



KIA PIKI TE ORA SUICIDE PREVENTION

PROGRAMME EVALUATION

FINAL REPORT

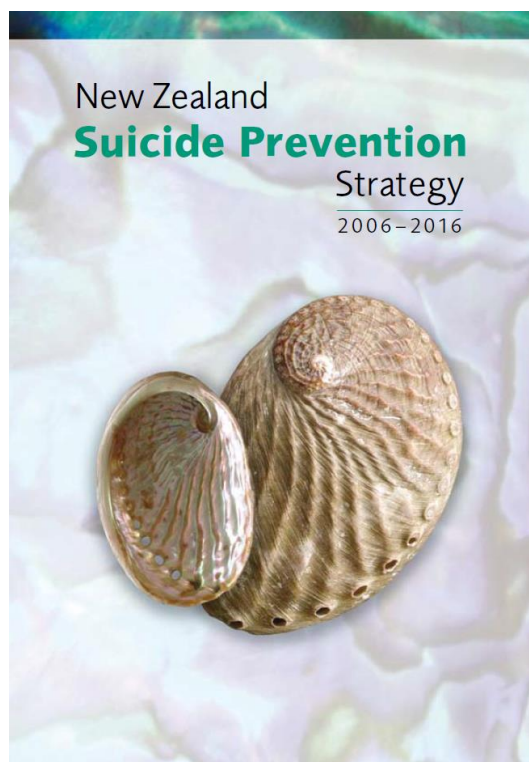
REPORT FOR THE MINISTRY OF HEALTH



December 2014

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EXECUTIVE SUMMARY

Background

In 1998 the Government released the New Zealand Youth Suicide Prevention Strategy ('Kia Piki Te Ora o Te Taitamariki' and 'In Our Hands'). As part of the implementation of the Strategy the Ministry of Health funded a programme called Kia Piki te Ora o Te Taitamariki in a number of Māori communities to address Māori youth suicides. In 2005, following consultation on the New Zealand Suicide Prevention Strategy 2006–2016, this programme was re-focused to an 'all age' suicide prevention programme and renamed Kia Piki te Ora (KPTO). The KPTO programme sought to 'enable inter-agency collaboration with Māori whānau, communities, hapū, iwi, service providers and agencies to promote collaborative and comprehensive approaches to suicide prevention'.

The KPTO programme makes up one element among others in contributing to the New Zealand Suicide Prevention Strategy 2006–2016. The strategy as a whole is intended to reduce suicide rates and the impacts of suicide on families, whānau, friends and communities. KPTO in particular is intended to have a distinctive character and approach grounded in tikanga Māori, focused on services by Māori and for Māori. Its activities include indigenous approaches based on identified cultural best practice models (e.g. Te Whare Tapa Whā¹ and Pōwhiri Poutama²) relevant to Māori suicide prevention and the programme's delivery focused on whānau ora and whānau wellbeing.

The KPTO programme focuses specifically on Māori. Its four overall goals are to:

- promote mental health and wellbeing for all Māori
- include engagement with all communities
- reduce access to the means of suicide
- contribute to reducing the harmful effects and impacts associated with suicide and suicidal behaviour on families, whānau, friends and the wider community.

KPTO providers are expected to play a linking role, bringing the community together in support of its goals. This linking role puts less emphasis on direct service provision to families, whānau and communities. KPTO providers have the freedom to tailor their activities to their own region, incorporating the plans and needs of local iwi, hapū, marae and whānau.

The Ministry of Health funded (or continues to fund) nine regional providers to deliver the revised 'all-age' KPTO Suicide Prevention Programme. KPTO providers employ 17 Coordinators in nine regions. The regions vary in size and population, and do not cover all of New Zealand's Māori population. The regions are:

- Northland Far North: Te Rūnanga o te Rarawa
- Northland Mid North: Ngāti Hine Health Trust
- South Auckland: Raukura Hauora o Tainui Trust
- Bay of Plenty: Te Ao Hou Trust
- Lakes District: Te Rūnanga o Ngāti Pikiao Trust
- Hawke's Bay: Te Kupenga Hauora – Ahuriri Charitable Trust
- Whanganui: Ngā Tai o te Awa Trust
- Christchurch: He Waka Tapu Ltd
- Invercargill / Southland: Ngā Kete Mātauranga Pounamu Charitable Trust.

¹ In Mason Durie's concept of Te Whare Tapa Whā, the four cornerstones (or sides) of Māori health are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

² Paraire Huata's Pōwhiri Poutama Framework is a framework applying culturally safe practice in Māori counselling, social work, mental health and social services.

