under the Mental Health (Compulsory Assessment and Treatment) Act 1992, section 132 of that Act requires the Director of Area Mental Health Services to notify the Director of Mental Health at the Ministry of Health.

The Director of Mental Health also needs to be informed if there is public interest in the death of a mental health and addictions service user (for example, if the death occurred in a public place), even if the person concerned was not being treated under the Act at the time of their death. This notification may be made by the DAMHS or by the Manager of Mental Health Services. Where there is media interest, the Director should be notified by telephone, followed by an email containing information about the circumstances of the death and any actions being taken by the DHB to review the care of the deceased.

Postvention

Suicide can have a harmful impact on others in the community. There is a risk of subsequent suicide attempts among vulnerable members of the community, particularly youth.

Postvention or post suicide support refers to activities in response to a suicide to reduce risk of further suicide attempts. As it is aimed at preventing further suicide, postvention can be seen as a form of suicide prevention.

A suicide cluster is the relatively rare phenomenon in which multiple suicides or suicide attempts occur closer together in time or geography, or through social connections, than would normally be expected. Suicide clusters may initiate widespread community concern and increase the risk of subsequent suicidal behaviour (this is referred to as suicide contagion).

Responses to possible clusters need to be rapid and intensive. The immediate aim of any postvention response is to manage a cluster or contagion, calm community distress and anxiety and minimise the risk of further suicidal behaviour.

Leadership of postvention responses

DHBs need to lead postvention responses to suicide clusters in their region, in partnership with the community.

Clinical Advisory Services Aotearoa (CASA) is a national service contracted by the Ministry of Health to provide postvention support to communities in the presence of contagion and clusters. In this case the **Community Postvention Response Service (CPRS)** will work alongside DHBs to assist their postvention response. The service the CPRS can provide ranges from assessment of community risk (in conjunction with key community stakeholders) or the provision of one-off consultations (to agencies or individuals) to long-term support for up to six months for communities experiencing contagion and/or clusters. The CPRS uses a model of partnership with local communities – combining its own expertise with community expertise and experience. This ensures that every postvention response is evidence-based and safe but responsive to individual geographical and cultural needs.

In the event of the suicide of a member of a school community, the Ministry of Education's **Traumatic Incident (TI)** team is available to coordinate a postvention response. Additionally, schools should have a suicide response plan in place as part of their traumatic incident response plan. Response to a suicide within a school will require close collaboration between DHBs, the CPRS, the TI and schools. Further guidance is available in the Ministry of Education's resource kit for schools **Preventing and responding to suicide**.

Receiving timely data on suspected suicides

The Coronial Data Sharing Service (CDS) notifies nominated staff within each DHB of suspected suicides in their region, as soon as possible after police inform coroners. This can be used to help:

- identify patterns that may indicate an emerging cluster, and therefore the need for a postvention response
- to allay the fears of communities when a series of suspected suicides or attempts is unlikely to indicate contagion.

Each DHB should become familiar with data on suspected suicides in their own area and bring local knowledge to bear in interpreting this information.

To find out more about CDS, see Appendix 5, pg 69.

For information about CDS's Privacy Impact Assessment, see Appendix 6, pg 72.

Monitoring emerging suicide clusters

Clinical Advisory Services Aotearoa monitors suicide data for emerging clusters, and will contact DHBs if necessary. If DHBs suspect an emerging cluster, they should contact CASA. Where there is uncertainty about the existence of a suicide cluster, CASA is responsible for determining its presence and advising the Ministry of Health.

When to initiate a postvention response

Where CASA confirms a suicide cluster, DHBs should activate a coordinated postvention response.

In determining an appropriate postvention response, DHBs need to consider the potential for contagion; the impact of the death on family/whānau, friends and the wider community; the circumstances of the death; and the level of community attention, including media and social media interest. Where a DHB identifies a high risk of contagion (but not a cluster), it should draw on expertise such as CASA's CPRS.

Where suicide clusters occur across DHB boundaries, CASA will alert the relevant DHBs and nominate one DHB to lead the postvention response. Close cooperation between DHBs and organisations across the whole of the impacted area is vital to an effective response.

Anticipatory planning

Although a DHB may lead the postvention response, postvention is a partnership between the DHB and the community. Established relationships with community stakeholders form the platform for rapid and effective community engagement in the event of a cluster.

Anticipatory planning is strongly recommended. Each DHB should consider establishing a suicide postvention stakeholder group with a senior organisational mandate. This group could develop and maintain a postvention response plan, agree on basic response protocols and agree on communication channels to support responses from individual organisations. This group should meet at least annually.

At a minimum a postvention group should include representation from:

- key DHB internal contacts
- local branches of key government agencies such as police and CYF
- local educational institutions and the Ministry of Education's TI team if the cluster includes young people
- NGOs with suicide prevention functions, such as Victim Support and Kia Piki te Ora
- representatives from organisations serving the impacted community, including iwi, local councils, etc.

Suicide clusters can occur in widely diverse communities. Some are linked geographically; some to a particular ethnic, social, cultural or age group; some to a community of interest; and some by engagement with a particular institution. Anticipatory planning activities must therefore be capable of responding to the particular needs of the community impacted by the cluster. For example, if a small or remote community is involved, it may be necessary to set up a stakeholder group with more localised representation. Postvention response must reflect the unique geographic, social and cultural needs of the affected community.

While it is important that the postvention group include community representation, the group needs to be small and agile. It needs to be able to act quickly and with authority. This group will differ from the larger, wider list of stakeholders involved in developing regional suicide prevention plans.

Activities of the postvention group

When the postvention response is activated, the initial priority goal is to take steps to contain the situation and de-escalate community concern.

Key activities may include:

- gathering facts about suicidal behaviours and deaths in the community. Some of this information may suggest necessary subsequent actions. For example, if the deaths were by the same means, the group could consider activities to reduce access to those means
- containing the level of detail shared about suicide deaths with the larger community and the media, and ensuring the accuracy of information released to the community
- assigning roles and responsibilities to members; for example:
 - a media liaison and spokesperson to work with media to encourage safe and accurate media coverage
 - a person responsible for liaising with bereaved families/whānau in terms of the community response
 - a person responsible for monitoring of social networking sites for signs of contagion and identification of at-risk individuals.
 - a person responsible for coordinating the process of identifying individuals with heightened suicide risk and keeping an ‘at-risk’ register (link to CPRS document), to ensure that vulnerable individuals are referred to appropriate agencies for support and follow-up.

The CPRS has produced a number of resources that help with screening, covering: screening using circles of vulnerability – a model for identifying those individuals potentially at risk after a death by suicide, identifying suicide concerns in children and young adolescents risk factors and triggers for suicidal behaviour in youth, acute and chronic suicide risk, warning signs for suicidal behaviour.

- facilitating agreements between services about referrals and service access
- making information available to the community, including mental health referral information and suicide prevention or bereavement resources
- implementing appropriate privacy protocols for managing personal information about individuals (for guidance on managing information on individuals at risk and suspected suicides for postvention purposes contact CASA)
- engaging community leaders in the response to suicide deaths. Sometimes the community desires a public meeting to discuss the situation; postvention response groups need to manage such events carefully so as not to escalate concerns. Memorial services and remembrance activities can play a role in the healing process; such services should strike a balance between creating appropriate opportunities for people to grieve and avoiding increasing risk for the vulnerable by glorifying suicide
- training and development related to suicide prevention, including within the community
- evaluating postvention responses after the immediate crisis has passed, and making changes to postvention plans where necessary. This can involve identifying unmet community needs and addressing them in the broader DHB suicide prevention plan
- managing the risk of cluster recurrences at specific times, such as anniversaries.

Examples from the sector

- South Canterbury Suicide Prevention plan
- Auckland DHB postvention plan
- West Coast Suicide Prevention and Postvention Plan
- Wairarapa Suicide Prevention and Postvention Plan.

Supporting resources

- CASA ‘Community Postvention Response’
- CASA ‘CPRS Community Resources’
- Ministry of Education Preventing and responding to suicide
- Ministry of Education Responding in an emergency or traumatic incident
- Ministry of Youth Development Guidance for Community Organisations involved in suicide postvention/

Appendix 2: Suicide prevention and postvention plan 2015–2017

District Health Board name

Date

Contact person and title

Endorsement by key parties to the plan

(senior management, other agencies or community groups)

..... Key party Date
..... Key party Date
..... Key party Date

This template is provided as a guide for DHBs to develop a Suicide Prevention and Postvention Plan.

DHB Suicide Prevention and Postvention Plan

Context

From 1 July 2014 all District Health Boards (DHBs) are required to develop and implement suicide prevention and postvention plans, and to facilitate integrated cross-agency and community responses to suicide in their area.

These plans are to cover activity from July 2015 to June 2017. The newly created Suicide Prevention and Postvention DHB toolkit will be available on the Ministry website from February 2015, to provide guidance on best practice for preventing suicide and responding to suicide clusters or contagion.

This template may be used to ensure that suicide prevention and postvention plans cover core aspects of activity, listed below. This is by no means the only suitable template, but the key areas of activity listed here must be included in any plan submitted. Where appropriate, information can be presented using charts, schematics and flow charts.

Suicide prevention and postvention plans are expected to be no longer than 10 pages.

Reporting requirements

- A draft suicide prevention and postvention plan is due to the Ministry by 20 April 2015. Please submit your plan to the Ministry via the DHB quarterly reporting website.
- The Ministry will review the plans and provide feedback so that final plans can be submitted by 20 July 2015.
- From July 2015 you will be required to select two or three actions to focus on. From December 2015, reporting will be by exception and focusing on highlights. Once the suicide prevention and postvention plan is confirmed, the actions selected for focus should be included in your 2015/16 DHB Annual Plan.
- A report about all of the activities in the plan (section four) will be required by 20 July 2016, once the plan has been operational for a full year.

Planning guidelines

Please use the italicised bullet points as a guide, then delete.

1 Introduction

- *An outline of the purpose and scope of the plan, acknowledging the contributing parties, including community groups.*
- *A summary of the local demographics, suicide statistics and identify at-risk populations (eg, youth, Māori, Pasifika, LGBTI, rural).*

2 Current status and linkages

- *Include a scan of prevention/postvention activities in the region. This should not be limited to DHB activities only.*
- *Describe how the proposed activities in the plan align with the goals of the New Zealand Suicide Prevention Strategy 2006–2016.*
- *Explain the linkages with other initiatives in the New Zealand Suicide Prevention Action Plan 2013–2016.*

3 Governance

- *Describe where and how governance responsibility for suicide prevention and postvention will be sited.*
- *Explain how governance will be managed.*

4 Stakeholder engagement

- *Identify key stakeholders including DHB linkages (internal and external) as well as PHOs, Police, schools, Child Youth and Family, NGOs, national providers, Māori and Pasifika groups and other community partners. These relationships should be reflected throughout the plan.*
- *Describe how local stakeholders have been engaged with in developing the plan.*
- *Explain the roles the various stakeholders will hold and how these relationships will be managed on an ongoing basis.*

5 Areas of activity (refer table on next page)

- *Please complete the table on the next page to record the activities you will be undertaking covering the five key areas. Include the objectives, deliverables (with dates) and expected outcomes. The final column will be used for reporting against these.*

6 Monitoring and evaluation

- *Describe how you will monitor and report on the plan's implementation.*
- *Describe how you will continue to improve the plan and its implementation, eg, by incorporating lessons learnt.*

7 Identification and mitigation of risk

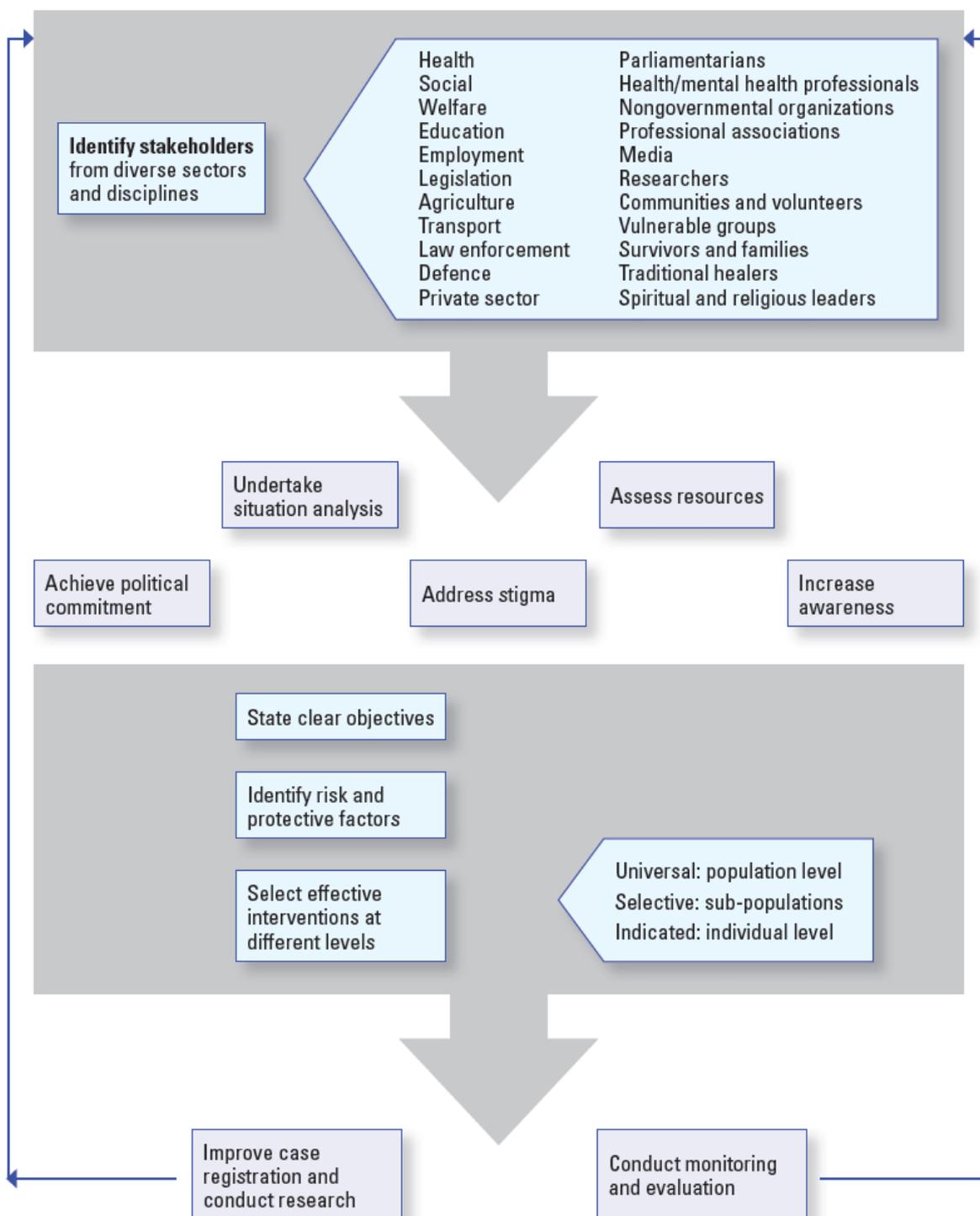
- *Describe any potential risks as the result of the planned activity.*
- *Describe mitigation strategies to address risk.*

5 Areas of activity

Please complete this table to record the activities you will be undertaking across the five key areas listed below. Include the objectives, deliverables (with dates) and expected outcomes. The final column will be used for reporting against these.

Area of activity	Objectives	Key activities, milestones and deliverables (with dates)	Expected outcomes	Reporting
A Resilience building activities in the region – activities to respond to early risks, promote mental health and wellbeing and help prevent suicide				
B Information on workforce development for health workers and key community gatekeepers to respond to distressed people in the community				
C Approaches specific to at-risk groups such as Māori, Pasifika and other vulnerable populations				
D Multi-agency postvention response in cluster and contagion situations				
E Postvention approaches in in-cluster situations				

Appendix 3: Suicide prevention planning flow chart



Source: World Health Organization

Appendix 4: Tools and templates to help with planning

Suicide prevention stakeholder analysis map

High			
Some			
Little			
	Little	Some	High

Suicide prevention stakeholder analysis tool

Stakeholder	Stake in the initiative	What do we need from them?	Perceived attitudes / risks	Risk if they are not engaged

Plan-Do-Study-Act cycle

For each change idea. Complete as many of this template as needed.

PDSA owner:	
What idea are you testing?	

Plan – What exactly do you plan to do to test this idea?	
What will you do?	
Who will do it?	
When and where?	

Do – Was the plan executed? Document any unexpected events or problems.	
Was the plan done?	
Describe any unexpected events or problems?	