KPTO evaluation

In May 2014 the Ministry of Health contracted Kāhui Tautoko Consulting Ltd to carry out an evaluation of the KPTO programme across the nine regions, focusing on service delivery for the period July 2010 to December 2013. The evaluation drew on a range of information sources to address questions about what KPTO delivers and what impacts have been demonstrated by its strategies and activities. Drawing on feedback from key stakeholders to assess the significance of the KPTO contribution, the evaluation identified numerous ways in which KPTO providers have contributed to suicide prevention or suicide responses in their communities. It also identified a number of concerns or areas to be considered further, and provided recommendations for the future structure and management of the programme.

The evaluation of the KPTO programme focused on both process and impact questions. Areas considered included:

- how each provider planned, delivered and monitored services in line with a KPTO Accountability Framework and All Age Suicide Prevention Programme Logic Model
- what service providers delivered
- how well programmes met each provider's objectives
- what impact was achieved in the communities
- what value was added to Māori suicide prevention in the communities
- how KPTO contributed to wider suicide prevention objectives
- cultural competency of the programme
- strengths and opportunities for improvement.

The evaluation drew on a variety of information sources:

- interviews and focus groups to develop and refine evaluation questions and instruments
- review of project plans, monitoring reports and other documents provided by the Ministry of Health
- nine regional two-day site visits, with further document reviews and interviews with 34 KPTO staff and 51 local stakeholders
- an online survey of stakeholders who were not available for interviews during site visits, including representatives from district health boards, Māori providers, New Zealand Police, social service providers and other non-governmental organisations. In total, 48 people were invited to respond to the survey. Of this total, 20 completed the online survey.

This report presents a summary of the findings of the nine individual site-specific process and impact evaluations. Individual site reports were also prepared for the nine KPTO regions and were given to KPTO providers for their review. These are incorporated into this report.

Evaluation results

What KPTO providers do best

The KPTO programme provides a way to coordinate locally developed and directed activities, giving effect to its intended role in coordinating change driven by or grounded in the community. KPTO providers are considered good at acting as a conduit between whānau, iwi, hapū and marae, on the one hand, and organisations such as the Police and District Health Boards, on the other. KPTO providers facilitate conversations in their communities to address suicide issues (whether preventatively or after suicides have occurred). The focus on kaupapa Māori is seen as a strength of the programme, allowing providers to promote wellbeing in culturally appropriate ways (referring to whānau ora as a general objective) and some align their services to the Government's Whānau Ora strategy. Stakeholders saw KPTO activities as successful because they were locally developed and adapted to local needs.

The evaluation concluded that the KPTO programme works best when there is continuity of staff and leaders in their communities and when KPTO staff members have extensive community experience. KPTO seems to have the greatest impact where other community organisations in the region adopt suicide prevention as part of their own vision and goals. Most KPTO providers have a history of service delivery in their communities and are able to work in partnership with key agencies in their region. KPTO Coordinators took part in variety of community events such as Waitangi Day celebrations and frequently carried out workshops or other activities at local marae.

Impact of KPTO activities

Questions about the impact of KPTO activities on their communities were largely addressed on the basis of judgements of stakeholders in the different regions. Stakeholders were asked about how KPTO Coordinators connected people from different groups and what happened as a result. They were also asked what value the KPTO programme added to suicide prevention and about the effectiveness of any collaboration with its staff for suicide prevention. All stakeholders expressed a belief that the KPTO programme provided a valuable resource for suicide prevention in the local Māori community. The broad scope of KPTO objectives, however, made it more difficult for stakeholders to assess the degree of its impact. Stakeholders also differed in the degree to which they were able to point to changes in their own services as a result of using the KPTO resource.

Stakeholders referred to improvements in communications, stronger relationships, creation of new projects or initiatives and KPTO presence on local advisory groups or interagency networks. KPTO Coordinators were seen as more effective when they took part in strategic groups or forums led by either KPTO or other organisations because participation in those groups gave them a voice in wider strategic decision-making. All stakeholders who participated in interviews or the online survey reported that KPTO was important for engaging with Māori in their region. Coordinators and other respondents noted that communication through KPTO helped to improve information sharing and policy development. Respondents said that KPTO also improved their access to Māori communities and schools. Another observation was that, as a result of KPTO relationships with local councils and district health boards, those organisations placed greater priority on suicide prevention in their plans.

Questions or issues for the future of KPTO service delivery

The evaluation highlighted several issues to be considered for the programme in future. These included:

- the breadth and appropriateness of KPTO objectives
- the size of the region covered by each provider
- how providers engage with stakeholders, including their communication approaches
- confusion about the role of the KPTO team and programme
- which roles should be carried out for the KPTO programme at a national level
- whether and how KPTO providers contribute to resources and capabilities in their region
- how well the KPTO objectives reflected Māori views of suicide and suicide prevention.