Study – Record, analyse and reflect on the results	
What did you find?	
What does it mean?	

Act – What will you take forward from this cycle? (next step / next PDSA cycle)	
What next?	

Overall continuous improvement plan

Your overall plan for your improvement activity for this area.

<p>What are we trying to accomplish? By answering this question you will develop your goal for improvement.</p>
<p>How will we know that a change is an improvement? By answering this question you will develop measures to track the achievement of your goal.</p>
<p>What changes can we make that can lead to an improvement? List your ideas for change. By answering this question you will develop the ideas you would like to test to achieve your goal.</p>

Appendix 5: Coronial Suspected Suicide Data Sharing Service (CDS) Explanatory Notes

Purpose

These explanatory notes introduce CDS, a service for sharing provisional coronial information on suspected suicides with District Health Boards (DHBs) in New Zealand.

Setting

Under the Coroners Act 2006, the Police must report every suicide to the coroner. While suspected suicides are investigated independently by individual coroners, the Chief Coroner maintains an overview and Coronial Services New Zealand (CSNZ) centrally collect information on suspected suicides. Where this provisional coronial data on suspected suicides might help suicide postvention efforts undertaken by other agencies, and data sharing agreements are in place, CSNZ may share this information with third parties.

In New Zealand, the Ministry of Health is responsible for leading a multi-tiered approach to suicide prevention. In New Zealand, there are 20 DHBs providing national coverage. DHBs play an important leadership and coordination role in suicide prevention and postvention activities within their populations.

What is CDS?

From 1 July 2014, the Ministry of Health established CDS to securely notify DHBs of instances of suspected suicides in their regions. Notifications consist of brief identifying information on suspected suicides sourced from CSNZ who obtain the information when the death is notified to the Coroner. The purpose of this service is to inform DHBs' local responses to suspected suicides in their regions.

CDS was initiated by the Ministry of Health in order to implement Action 11.2 of the New Zealand Suicide Prevention Action Plan (2013-2016; NZSPAP)¹.

CDS is delivered by Clinical Advisory Services Aotearoa (CASA). CASA is already contracted by the Ministry of Health to deliver the National Community Postvention Response Service (CPRS). CPRS assists in the early detection of emerging suicide clusters and contagion and coordinating community responses to suicide clusters and contagion. In addition to DHBs, CDS alerts CPRS to all CSNZ notifications about suspected suicides to support the roles and functions of CPRS.

¹ Action 11.2 Establish a function to analyse and share up-to-date provisional coronial data on suicide deaths with agencies working in local areas to help prevent further suicides (NZSPAP 2013-2016).

What is the CDS Memorandum of Understanding (MoU)?

There is a MOU between CSNZ, the Ministry of Health, CASA and all 20 DHBs. This MOU sets out the purpose and process to provide notifications from CSNZ to DHBs. It outlines how CSNZ agrees to provide brief information on suspected suicides to assist DHBs to support their timely and appropriate local responses to suspected suicides (postvention) for the purposes of preventing or lessening a serious threat to public health or public safety or the life or health of an individual (Principle 11(f), Privacy Act 1993).

In sharing this information, CSNZ expects that DHBs party to the MoU will use the information for this intended purpose only, and provide a timely and appropriate local response to suspected suicides.

The MoU describes expectations of all parties in respect of the collection, use, disclosure and retention or disposal of information from CSNZ. A Privacy Impact Assessment evaluates the CDS process in relation to its potential to impact on a person's privacy, as set out in New Zealand's Health Information Privacy Code 1994.

In agreeing to the MoU, DHBs receive timely information on suspected suicides of relevance to their region.

What is the rationale for the timely sharing of provisional coronial information on suspected suicides?

Suicide prevention and postvention activities are included in the National Services Coverage Schedule expectations of DHBs and in the DHB annual planning requirements.

From 1 July 2014, DHBs have been expected to develop district suicide prevention and postvention plans which, amongst other requirements, show evidence of how a DHB will facilitate integrated cross-agency collaboration in respect of local responses to suspected suicides.

Suicide Postvention refers to the wide range of activities that are undertaken directly after a suicide in a community due to the potentially harmful effect the suicide may have on others (particularly but not exclusively for youth) who may also engage in suicide related behaviours or attempt suicide (referred to as contagion). Thus suicide postvention is also suicide prevention.

Timely provisional coronial data on suspected suicides is an important element of local responses to these deaths for all agencies in order to:

- provide timely and appropriate active outreach, support and other suicide postvention services to family and communities bereaved by suicide (Action Area 4 of the NZSPAP 2013-2016)
- coordinate inter-agency collaboration, as well as wider community involvement, in suicide postvention responses designed to identify potentially vulnerable individuals and ensure that they are linked with appropriate supports and services (Action Area 4 of the NZSPAP 2013-2016)

- reduce community distress and anxiety, and minimise risk contributing to any further suicidal behaviour (Action Area 5 of the NZSPAP 2013-2016)
- enable an accurate assessment of current local patterns of suspected suicides in order to discern possible suicide cluster or contagion (Action Area 5 of the NZSPAP 2013-2016).

What information do DHBs get from CSNZ?

The information provided by CSNZ in notifications contains, where possible:

- name of the deceased
- date of birth of the deceased
- date of death of the deceased
- location of the death
- usual place of residence of the deceased
- ethnicity
- gender
- means of death.

When do DHBs get notifications from CSNZ?

On standard business working days, between the hours of 7 am and 5 pm, where CSNZ has notified CASA of a death due to suspected suicide via secure encrypted webmail, this information is transmitted to all relevant DHBs (also using secure encrypted webmail) within a maximum response time of two hours.

How is access to information from CSNZ controlled and authorised?

All requests to CASA from DHBs for access to notifications from CSNZ must be approved by a registered and duly authorised representative of the relevant DHB.

All requests for authorisation will only be approved by CASA on the basis that the designated applicant has a role, function or accountability with a DHB's local responses to suspected suicide.

The information is provided by CSNZ on the understanding that it will be used by DHBs to support their timely and appropriate local responses to suspected suicides. It is provisional information, is highly sensitive, and remains the property of CSNZ.

The CDS Memorandum of Understanding (MoU) has been developed to set out expectations for the continued receipt of this information.

Any DHB party to the CDS MoU is responsible for the collection, use, disclosure, retention and disposal of the information received, and has undertaken to ensure that access to the information provided is managed in accordance with the Privacy Act 1993, the Health Information Privacy Code 1994, and the Health Information Security Framework.

If you have any questions about CDS or these explanatory notes please contact Roger Shave, CDS Project Manager, email: roger.shave@casa.org.nz website: www.casa.org.nz

Appendix 6: Coronial Suspected Suicide Data Sharing Service (CDS) – Privacy Impact Assessment

Part 1

About this Privacy Impact Assessment

The Office of the Privacy Commissioner describes a Privacy Impact Assessment (PIA) as “a systematic process that evaluates a proposal in terms of its impact upon privacy”.²

The Ministry of Health (the Ministry), in undertaking a PIA of a proposed IT system, reviews the system’s risk from the point of view of the key stakeholders in relation to the Health Information Privacy Code 1994 (the Code). Accordingly, in undertaking a PIA for Coronial Suspected Suicide Data Sharing Service (CDS), privacy risks are considered in terms of the brief information on suspected self-inflicted deaths made available to health agencies including the Ministry (through its agent Clinical Advisory Services Aotearoa (CASA), and to District Health Boards (DHBs)). This information is made available by Coronial Services New Zealand (CSNZ) to support local responses after a death by suspected suicide.

Definitions used in this document

CASA: Clinical Advisory Services Aotearoa	CASA is contracted by the Ministry to deliver CDS. CASA is also contracted by the Ministry to deliver the national Community Postvention Response Service (CPRS), to assist DHBs in coordinating community responses to suicide clusters and contagion.
CDS: Coronial Suspected Suicide Data Sharing Service	A service to securely disseminate to DHBs brief details on suspected suicides as they occur. The CDS service is facilitated by CASA under contract to the Ministry of Health, as outlined in the Memorandum of Understanding (MoU) and Appendices attached to this document.
CDS Notification	Brief details on a suspected suicide provided to relevant DHB/s, compiled by CSNZ from information provided by NZ Police to the Coroner.
CISCO: Cisco Ironport Email Security System	Technology employed by CASA, as agent to the Ministry, to secure access to CDS Notifications being disseminated to DHBs.
CSNZ: Coronial Services New Zealand; the Coroner	Agency responsible for coronial investigations from which CDS Notifications originate.
Ministry of Health (the Ministry)	Lead agency responsible for implementing Action 11.2 of the New Zealand Suicide Prevention Action Plan 2013–2016, which requires the Ministry: “establish a function to analyse and share up to date provisional coronial data on suicide deaths with agencies working in local areas to help prevent further suicides”.
MOU: Memorandum of Understanding	The document signed by CSNZ, the Ministry of Health, CASA and individual DHBs which sets out the purpose, expectations of parties and process for CDS (refer pages 16–24 of this document).

² Office of the Privacy Commissioner, Privacy Impact Assessment Handbook, 2007 Accessed 9 July 2014. <http://www.privacy.org.nz/assets/Uploads/Privacy-Impact-Assessment-Handbook-June2007.pdf>

Definitions used in this document	
PIA: Privacy Impact Assessment	A systematic process that evaluates a proposal in terms of its impact upon privacy.
Postvention	Activities undertaken directly after a suicide in a community due to the potentially harmful effect the suicide may have on others (particularly, but not exclusively, for youth) who may also attempt suicide (referred to as contagion). Thus, suicide postvention is also suicide prevention.
SPAP: New Zealand Suicide Prevention Action Plan 2013–2016	This second action plan consisting of 30 actions led by a range of agencies, is working towards the goals of the <i>New Zealand Suicide Prevention Strategy 2006–16</i> . The Ministry of Health leads the government's work programme on suicide prevention.

Privacy rights for deceased persons

Because the individual to whom the information relates is deceased and with limited exceptions the law does not apply privacy rights to the deceased, this PIA considers the sensitivity of the information and the need to protect the privacy of the bereaved family. It should be noted that while the Health Information Privacy Code (the Code) does not apply to deceased people, the Rules in the Code could apply to relatives of the deceased where the relative is identifiable from the information.

In relation to a family's privacy rights as representative of the deceased, the Code defines 'representative' in relation to a deceased individual as an individual who is that person's executor or administrator, unless they are under the age of 16 at time of death in which case it will be the deceased's parent or guardian.

Background

The Ministry is responsible for leading a multi-tiered approach to suicide prevention, and for leading implementation of both the New Zealand Suicide Prevention Strategy³ and the New Zealand Suicide Prevention Action Plan (2013–2016) (SPAP).⁴

Beginning in October 2012, the Chief Coroner has been responding to a request from northern DHBs to be notified with real time, up-to-date information on suspected suicide deaths to inform their local postvention responses. This project grew from a need for reliable and timely information on suspected suicides to manage misinformation and local rumours.

The SPAP also recognised this need, with Action 11.2 requiring the Ministry to “*establish a function to analyse and share up to date provisional coronial data on suicide deaths with agencies working in local areas to help prevent further suicides*”. To implement Action 11.2, from 1 July 2014 a national service for securely sharing information is being established by the Ministry that builds on the early impetus of the Chief Coroner's project. The new national service is the Coronial Suspected Suicide Data Sharing Service (CDS).

Coronial Suspected Suicide Data Sharing (CDS)

CDS enables CSNZ to make available brief coronial information on suspected suicide deaths to health agencies party to the MoU, included in pages 16–24 of this PIA. CASA is contracted by the Ministry to deliver CDS. CASA is also contracted by the Ministry to deliver the national Community Postvention Response Service (CPRS), to assist DHBs in coordinating community responses to suicide clusters and contagion.

³ Ministry of Health. 2006. *New Zealand Suicide Prevention Strategy 2006–2016*. Wellington: Ministry of Health.

⁴ Ministry of Health. 2013. *New Zealand Suicide Prevention Action Plan 2013–2016*. Wellington: Ministry of Health.

Under CDS, CASA will facilitate the secure transmission from CSNZ to Authorised Recipients in DHBs of a notification (CDS Notification) containing brief details on a suspected suicide death. A CDS Notification is encrypted and requires authentication of the Authorised Recipient to enable them to decrypt and view the details in the notification. A full description of the CDS process can be found in the attached MoU, Appendix 2.

CSNZ, CASA, the Ministry and individual DHBs will be parties to the MoU. This MoU requires recipient parties to ensure that any access by their employees or agents to a CDS Notification is for the purpose outlined in the MoU and supporting CDS documentation, and managed in accordance with the Privacy Act 1993, the Health Information Privacy Code 1994, and the Health Information Security Framework.

Suicide is a major issue that is of real concern to New Zealand communities. Every year approximately 500 people take their own lives, affecting the lives of many others. However, suicide is a low base-rate event. Given the relatively low numbers of suicide events triggering a CDS Notification, a formal governance committee to manage CDS will not be established. Instead, CDS will be led by a Clinical Advisor overseen by CASA's clinical leadership team, which will be responsible for providing monthly performance reports to the Ministry as required by the contract. A project lead within the Ministry's Sector Capability and Implementation business unit will be the key contact with CASA, with governance provided by the Suicide Prevention Managers' Group, and the Mental Health and Addictions Governance Group, as circumstances require. The Director of Mental Health is a member of both groups. The Ministry's usual accountability and project management functions include responsibility for maintaining a risk and mitigation register.

Senior officials from each DHB party to the MoU, are required to sign the MoU and designate a person who can authorise recipients of CDS Notifications. The Cisco system that underpins the CDS process provides functionality for fully auditing access to a CDS Notification. This means that CASA can report to the Ministry when and by whom a CDS Notification has been accessed. In addition to this auditing, DHBs are required to submit district suicide prevention and postvention plans, which will be expected to identify how information received in CDS Notifications is being used.

Taken together, these governance and monitoring provisions are a suitable substitute for a formal governance committee.

Part 2 – Privacy analysis

The analysis that follows makes an assessment of CDS in relation to the Health Information Privacy Code 1994, Rules 1–12. The following table summarises the analysis on pages 7–15.

Summary of rule	Key point	Risk assessment
Rule 1: Purpose for collecting information must be lawful	The information is collected for a lawful purpose, which is in accordance with the Coroners Act. In their role as agent of the Coroner, NZ Police are the originators of the information from which brief details (<i>listed in paragraph 1.6 below</i>) are selected by CSNZ to be provided to health agencies party to the MoU. The Ministry, through its agent CASA, is collecting the information from CSNZ in order to inform suicide postvention services.	Low risk
Rule 2: Collecting information from the individual	As the individual is deceased it is not possible to collect the information from the individual. Instead, the NZ Police collect this information in accordance with the Coroners Act 2006. The Ministry, through its agent CASA then collects the information from CSNZ pursuant to an MoU.	Low risk
Rule 3: Obligation to advise individual of reason they are collecting the information, how it is to be used and who are the intended recipients	As the individual is deceased it is not possible to inform the individual of the fact of, and reasons for, collection.	Not applicable
Rule 4: Lawful manner of collection	Collection is lawful pursuant to an MoU between CSNZ, the Ministry, CASA and individual DHBs. The release of the information by CSNZ to the Ministry is authorised by the Chief Coroner in accordance with s7 (l) of the Coroners Act 2006.	Low risk
Rule 5: Storage and security of information	Information compiled by CSNZ to form a CDS Notification is transmitted to CASA by encrypted email. There are two main risks: <ul style="list-style-type: none"> the Authorised Recipient, copies the information (eg, print screen and then photocopied) and passed on inappropriately the Ministry cannot control who any party to the MoU might authorise to receive a CDS Notification. The MOU sets out the Ministry's expectations as to privacy. Non-compliance could lead to termination of transmission to a DHB or voiding an Authorised Recipient's access rights.	Moderate risk
Rule 6: Access to information	This rule is not applicable in regard to the individual who is deceased. If a member of the deceased individual's family is also the legal representative of the individual then they may have access under s22F of the Health Act 1956, Rule 11(4) of the Health Information Privacy Code or pursuant to the Official Information Act (OIA) 1982.	Not applicable to individual but access needs to be considered by representative (family) (s22F Health Act), Rule 11(4) of the Code or OIA
Rule 7: Entitled to request correction	Although relatives of a deceased person may request correction of information there is no obligation on the agency to action the request. The presumption however is that any such request will be considered on its merits.	Not applicable
Rule 8: Accuracy of information	A CDS Notification is limited to brief details on the death/deceased individual and are generally accurate. Where inaccuracies are identified by any parties to the MoU, steps are taken to rectify errors, and make other recipients aware of any amendments.	Low risk