It was widely agreed that KPTO providers should contribute to wellbeing, including resilience, and should engage with community members. Other objectives, such as reducing access to the means of suicide, received less consistent agreement and support. The evaluation also suggested including a specific kaupapa Māori focus for each KPTO objective.

Hawke's Bay, South Auckland and Canterbury are large regions for KPTO providers to cover with only a few Coordinators. As a result, KPTO Coordinators had to limit their service in some areas of their region. In Hawke's Bay, for example, KPTO Coordinators focused largely on Napier and Wairoa, and spent less time in the central Hawke's Bay region due to limited capacity.

KPTO Coordinators were able to engage with key stakeholders best when they already had high profiles in their region and had existing relationships to build on. Their success in engaging community members was also enhanced when they had more continuous relationships with their communities.

The evaluation identified differences in expectations of the KPTO programme. Some stakeholders were unsure about how it fitted into the range of suicide prevention and response programmes in their region. It was apparent that KPTO providers had a wide range of potential audiences to engage with, such as local government agencies, district health boards, whānau, iwi and hapū, and their priorities for such engagement may not be clear. Although the programme is primarily directed at suicide prevention, some stakeholders expected Coordinators to provide crisis intervention and to respond after suicides had occurred. KPTO Coordinators were expected to organise whānau meetings related to suicide attempts, help mainstream agencies provide front-line care to those at risk of suicide and generally act as the local 'Māori suicide expert'. KPTO Coordinators responded to suicides in some regions in order to maintain whānau trust and to enhance collaboration with other organisations in their region.

The evaluation highlighted a need for greater national coordination or leadership in several regions, including the coordination of training for KPTO Coordinators, the development of consistent branding and communication materials, and the development of resources for use at the local level.

KPTO providers differed in the resources they provided for use in their communities. For example, some had toolkits for use in marae, including checklists for identifying people at risk of suicide and materials for promoting greater resilience. Others had media toolkits and induction manuals for staff. These resources were generally developed separately by different KPTO providers, depending on their capabilities and the needs in their region.

As the evaluation established, the KPTO programme was being delivered in a culturally competent way in all regions, allowing people to apply their own knowledge of changing cultural practices in local contexts. Questions were raised, however, about how well the activities in the annual service plans reflected Māori models of health care or Māori views on suicide and suicide prevention. Some stakeholders suggested that the overall KPTO framework should be reconsidered within the Māori cultural context.

Limitations of the evaluation

The evaluation drew heavily on the experience of KPTO providers, only five of whom were employed during the entire evaluation period of 1 July 2010 to 31 December 2013. Because some Coordinators lacked knowledge and/or experience in the role, they were able to provide only limited information. Data from the online survey was limited in its usefulness and coverage due to the relatively low response rate (by 20 out of 48 people asked to respond). A wider range of stakeholders might have provided other views on the operation and impacts of KPTO. Finally, the KPTO programme is itself only one part of a wider strategy for preventing suicide, which limits its ability to demonstrate progress towards the longer-term goals of fewer suicides and reduced harm from suicide. Future evaluations of suicide prevention should assess KPTO as one element along with other components of the strategy.

Recommendations

In light of the evaluation findings, five recommendations are made for consideration in making decisions on the future of KPTO.

- 1) Review KPTO objectives and the scope of services to ensure that they are realistic and consistent with Māori cultural values and views of suicide. If the KPTO programme is intended to primarily support suicide prevention, then it should be made clear that agency requests to support emergency responses is not the preferred focus.
- 2) Communicate expectations of the KPTO programme more clearly to a wide range of stakeholders, through a variety of means that include news media and common messages.
- 3) Review the distribution of KPTO providers in terms of both geographical distribution and the appropriate size of the region covered by each provider.
- 4) Consider establishing a structured national leadership mechanism for the KPTO programme. National leadership could provide training for Coordinators, develop consistent resources and guidelines, develop a consistent communication plan and brand, share information across different providers to improve learning about what works under different circumstances, and coordinate programme delivery.
- 5) Review funding levels for KPTO providers to ensure that they are able to meet their objectives.