Summary of rule	Key point	Risk assessment
Rule 9: Retention and disposal of health information	Though information on the death of the deceased is not health information, recipient health agencies will be expected to treat the information received in a CDS Notification as health information, which is expected to be kept for 10 years.	Low risk
Rule 10: Information held for one purpose cannot be used for another purpose	The purpose of the information in a CDS Notification is to support local responses to suspected suicides, and protocols for its use are set out in CDS documentation. If the Ministry becomes aware that any party is using the information in a CDS Notification for a different purpose, termination of access or other appropriate disciplinary procedures and processes would apply.	Moderate risk
Rule 11: Information must not be disclosed unless one of the exceptions applies	Disclosure of information in a CDS Notification to appropriate staff within the DHB or appropriate third parties for the purpose for which the information was obtained is acceptable under Rule 11.	Low risk
Rule 12: Assignment of a unique identifier	A unique identifier is not contained in a CDS Notification.	Low risk
Conclusion	CDS has narrow parameters and was developed to safeguard the transmission of brief coronial information on a deceased individual to Authorised Recipients in health agencies party to an MOU. Because the Code and the Privacy Act were set up to consider the interests of an individual to whom the information relates, not all the Rules apply. Consideration has, however, been given to the sensitivities of the relatives of the deceased individual.	Low risk

Health information privacy rules

1. Rule 1

Health information must not be collected by any health agency unless:

- the information is collected for a lawful purpose connected with a function or activity of the health agency; and
- the collection of the information is necessary for that purpose.

- 1.1 The purpose of the Ministry collecting the information included in a CDS Notification from CSNZ is to inform local responses to suspected suicides. This same purpose applies to the various DHBs who are collecting the information from the Ministry's agent CASA.
- 1.2 Suicide postvention refers to the wide range of activities that are undertaken directly after a suicide in a community due to the potentially harmful effect the suicide may have on others (particularly, but not exclusively, for youth) who may also attempt suicide (referred to as contagion). Thus suicide postvention is also suicide prevention.
- 1.3 Suicide prevention and postvention activities are now included in the Ministry's expectations for DHBs in the National Services Coverage Schedule and in the DHB Annual Planning guidance. From 1 July 2014, DHBs are expected to develop district suicide prevention and postvention plans which, amongst other requirements, will outline how a DHB will facilitate integrated cross-agency collaboration in respect of local responses to suicide clusters/contagion.

- 1.4 The government, through Action 11.2 of the SPAP, has tasked the Ministry with establishing a function to share provisional coronial data on suicide deaths with DHBs, to facilitate DHBs carrying out a local postvention response to help prevent further suicides. In order to establish this function, the Ministry is collecting the necessary information from CSNZ. This is a lawful purpose associated with the Ministry's role in looking after the public health of New Zealanders.
- 1.5 Up-to-date provisional coronial data on suspected suicide deaths is an important element of local responses to these deaths for agencies working in local areas in order to:
- provide timely and appropriate active outreach, support and other suicide postvention services to family, whanau, communities and others bereaved by suicide (SPAP Action Area 4)
 - coordinate inter-agency collaboration, as well as wider community involvement, in suicide postvention responses designed to identify potentially vulnerable individuals and ensure that they are linked with appropriate supports and services (SPAP Action Area 4)
 - reduce community distress and anxiety, and minimise risk contributing to any further suicidal behaviour (SPAP Action Area 5)
 - enable an accurate assessment of current local patterns of suicide deaths in order to discern possible suicide cluster or contagion (SPAP Action Area 5).
- 1.6 The information collected as part of a CDS Notification will contain where possible:
- name of the deceased
 - date of birth of the deceased
 - date of death of the deceased
 - location of the death
 - usual residence of the deceased
 - ethnicity
 - means of death.

Risk assessment

- 1.7 The purpose of collecting the information is made clear in the MoU and accompanying CDS documentation and is to assist DHBs in their responsibilities to protect life, which includes developing suicide prevention and postvention plans. This is in line with their obligations under section 22 of the New Zealand Public Health and Disability Act 2000. It is therefore considered that the risk of breaching this rule is low.

2. Rule 2

Where a health agency collects health information, the health agency must collect the information directly from the individual concerned, [unless] ...

- the individual concerned authorises collection of the information from someone else ...
- the individual is unable to give his or her authority and the health agency collects the information from the individual's representative ...
- compliance would:
 - prejudice the interests of the individual concerned ...
 - prejudice the safety of any individual ...
- compliance is not reasonably practicable ...
- the information is publicly available information
- the information:
 - will not be used in a form in which the individual concerned is identified, or
 - will be used for statistical purposes. and will not be published in a form that could reasonably be expected to identify the individual concerned, or
 - will be used for research purposes (for which approval by an ethics committee, if required, has been given)
- non-compliance is necessary to avoid prejudice to the maintenance of the law.

2.1 As the individual to whom the information in a CDS Notification refers is deceased, this information can only be retrieved from a third party. New Zealand Police, as agents of the Coroner, collect information on a deceased individual in accordance with the Coroners' Act 2006. The Coroner selects brief details from this information on suspected self-inflicted deaths, and makes these details available in a CDS Notification to health agencies party to the MoU.

Risk assessment

2.2 It is beyond the remit of this PIA to consider the actions of the New Zealand Police in collecting this information and providing it to CSNZ. However, CASA as the agent for the Ministry is also the collector of personal information from CSNZ. Because the individual is deceased collection from the individual is not possible. It is considered that the risk of breaching this rule is low.

3. Rule 3

Where a health agency collects health information directly from the individual ... the health agency must take such steps as are, in the circumstances, reasonable to ensure that the individual ... is aware of:

- the fact that the information is being collected
- the purpose for which the information is being collected
- the intended recipients of the information.

3.1 The information about the deceased individual is collected in the first instance by New Zealand Police as agents of the Coroner. Any obligation in regard to advising the representative of the deceased individual (often the family) under the Coroners Act 2006, is beyond the remit of this PIA.

3.2 The Ministry collects the information from CSNZ. The Ministry recognises that the sensitive nature of information in a CDS Notification means that health agencies are expected to consider the privacy of the bereaved families, and be guided by the spirit of the rule.

Risk assessment

3.3 As the information has been collected by the New Zealand Police as agent of the Coroner, and the Ministry has subsequently collected the information from CSNZ, this rule does not apply to health agencies. However, recipient health agencies are expected to note the spirit of this rule.

4. Rule 4

Health information must not be collected by a health agency by unlawful means or by means that, in the circumstances of the case are unfair or intrude to an unreasonable extent upon the personal affairs of the individual concerned.

4.1 The information is being collected by the Ministry through its agent CASA from CSNZ for the purpose of informing local responses to suspected suicides. This is a lawful purpose, and as noted above, is in line with Section 22 of the Health and Disability Act 2000. It is being collected pursuant to the MOU between CSNZ, the Ministry, CASA and each individual DHB.

4.2 The release of the information by CSNZ to the Ministry is authorised by the Chief Coroner in accordance with section 7(1) of the Coroners Act 2006.

Risk assessment

4.3 The means of collection is set out in the MOU and is lawful. Because the individual is deceased, the means of collection cannot be said to intrude to an unreasonable extent on the deceased's affairs.

4.4 In the spirit of the rule, consideration has been given to the impact collection would have on the deceased's family. Given the nature of the information, the use it will be put to, and guidance and protocols around its use provided to recipient health agencies, the Ministry does not consider the collection will intrude to an unreasonable extent on the affairs of the deceased individual's family. Accordingly, the risk of breaching this rule is low.

5. Rule 5

A health agency that holds health information must ensure that the information is protected ... against loss, [inappropriate] access ..., use, modification, or disclosure ... or other misuse ...