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INTRODUCTION

Background

In 1998 the Government released the New Zealand Youth Suicide Prevention Strategy ('Kia Piki Te Ora o Te Taitamariki' and 'In Our Hands'). As part of the implementation of the Strategy the Ministry of Health funded a programme called Kia Piki te Ora o Te Taitamariki in a number of Māori communities to address Māori youth suicides. In 2005, following consultation on the New Zealand Suicide Prevention Strategy 2006–2016, this programme was re-focused to an 'all age' suicide prevention programme and renamed Kia Piki te Ora (KPTO). The KPTO programme sought to 'enable inter-agency collaboration with Māori whānau, communities, hapū, iwi, service providers and agencies to promote collaborative and comprehensive approaches to suicide prevention'.

In 2006 the Government released the final all-age New Zealand Suicide Prevention Strategy 2006–2016 (the Strategy), which provided a high-level framework for reducing the rates of suicide and suicidal behaviour in New Zealand. The purposes of the Strategy were 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; and
- Reduce inequalities in suicide and suicidal behaviour.

The Strategy acknowledges that there are inequalities between Māori and non-Māori suicide rates: one in five people who die by suicide are Māori, and rates of youth suicides are two and a half times higher for Māori youth compared with non-Māori youth. KPTO recognised that government agencies and community groups would have different strategic frameworks for, and responses to, how they worked with Māori to address Māori needs and to ensure that their interventions were accessible, effective and appropriate for Māori.³ The KPTO programme sought to 'enable inter-agency collaboration with Māori whānau, communities, hapū, iwi, service providers and agencies to promote collaborative and comprehensive approaches to suicide prevention'.

The KPTO programme makes up one element among others in contributing to the New Zealand Suicide Prevention Strategy 2006–2016. The strategy as a whole is intended to reduce suicide rates and the impacts of suicide on families, whānau, friends and communities. KPTO in particular is intended to have a distinctive character and approach grounded in tikanga Māori. Tikanga Māori principles and practices are central to the programme. The programme is by Māori for Māori, with an emphasis on whānau, hapū, and iwi development. Te Ao Māori is central, where cultural traditions and practices are a means to strengthen a community response to suicide. This approach recognises that the communities at risk have the potential capacity to build on its strengths and use these to address the issues. Its activities include indigenous approaches based on identified cultural best practice models (e.g. Te Whare Tapa Whā⁴ and Pōwhiri Poutama⁵) relevant to Māori suicide prevention and the programme's delivery focused on the concept of whānau ora and whānau wellbeing.

The KPTO programme aligns with four of the seven goals of the New Zealand Suicide Prevention Strategy 2006–2016:

- promote mental health and wellbeing for all Māori

³ Associate Minister of Health (2006), p 14 (Be Responsive to Māori).

⁴ In Mason Durie's concept of Te Whare Tapa Whā, the four cornerstones (or sides) of Māori health are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

⁵ Paraire Huata's Pōwhiri Poutama Framework is a framework applying culturally safe practice in Māori counselling, social work, mental health and social services.

- include engagement with all communities
- reduce access to the means of suicide
- contribute to reducing the harmful effects and impacts associated with suicide and suicidal behaviour on families, whānau, friends and the wider community.

The KPTO programme has a specific All Age Suicide Programme Logic Model that details the ultimate, long term, intermediate term, medium and short term outcomes and objectives. KPTO providers are expected to play a linking role, bringing the community together in support of its goals. This linking role puts less emphasis on direct service provision to families, whānau and communities. KPTO providers have the freedom to tailor their activities to their own region, incorporating the plans and needs of local iwi, hapū, marae and whānau.

The Ministry of Health funded (or continued to fund) nine regional providers to deliver the revised 'all-age' KPTO Suicide Prevention Programme. It should be noted that originally there were six providers. Two providers were added in 2006 and Invercargill / Southland were added in 2011. KPTO providers employ 17 Coordinators in nine regions. The regions vary in size and population, and do not cover all of New Zealand's Māori population. The regions are:

- Northland Far North: Te Rūnanga o te Rarawa
- Northland Mid North: Ngāti Hine Health Trust
- South Auckland: Raukura Hauora o Tainui Trust
- Bay of Plenty: Te Ao Hou Trust
- Lakes District: Te Rūnanga o Ngāti Pikiao Trust
- Hawke's Bay: Te Kupenga Hauora – Ahuriri Charitable Trust
- Whanganui: Ngā Tai o te Awa Trust
- Christchurch: He Waka Tapu Ltd
- Invercargill/Southland: Ngā Kete Mātauranga Pounamu Charitable Trust.

KPTO evaluation

In May 2014 the Ministry of Health contracted Kāhui Tautoko Consulting Ltd to carry out an evaluation of the KPTO programme across nine regions, focusing on service delivery for the period July 2010 to December 2013. KTCL utilised underlying principles of Kaupapa Māori research to shape the approach to the evaluation. This included the appropriate expression of tikanga and kaupapa, the emphasis of whakawhānaungatanga (making and renewing relationships), the promotion of kanohi ki te kanohi (face to face) methods of inquiry, the importance of collective benefit and reciprocity, as well as the prominence given to the voices of Māori participants. The methodology of the evaluation is explained in more detail in the appendix of this report.

The evaluation of the KPTO programme focused on both process and impact questions. Areas considered included:

- how each provider planned, delivered and monitored services in line with a KPTO Accountability Framework and All Age Suicide Prevention Programme Logic Model
- what service providers delivered
- how well programmes met each provider's objectives
- what impact was achieved in the communities
- what value was added to Māori suicide prevention in the communities
- how KPTO contributed to wider suicide prevention objectives
- cultural competency of the programme
- strengths and opportunities for improvement.

KTCL completed site visits to all nine regional providers during the July – August 2014 period.

The evaluation drew on a variety of information sources:

- interviews and focus groups to develop and refine evaluation questions and instruments
- review of project plans, monitoring reports and other documents provided by the Ministry of Health
- nine regional two-day site visits, with further document reviews and interviews with 34 KPTO staff and 51 local stakeholders
- an online survey of stakeholders who were not available for interviews during site visits, including representatives from district health boards, Māori providers, New Zealand Police, social service providers and other non-governmental organisations. In total, 48 people were invited to respond to the survey. Of this total, 20 completed the online survey.

KTCL analysed data from document reviews and responses from participants into themes for each evaluation question. Where appropriate the following terms were used to describe the quantity of staff or stakeholder responses to various questions in the evaluation, for ease of reading:

- 'Majority' of participants – 75% or more made or affirmed this statement or finding;
- 'Most' or 'many' of the participants – 50% - 75% made or affirmed this statement or finding;
- 'Some' of the participants – 25% - 50% made or affirmed this statement or finding; and
- A 'few' – 25% or less of participants made or affirmed this statement or finding.

Drawing on feedback from key stakeholders to assess the significance of the KPTO contribution, the evaluation identified numerous ways in which KPTO providers have contributed to suicide prevention or suicide responses in their communities. It also identified a number of concerns or areas to be considered further, and provided recommendations for the future structure and management of the programme.

This report presents a summary of the findings of the nine individual site-specific process and impact evaluations. Individual site reports were also prepared for the nine KPTO regions and were given to KPTO providers for their review. These are incorporated into this report.



1. OVERALL FINDINGS

This section consists of three parts. The findings from the individual evaluations of the nine KPTO providers are summarised in relation to process (Section 1.1) and then impact (Section 1.2). Finally Section 1.3 looks at how the findings about the KPTO programme fit with its Accountability Framework and All Age Suicide Programme Logic Model.

1.1 Process evaluation themes

1.1.1 Programme delivery activities

All of the service organisations and KPTO providers were relatively well known in their respective regions and only a few whānau or stakeholders involved in the evaluation process did not know about the KPTO programme. It was clear that KPTO staff spent significant time building key stakeholder relationships and influenced organisations to prioritise suicide prevention and increase the number of activities and programmes across each region.

KPTO activities included indigenous approaches based on identified cultural best practice models (e.g. Te Whare Tapa Whā⁶ and Pōwhiri Poutama⁷) relevant to Māori suicide prevention and KPTO delivery focused on the concept of whānau ora and whānau wellbeing.

Service partnerships were strong in most regions. Providers had good relationships with key agencies including Community Action Youth and Drugs (CAYAD) services; district health board (DHB) mental health, public health and injury prevention programmes; government partners including Police and Child, Youth and Family; and schools and local authorities. These relationships enabled service providers to mobilise collaborative efforts around a number of innovative strategies and initiatives (e.g. RAID Movement, 'Got Your Back' campaign, Papakura High School project, Safer Community initiatives, Marae wānanga, Matariki celebrations, Fusion Group) at a local level. These partnerships helped providers and the KPTO programme to deliver on a number of mental health promotional efforts across their region. There were specific examples of KPTO providers working with media (to influence safe reporting of suicide) but this practice was not nationally consistent and in some regions it was not in evidence.

The evaluation identified that the main challenges in programme delivery were:

- providers operating outside of scope of KPTO (i.e. undertaking intervention and postvention activity)
- stakeholders' expectation that KPTO providers would undertake intervention and postvention activity
- providers with large geographical regions trying to reach all parts of their region equitably
- the majority of providers not engaging with media on safe reporting.