- 5.1 As outlined in Appendix 2 of the attached MoU, CSNZ makes available a CDS Notification of a suspected suicide using a secure Cisco email system which is managed by CASA as agent of the Ministry.
- 5.2 Information compiled by CSNZ to form a CDS Notification is transmitted to CASA by encrypted email. CASA determine which DHB or DHBs the notification relates to, and send the CDS Notification by encrypted email directly to the email address held by CASA for any DHB-approved Authorised Recipients.
- 5.3 CASA direct CDS Notifications to the DHB's Authorised Recipient/s by including the relevant addressee in the 'to' line. The decryption key to access and read the encrypted email is available only to the Authorised Recipient of that notification. CDS Notifications cannot be forwarded to other email addresses.
- 5.4 The Ministry has ensured the security around access to a CDS Notification is high, and requires any person designated by a DHB to be an Authorised Recipient to be aware of their obligations under the Privacy Act and the Code, and to have signed a confidentiality agreement.
- 5.5 The Ministry has no control over who is made an Authorised Recipient. However, an Authorised Recipient is only able to decrypt a unique CDS Notification sent directly to their email address by CASA. It is not possible for one authorised recipient to email or forward the CDS Notification directly to another, even if the other person also happens to be an Authorised Recipient.
- 5.6 Outside the CDS system there remains a risk that an Authorised Recipient of a CDS Notification could still handle the information in a way that would lead to a breach of this Rule. Further detail on how this may occur and ways in which it could be managed is set out under the risk assessment below.
- 5.7 Security of the information in CDS Notifications is critical because of the strong sensitivities around this information, particularly for the bereaved family. Although this risk cannot be eliminated, the MOU requires DHBs to nominate an employee or agent of a DHB party to the MOU to be authorised to access CDS Notifications by way of a unique user name and secure password. Moreover, the employees or agents are themselves required to sign a confidentiality agreement. It is expected that any breach of the confidentiality agreement would result in the DHB taking appropriate action against their employee or agent. The process for registration of authorised persons is described the attached MOU, Appendix 3.

Risk assessment

- 5.8 The primary risk is that an Authorised Recipient accessing a CDS Notification does one of the following:
- a) photographs or prints the screen and distributes hard copies which cannot be traced
 - b) leaves a hard copy of the information in an accessible place (eg, on their desk)
 - c) does not log off the system, leaving their log on accessible to another person
 - d) communicates the information to others inappropriately.
- 5.9 The MoU and accompanying CDS documentation sets out the expectations of health agencies and DHBs. In particular, it expects them to have in place appropriate confidentiality rules to deal with privacy breaches appropriately and in accordance with the Privacy Act and Health Information Privacy Code. However, each DHB has different privacy policies and will handle such breaches differently. The process has been set up to ensure that each Authorised Recipient is aware of the expectations and rules around the privacy of the information within a CDS Notification and has signed a confidentiality agreement outlining the requirements of confidentiality.
- 5.10 For these reasons it is considered that the risk of breaching this rule is moderate.

6. Rule 6

Where a health agency holds health information in such a way that it can readily be retrieved, the individual concerned is entitled:

- to obtain from the agency confirmation of whether or not the agency holds such health information
- to have access to that health information

... the individual must be advised that under Rule 7 the individual may request correction of that information.

- 6.1 As the individual to whom the information in a CDS Notification relates is deceased, this provision is not applicable to the individual, but may be applicable in respect of a representative of the deceased pursuant to section 22F of the Health Act 1956 and Rule 11(4)(b) of the Health Information Privacy Code 1994.
- 6.2 It is appropriate however, to consider under this Rule two associated requests for personal identifiable information. These are:
- a) a request under the Official Information Act 1982 and
 - b) Section 22F of the Health Act 1956 which covers communication of information for diagnostic and other purposes.

Official Information Act 1982

- 6.3 The Ministry and DHBs are (and some other public health services may be) subject to the Official Information Act 1982 (OIA). It is possible therefore that a request to see the information held on a deceased person may be made. Where a request is made the DHB must consider the request within 20 working days. Privacy interests of deceased people may be protected to some degree (see grounds under section 9(2)(a) and section 29(1)(a) of the Privacy Act) where the privacy of another (including a deceased person) might unjustifiably be compromised.

- 6.4 One ground that will need to be considered is whether the need to ‘protect the privacy of natural persons, including that of deceased natural persons⁵ in the particular case is outweighed by the public interest in having the information disclosed.
- 6.5 It is expected that all DHBs and health agencies subject to the OIA should have in place appropriate procedures for dealing with such OIA requests. The Ministry has an established procedure for managing and responding to OIA requests.

Health Act 1956 (section 22F)

- 6.6 Section 22F (1) provides that:

‘(1) Every person who holds health information of any kind shall, at the request of the individual about whom the information is held, or a representative of that individual, or any other person that is providing, or is to provide, services to that individual, disclose that information to that individual or, as the case requires, to that representative or to that other person.’

- 6.7 Again, it is expected that DHBs will have in place appropriate policies and procedures for dealing with such requests. It is noted however that such requests must be complied with except where this would be contrary to the interests or wishes of the deceased.

Risk assessment

- 6.8 Given the individual to whom the information in a CDS Notification relates is deceased, Rule 6 does not apply to them. However, this rule may apply in situations where a representative of the deceased makes a request to a DHB to access DHB records for the deceased. The Code defines ‘representative’ in relation to a deceased individual as an individual who is that person’s executor or administrator, unless they are under the age of 16 at time of death, in which case it will be the deceased’s parent or guardian.
- 6.9 There may be requests for the information received by a health agency through a CDS Notification to be disclosed pursuant to either the OIA 1982 or to Rule 22F of the Health Act 1956, for which DHBs have policies and practices for managing. It is therefore considered that the risk of breaching this rule is low.

7. Rule 7

Where a health agency holds health information, the individual concerned is entitled to request correction of the information and to request that there be attached to the information a statement of the correction sought but not made.

- 7.1 Again, because the individual to whom the information in a CDS Notification relates is deceased, this provision does not apply. While a representative of the deceased may request that information be corrected, the agency is under no obligation to do so. There is however, a presumption that any correction request will be considered based on its merits.
- 7.2 For the reasons stated above, this rule is not applicable.

⁵ Section 9(2)(a) OIA 1982.

8. Rule 8

A health agency that holds health information must not use that information without taking such steps ... to ensure that ... the information is accurate, up to date, complete, relevant, and not misleading.

- 8.1 Information contained in CDS Notifications is limited to brief details on the deceased (*see paragraph 1.6*) and is selected by CSNZ from the information NZ Police include in their referral of a death for investigation by a Coroner.
- 8.2 Given the purpose for CDS is to support timely local responses to suspected suicides, this necessitates transmission taking place as soon as possible after CSNZ receive the information from NZ Police. This means the information contained in CDS Notifications can at times be incomplete. Where this is the case, processes are in place to rectify missing or incorrect information as more detail becomes available (such as correcting spelling, or identifying a home address in a different DHB than first thought). If however, an error is identified, CDS documentation outlines expectations that any party to the MOU that becomes aware of an error will make CASA aware of this, and CASA will advise CSNZ of the error. It is expected that CSNZ would take such steps as necessary to have the record amended.

Risk assessment

- 8.3 Information in a CDS Notification consists of brief details only and has historically been shown to be generally accurate. In situations of uncertainty a relevant field can be omitted from a CDS Notification, for example: the “usual residence” field may be left blank. This means the starting point for the level of risk of a breach of this rule is low. However, should an error occur, there is still a risk that either it is not picked up by a DHB, or this error is not communicated to CASA. Given the nature and urgency of the expected action arising from a CDS Notification, the Ministry accepts that there may be risks around inaccurate information, but the parties’ awareness of a potential occurrence means that the impact is low. Overall, it is considered that the risk of this rule being breached is low.

9. Rule 9

A health agency that holds health information must not keep that information for longer than is required for the purposes for which the information may lawfully be used.

- 9.1 The information in a CDS Notification will be used for a health purpose; namely, to inform local responses to suspected suicides. For this reason, the information in a CDS Notification is expected to be managed by a recipient health agency as health information, and be kept for 10 years, being the minimum period for which health information must be kept.

Risk assessment

- 9.2 Retaining the information for this period is reasonable and lawful given the purpose for which it is collected. It is considered the risk of breaching this rule is low.

10. Rule 10

A health agency that holds health information obtained in connection with one purpose must not use the information for any other purpose unless:

- authorised by the individual concerned
- the purpose for which the information is used is directly related to the purpose in connection with which the information was obtained
- the information is publicly available
- the use of the information for that purpose is necessary to prevent or lessen a serious or imminent threat to public health or public safety; or the life or health of the individual concerned or another individual
- the information will not be used in a form in which the individual concerned is identified, or will be used for statistical purposes or research purposes and will not be published in a form that could reasonably be expected to identify the individual concerned, or
- that non-compliance is necessary to avoid prejudice to the maintenance of the law.