The majority of KPTO providers undertook robust service planning aligned closely to the Accountability Framework and the All Age Suicide Programme Logic Model. The evidence indicated these providers had clear knowledge of delivery expectations and activities that should be conducted annually. These providers also reported well on both a monthly and six-monthly basis,

⁶ In Mason Durie's concept of Te Whare Tapa Whā, the four cornerstones (or sides) of Māori health are whānau (family health), tinana (physical health), hinengaro (mental health) and wairua (spiritual health).

⁷ Paraire Huata's Pōwhiri Poutama Framework is a framework applying culturally safe practice in Māori counselling, social work, mental health and social services.

and maintained records of specific evaluations of their activities. The evaluation findings in turn were used to inform future service plans.

Many used local data from the DHB and Coroner; others used needs assessment reports and information from partners. Conversely, some KPTO plans influenced the development of other organisational plans (e.g. DHB Māori health plans; local authority Safer Community plans).

1.1.2 Programme delivery strengths

Strong kaupapa Māori focus: There were many examples of culturally based, best-practice models relevant to Māori suicide prevention, particularly those that focused on building resilience and spiritual connectedness in communities across the country. KPTO programme delivery in all regions focused strongly on whānau ora and whānau wellbeing. Four sites noted that this focus was deliberately aligned with the Government's Whānau Ora strategy, which also stressed a whānau wellbeing approach. Drawing on te ao Māori, many used different frameworks such as Te Whare Tapa Whā and the Pōwhiri Poutama models to design and deliver their programme.

Wide variety of tailored approaches: One of the foundations of the KPTO strategy was a recognition that *'government agencies and community groups would have different strategic frameworks for, and responses to, how they worked with Māori to address Māori needs and to ensure interventions were accessible, effective and appropriate for Māori'*.⁸ KPTO programmes across the country adopted and tailored approaches for their region that: built on local tikanga Māori practices; incorporated Māori language of the area; incorporated the preferences of the local iwi and marae as to how work should happen; and used philosophical models to plan and implement the programme that were locally developed or appropriate to local history and tikanga.

For example, Te Rūnanga o Te Rarawa used Māori models to promote awareness of suicide prevention. Evaluations of its rongoā and manu aute activities found that, as a result of programme workshop attendance, the majority of respondents (90 percent) felt more connected to the community and were empowered to make better life changes. In addition, 70 percent reported improved family relationships and 65 percent indicated improved self-esteem as a result of their participation in the KPTO programme. In another example, eight organisations in Whanganui worked together with a shared commitment to increase suicide prevention activity in the region. As a result of the collaboration and advocacy of these organisations, the local district council improved lighting and installed cameras at high-suicide spots in Whanganui to reduce suicide attempts at these sites. Further examples are provided in Section 3.

Successful interagency partnerships: As the KPTO strategy promotes, successful outcomes were enhanced when KPTO staff focused strongly on collaborating with key agencies in their region, when they advocated at strategic levels and when they worked closely with whānau. Two good examples are the Whanganui Safer Community Council, which involved a wide interagency collaboration including the KPTO provider Ngā Tai o Te Awa, and the Fusion Group in the Northland Far North, which also had broad and strategic representation. KPTO providers' work in focusing on Māori models of practice also required the staff to work closely with whānau and the Māori community to tailor their approaches. There was clear evidence that KPTO providers were working collaboratively with other stakeholders including their Māori constituency. Only one of the providers was yet to form or participate in a formal regional network of stakeholders that could promote, plan and advocate for suicide prevention in their region.

⁸ Associate Minister of Health (2006), p. 14 (Be Responsive to Māori).

Successful Māori community engagement: There was strong evidence that all providers prioritised Māori community engagement. For example, many KPTO providers were present at major community events, such as Waitangi Day celebrations and Rātana Pā celebrations, and smaller community events. The majority of providers also built relationships with local marae and delivered on-site workshops and health promotion activities at marae wherever they could.

Experienced service organisations: Most of the service providers had a long history of service delivery in their communities. Many were accredited organisations with sound policies, processes and planning tools. The majority had strategic plans and business plans that were aligned to the plans of their district health board and other agencies. None of the providers would be considered 'new' to the business of this type of programme delivery.

1.1.3 Programme delivery challenges

KPTO providers faced a range of challenges to successful service delivery, including the following.

Large regions to cover: In Hawke's Bay, South Auckland, the Northland Far North and Canterbury, the KPTO programme was delivered across a large geographical region. As a result, the providers in these regions found it challenging to reach all areas in their region consistently due to the limitations of resourcing, human capacity and travel distances. In the Hawke's Bay region, one KPTO Coordinator focused on working with communities in Napier and Wairoa while the other focused on the Hastings region. Consequently the central Hawke's Bay region, which is almost three hours' drive (260 km) from the northernmost point of the region, received only limited coverage. Raukura Hauora o Tainui focused its programme solely on South Auckland although its region ranged from Kaiaua in the east, to Port Waikato in the west, to Pakuranga in the north and Manukau in South Auckland. Due to the lack of available resources and therefore capacity to reach these large regions, the reach of the programme was limited. In Canterbury, one KPTO Coordinator attempted to provide services as far north as Nelson and as far west as Westport. Yet during the 3.5-year evaluation period, this Coordinator had managed only one visit to Nelson, for instance, due to the demand of work in Christchurch and the need to cover other areas in the region.

Engaging some service partners: Providers' influence on and engagement with key stakeholder groups across all regions varied. If senior KPTO leaders already had a high profile with other agencies and stakeholders, it was often easier for the KPTO Coordinators to engage those agencies in their work. In other cases, some participants commented that trying to get consistent engagement from some sectors was a challenge. Two providers reported finding it challenging to engage at a strategic level with service partners particularly in the education and social development sectors (Child, Youth and Family; Work and Income). Overall, engagement with these sectors appeared to be the most challenging for KPTO Coordinators in their work to engage with all service partners, although three providers indicated successful engagement at an individual school level.

Confusion about the role of the KPTO team and programme: Another challenge for programme delivery was an expectation (held by whānau as well as agencies and service partners) that the KPTO Coordinators were there to help with suicide crisis response as well as crisis prevention whenever someone was known to be displaying suicidal behaviour. In three regions, stakeholders saw KPTO Coordinators as the resident 'Māori suicide expert'. A few stakeholders felt that: KPTO Coordinators should be available whenever there was a suicide-related incident; these personnel should bring in kaumātua; Coordinators should organise whānau meetings related to suicide attempts; Coordinators should help mainstream agencies and service providers with front-line care; and generally Coordinators should be there as an aide for suicide intervention and/or postvention.

Often these expectations were formed because the KPTO Coordinators, with the identifiable KPTO suicide-related brand, were the most visible Māori 'face' for suicide in the region. In four regions, KPTO Coordinators had in fact supported their colleagues and families in suicide response activity, which reinforced the impression that they were a type of first responder to these situations. Some Coordinators indicated that they performed this role to enhance collaboration with partners who requested their support and to be responsive to whānau so that they maintained their trust. Two KPTO Coordinators commented that they were happy to undertake training that may support this type of collaborative response where they would attend suicide incidents as part of the response team. Another Coordinator felt that it was difficult not to respond when no other resources were available for whānau in their region.

This finding was also borne out by the stakeholder survey: half of the respondents were unsure of what the role of the KPTO programme and Coordinators was, and why front-line services for individuals or families were sometimes unavailable. Some respondents felt that the KPTO team was 'not delivering a good service' because the Coordinators were not always available to respond to suicide crises. One stakeholder commented that KPTO Coordinators 'could be more effective in supporting crises'. Overall the findings indicated a need to clarify and manage the role of the KPTO programme and to affirm the role of a Coordinator is to act as a 'community facilitator' or 'community developer' in a health promotion programme, rather than as a front-line first responder to suicide-related crises. Otherwise external stakeholders will continue to criticise the KPTO teams in each region unfairly because of their unreasonable expectations that the programme undertakes crisis response for which most Coordinators are not trained or funded to do.

1.1.4 Planning and monitoring of service delivery

In the vast majority of regions, the annual service plans were developed in alignment with the KPTO Accountability Framework and All Age Suicide Programme Logic Model. These plans included a description of activities along with short-term and long-term outcomes, performance measures and data collection methods. Some drew on additional data that they obtained from their local DHB including coroner data, community hui information, previous client evaluations and needs assessment reports (some done for a whānau ora project, for instance), or from other sources to further inform their plans. Many service plans were one element of the organisation's strategic plan, service plan or business plan. As well as annual plans and regular reports, some providers used workshop evaluations to inform programme enhancements and evidence impact. Only one of the nine providers did not have a formal annual service plan aligned to the KPTO Accountability Framework and All Age Suicide Programme Logic Model. With multiple sources of information and the guidance of the Accountability Framework and All Age Suicide Programme Logic Model, Coordinators had a sound framework for preparing their plans. The majority of staff noted that these tools were useful and effective for planning purposes.