10.1 Health agencies party to the MoU, including the Ministry, receive the information on suspected suicides for a specific purpose: to support local responses after a suspected suicide. It is not anticipated that health agencies party to the MoU would use the information for a different purpose given the level of information and checks in place set up by the Parties. If the Ministry or its agent CASA become aware that a DHB employee or a agent of employee of the Ministry is using information in the CDS Notification for a different purpose than that set out in the MoU, the Ministry will move to immediately suspend the DHB's or Ministry agent's access to CDS Notifications, either until the situation was rectified, or until the MoU was terminated.

10.2 Should an employee or agent of a health agency party to the MoU be found to have used the information in a CDS Notification for reasons other than the expressed purpose, they can expect to be subject to appropriate action as part of standard employment or contractual obligations.

Risk assessment

10.3 Health agencies are expected to understand the rules around privacy, and that information collected for one purpose cannot be used for another, unless one of the exceptions to the Rule applies. Health agencies are expected to have in place relevant confidentiality and privacy policies that their staff are expected to comply with. Overall, it is considered that the risk of breaching this rule is low.

11. Rule 11

A health agency that holds health information must not disclose the information unless:

- the disclosure is to the individual concerned ... or
- the disclosure is authorised by the individual concerned ... or
- the disclosure of the information is one of the purposes in connection with which the information was obtained, or
- the source of the information is a publicly available publication ...

11.1 Rule 11 prohibits disclosure of information unless it is to the individual concerned or their representative or authorised by them.

11.2 The Ministry believes that the disclosure of the information on a deceased individual contained in the CDS Notification may be necessary despite Rule 11, to prevent or lessen a serious threat to public health and the life or health of an individual (Principle 11(f), Privacy Act 1993). In terms of the test for a serious threat it is considered that while the threat is not extremely likely, it is both imminent and extremely serious.

11.3 The Ministry also notes that the disclosure of information in the CDS Notification is directly related to one of the purposes for which the information was collected. The Ministry collects the information specifically to inform local suicide postvention responses led by a relevant DHB or DHBs.

11.4 It is the health agencies' responsibility to set protocols to manage any subsequent information disclosure and take action as part of standard employment or contractual obligations if an Authorised Recipient discloses information in non-compliance with Rule 11.

Risk assessment

11.5 For the reasons stated above, the risk of breaching this rule is low.

12. Rule 12

A health agency must not assign a unique identifier to an individual unless the assignment of that identifier is necessary to enable the health agency to carry out any one or more of its functions efficiently ...

12.1 A unique identifier is not contained in a CDS Notification. A CDS Notification contains brief details on a deceased individual. Should a health agency associate the information with a unique identifier (such as the deceased individual's National Health Identification (NHI) number), this is acceptable where necessary to carry out its functions in relation to the purpose of CDS.

Risk assessment

12.2 As neither the NHI nor any other unique identifier is included in a CDS Notification, the risk of breaching this rule is low.

13. Conclusion

- 13.1 CDS has narrow parameters and was developed to safeguard the transmission of brief coronial information to Authorised Recipients. The information in a CDS Notification is emailed in encrypted form which is accessible by password and only by Authorised Recipients.
- 13.2 Because the information contained in a CDS Notification pertains to a deceased individual, not all of the Health Information Privacy rules apply. The sensitivity of the information a CDS Notification contains means health agencies party to the MOU are expected to treat the information received in the same way as personal health information. The privacy of the bereaved family of the deceased needs to be respected at all times, and health agencies need to be aware that a CDS Notification may contain identifiable information about the relatives of the deceased.
- 13.3 Overall, it is considered that CDS is low risk.

Memorandum of Understanding

between

Coronial Services of New Zealand, Ministry of Health, Clinical Advisory Services Aotearoa Limited, and XX District Health Board

Parties

The Parties to this Memorandum of Understanding (MoU) are Coronial Services of New Zealand (CSNZ), Ministry of Health (MoH), Clinical Advisory Services Aotearoa Limited (CASA), and XX District Health Board (DHB) within New Zealand.

Purpose

This MoU outlines the understanding and agreement between Parties to support local responses after a death by suspected suicide. It describes expectations in respect of the collection, use, disclosure and retention, disposal of Coronial Information provided by CSNZ in respect of deaths by suspected suicide (Notifications).

This MoU is being put in place to support implementation of the New Zealand Suicide Prevention Action Plan 2013-2016 published by MoH, specifically: Action 11.2 *“Establish a function to analyse and share up-to-date provisional coronial data on suicide deaths with agencies working in local areas to help prevent further suicides”*.

CSNZ agrees to provide Notifications to CASA and XX DHB for the purpose of supporting local responses to suspected suicides so as to prevent or lessen a serious threat to public health or public safety or the life or health of an individual, (Principle 11(f), Privacy Act 1993). This function of sharing provisional Coronial Information on suspected suicides with DHBs constitutes the Coronial Suspected Suicide Data Sharing Service (CDS).

Expectations of parties

CSNZ is providing Notifications on the expectation that XX DHB has a mechanism for providing a timely and appropriate local response to suspected suicides occurring in their region.

The MoH, through its agent **CASA**, is facilitating the secure sharing of Notifications to XX DHB to assist XX DHB to provide timely and appropriate local responses to suspected suicides.

XX DHB, in receiving Notifications for the purposes of providing a timely and appropriate local response to suspected suicides, will ensure that any access to any Coronial Information arising from the Notifications is managed in accordance with the Privacy Act 1993, the Health Information Privacy Code 1994, and the Health Information Security Framework.

Outcomes

The desired outcome of this MoU is that as a result of receiving the Notification:

DHB

- XX DHB will have timely, reliable information to inform its local responses to suspected suicides occurring in its region, and
- XX DHB will have the necessary information to facilitate cross-agency collaboration in respect of responding to suicide clusters/contagion (as required as part of the National Services Coverage Schedule), and
- XX DHB will work alongside other DHBs, as required as part of the National Services Coverage Schedule, to coordinate postvention efforts where the Notification crosses DHB regional boundaries.

CASA as agent of MoH

- CASA will have timely, reliable information to support the roles and functions of the National Community Postvention Response (CPRS). This function is part of a separate contract between the Ministry of Health and CASA.

Agreement

The Parties agree to:

1. Information provision

CSNZ will, as soon as available, provide Notifications as specified in Appendix 1 of this MoU, via secure@coroner.casa.org.nz to CASA.

2. Information security

CASA will establish and manage:

- i. the process for enabling sensitive Coronial Information from CSNZ to be held securely at secure@coroner.casa.org.nz for access by authorised designated XX DHB recipients using the Cisco Ironport Email Security System (as specified in Appendix 2), and
- ii. the process for authorising designated XX DHB recipients who may access secure encrypted notifications at secure@coroner.casa.org.nz (as specified in Appendix 3).

All Parties to this MoU will ensure that any access by their employees or agents to the Notification is managed in accordance with the Privacy Act 1993, the Health Information Privacy Code 1994, and the Health Information Security Framework.

3. Confidentiality

Any Party to this MoU who deals with Notifications or Coronial Information must ensure that any employee or agent of theirs, who accesses such information, does so in a confidential manner and has signed a confidentiality agreement. XX DHB in convening a local postvention response group, is responsible for the confidentiality and security of any parts of the Notification shared with this group, and must be satisfied that any disclosure of information obtained from access to the Notification will be managed in accordance with the Official Information Act, the Privacy Act 1993, the Health Information Privacy

Code and the Health Information Security Framework, and any specific health information security policies of XX DHB as may apply.

4. Monitoring

CASA, which is establishing and managing CDS via secure@coroner.asa.org.nz, is responsible for providing records of access to the Notification, and reporting on this to the MoH and CSNZ as required. Reporting on this and other operational matters in relation to the provision of CDS will occur monthly through regular meetings between CASA, CSNZ and the MoH, to ensure CDS operates as intended and based on the expectations in this MoU.

Variation

This MoU can only be varied by a written agreement duly signed by persons authorised to sign this MoU on behalf of the Parties hereto. The Contact Manager for any proposed changes is CASA.

Review

This MoU shall be reviewed annually or at such other time as may be agreed by the Parties.

Term

This MoU will continue in effect until terminated by all Parties through serving three months' notice in writing.

Effective date

This MoU will come into force on the date that it is signed by all Parties.

Definitions

In this Memorandum of Understanding, unless the context otherwise requires:

“Notifications” – means only the following fields of Coronial Information on suspected suicides in New Zealand provided by CSNZ.

“Coronial Information” must contain where possible:

- name of the deceased, and
- date of birth of the deceased, and
- date of death of the deceased, and
- location of the death, and
- usual residence of the deceased, and
- ethnicity, and
- means of death.

“NIIO” – means National Initial Investigation Office of CSNZ.

“DHBs” – means any other District Health Board within New Zealand whether party or not to this MoU.

“Recipient” – means an employee or agent of XX DHB who is duly authorised by XX DHB to access the secure encrypted notification held at secure@coroner.casa.org.nz.

“CPRS” – means Community Postvention Response Service.

“CDS” – means the Coronial Suspected Suicide Data Sharing Service.

Signatories

Executed by its duly authorised representative signed for and on behalf of:

Coronial Services of New Zealand

Judge Neil McLean:

Chief Coroner:

Date:

Ministry of Health

Name:

Position:

Date:

Clinical Advisory Services Aotearoa Limited

Name:

Position:

Date:

_____ District Health Board

Name:

Position:

Date:

Appendix 1: Notifications from CSNZ to CASA and XX DHB

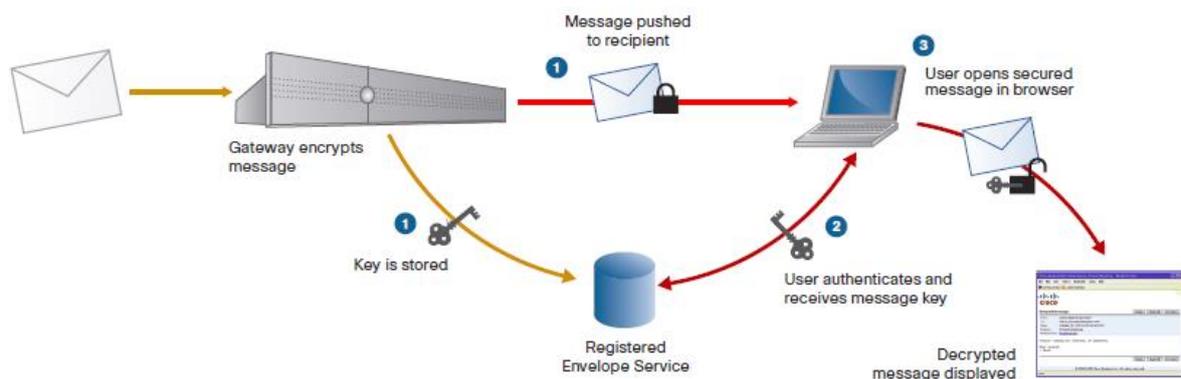
On standard business working days, between the hours of 7 am and 5 pm, where CSNZ has provided Notification of a death due to suspected suicide via the secure webmail address secure@coroner.casa.org.nz to CASA, CASA will, if relevant, inform XX DHB of the Notification within a maximum response time of two hours. The Coronial Information provided in the Notification must contain where possible:

- name of the deceased, and
- date of birth of the deceased, and
- date of death of the deceased, and
- location of the death, and
- usual residence of the deceased, and
- ethnicity, and
- means of death.

Appendix 2: Overview of the Cisco Ironport Email Security System used by CASA to secure access to Notifications from CSNZ held at secure@coroner.casa.org.nz

The Cisco Ironport Email Security System is being deployed by CASA on behalf of the MoH for the purpose of providing XX DHB with timely and secure access to sensitive information from CSNZ about suspected suicides with relevance to their region. The purpose of this is to support XX DHB in its local responses to suspected suicides so as to prevent or lessen a serious threat to public health or public safety or the life or health of an individual (Principle 11(f), Privacy Act 1993).

The broad overview of the process is illustrated in this diagram:



The finer points of the provision of and access to sensitive Coronial Information from CSNZ are:

- a Message Originator (MO) at the National Initial Investigation Office (NIIO) CSNZ logs into the SSL website for the Cisco Ironport Email Encryption appliance. The MO writes the Notification of a suspected suicide in their web browser and addresses it to secure@coroner.casa.org.nz. This works just like webmail
- in “real-time” (as soon as sent by the MO to secure@coroner.casa.org.nz), both the CASA Project Manager and administrator for CDS will be sent an email advising that an encrypted Notification of a suspected suicide is waiting for them. The advisory email does not include any details of the suspected suicide. Instead, this email includes an attachment which directs the user to the “Cisco Registered Envelope Service” to sign in so as to access and decrypt the specific Notification being held at the SSL website address secure@coroner.casa.org.nz
- between 7 am and 5pm on standard business working days, within two hours of arriving at secure@coroner.casa.org.nz, the CASA CDS Project Manager and/or administrator will review Notifications of suspected suicides and, if relevant, forward advisory emails onto the designated XX DHB recipient(s) as agreed and authorised by XX DHB (see Appendix 3 for details of this authorisation process)
- the designated XX DHB recipient(s) get an advisory email telling them that there is an encrypted Notification from CSNZ waiting for them at secure@coroner.casa.org.nz. That person (once registered and authorised as per the process in Appendix 3) can simply click on the attachment in the advisory email which will take them directly to the SSL web site, where they can access and decrypt the Notification.

Points to note are:

- at all times, sensitive information contained in Notifications from CSNZ is accessed through the secure encrypted SSL web site (the Cisco Ironport Email Encryption Appliance) at address secure@coroner.casa.org.nz
- unsecure advisory emails are sent to let registered and authorised recipients of Notifications know that they have an encrypted notification of a suspected suicide waiting for them; these emails do not contain any sensitive information
- unsecure emails contain only an attachment directing the person to the “Cisco Registered Envelope Service”. Although this email may be forwarded to others, only those recipients who are registered and authorised with CDS, and have been listed specifically by CASA as an intended recipient of a specific encrypted Notification held at secure@coroner.casa.org.nz, will be able to open and decrypt the Notification.

Appendix 3: Process for XX DHB to register and authorise designated recipient(s) access to Notifications from CSNZ held at secure@coroner.casa.org.nz

1. The XX DHB signatory to this MoU, or other person authorised to approve XX DHB recipient(s) access to Notifications held at secure@coroner.casa.org.nz on behalf of XX DHB, will first register with the “Cisco Registered Envelope Service”. When that person gets to the “Cisco Registered Envelope Service” sign in page they will need to select the option to create a new account based on their work email address. They will then get sent an email with a link to click on to prove that they own that email address along with the terms and conditions of using CDS. By undertaking this process CASA is able to ensure that its subsequent process and approval of XX DHB recipient(s) access to Notifications held at secure@coroner.casa.org.nz is secure and auditable.
2. Any access to Notifications held at secure@coroner.casa.org.nz by a designated XX DHB recipient will require registration with the “Cisco Registered Envelope Service” and authorisation by the aforementioned duly authorised and registered agent of XX DHB.
3. On receipt of authorisation of a designated XX DHB recipient from XX DHB via secure@coroner.casa.org.nz by CASA, that designated XX DHB recipient will be contacted by CASA who will request that they sign up to the “Cisco Registered Envelope Service”. When the user gets to the “Cisco Registered Envelope Service” sign in page they will need to select the option to create a new account based on their work email address. They will then get sent an email with a link to click on to prove that they own that email address along with the terms and conditions of using CDS.
4. Once the registration sign up process is completed the authorised XX DHB recipient will be able to access and decrypt Notifications held at secure@coroner.casa.org.nz.
5. secure@coroner.casa.org.nz is managed by CASA.
6. All requests from XX DHB for the authorisation of designated recipients must be directed to and approved by CASA.
7. XX DHB is responsible for notifying CASA of any changes to its authorisation of designated recipients for example due to staff resignation or leave or change of job.

8. All requests to CASA from XX DHB for the authorisation of designated recipients access to Notifications held at secure@coroner.casa.org.nz will be approved only on the basis:
 - a. that the designated applicant has a role, function or accountability in XX DHB's local responses to suspected suicides so as to prevent or lessen a serious threat to public health or public safety or the life or health of an individual as intended by CSNZ and Principle 11(f) of the Privacy Act 1993, and
 - b. CASA's receipt of authorisation via secure@coroner.casa.org.nz for the designated recipient from XX DHB's registered authorising agent as described above).
9. Any problems with access to Notifications held at secure@coroner.casa.org.nz or other operational matters regarding CDS must be directed to CASA in the first instance.