The KPTO Coordinators for South Auckland, who had been employed in this role for less than three months, were not involved in the development of their annual service plan. Therefore the evaluation team could not determine what processes had been involved in producing the plan but it could observe their draft annual service plan and planning activities for the current year. The South Auckland KPTO Coordinators commented that they were concerned about the need for them to cover a population of 1.7 million in Auckland and Tainui (with no other KPTO provider sites in Auckland) while other regions (such as Northland and Rotorua with populations of 120,000 and 70,000 respectively) had a similar level of resources. KPTO staff also commented that there was no central point of reference for information including 'hands-on' statistics for KPTO as a national programme that would help to prioritise their planning activities.

All KPTO sites had effective monitoring and reporting systems. They provided six-monthly performance returns to the Ministry of Health and KPTO Coordinators provided monthly reports to the Service Manager. Reports included outputs and outcomes achieved, highlights for the period, difficulties or barriers to implementation of KPTO and opportunities for improving implementation of KPTO. The evaluation team sighted workshop and training evaluations for the majority of the KPTO sites. The majority of KPTO sites also actively evaluated programmes and activities. They gave evaluation forms to workshop and training participants and used the results to make service improvements and to develop the next annual service plan. Two KPTO sites, whose Coordinators were not employed during the evaluation period, provided limited or no response and documentation as retrospective evidence of any monitoring processes.

1.1.5 Programme delivery examples

KPTO Coordinators undertook a wide variety of initiatives related to health promotion, stakeholder relationships and resource development. They also took the time to develop their own capacity and their work tools. Listed below are examples of programme delivery and activity by region (recognising that Coordinator activity was not limited to these examples).

Māori mental health promotion

- **Whanganui:** KPTO staff, alongside trained counsellors, presented the ‘Got Your Back’ campaign to student leaders in secondary schools in the Whanganui and Rangitikei region. The campaign sought to support students to create or identify a network of people they could call on for advice on issues they might be struggling with in their lives. Other education speaking forums focused on physical and cyber-bullying.
- **Northland Far North:** Education workshops and consultations were held with kura kaupapa and secondary schools to promote positive texting in schools in response to a considerable amount of cyber-bullying and suicidal ideation. The workshops also encouraged individuals and whānau to participate in resilience building in both the whānau and the community.
- **Northland Mid North:** Te Whakauruora Māori Suicide Prevention Resource was used to orient KPTO service delivery to better reflect philosophies of te ao Māori (Mid North) before He Tohu Rangatira was delivered to Te Kura Kaupapa Māori o Kaikohe and Motatau School. He Tohu Rangatira, the flagship programme of the organisation’s healthy lifestyles campaign, sought to encourage participation in Māori cultural activities in whānau and marae.
- **South Auckland:** Initiatives included: Tihei Mauri Ora supporting whānau back to wellness; youth mental health summit national conference; performing arts initiative encouraging rangatahi to enter a career related to drama; workshops on positive use and behaviour related to social media in response to issues such as cyber-bullying; a research project to improve the understanding of the content and effects of synthetic drugs; strong association with the local CAYAD team in planning and delivering mental health promotion; supporting the ‘What’s on your plate’ mental health project; and supporting the Wairua Netball Club with an alcohol- and drug-free campaign and policy. Rongoā practice was introduced to the community including thorough workshops and training sessions.
- **Lakes District:** Te Arawa Men’s Health Day managed by Te Rūnanga o Ngāti Pikiao Trust included messages around coping with depression. Other activities were: community awareness wānanga; Project Lighthouse in Taupo; the Respond to All in Distress (RAID) Movement; Ride Against Teenage Suicide (RATS); Kaingaroa provider community workshops; mental health forums; Te Rau Matatini hui; Mike King presentations; and sports events. KPTO staff also took part in a number of radio interviews to promote the support that was available and to explain the differences between clinical intervention and the KPTO prevention programme.
- **Hawke’s Bay:** Health promotion hui with organisations from Mahia and down to Takapau raised the awareness of suicide prevention in the community. KPTO reports highlighted media engagement activities with the *Hawke’s Bay Today* newspaper, Radio Kidnappers and Radio

Kahungunu. Staff advised that they participate in question-and-answer media broadcasts at least three times a year, with the objective of raising the awareness of suicide prevention among the Hawke's Bay community.

- **Christchurch:** In August 2013 KPTO staff, in partnership with Pacific Health, developed the 'I Got Your Back' campaign. The campaign sought to encourage positive behaviour including support and understanding. He Waka Tapu and the Pacific Trust launched the campaign at the annual Bro's v Uso's rugby league event, the largest Māori and Pacific event in the South Island, which drew over 5000 spectators. The event organisers supported the promotion of a community strengths-based message, which helped to increase interest in the 'I Got Your Back' campaign and the messages against domestic violence, bullying, alcohol and drugs, on-field and off-field violence, and suicide. In November 2013, KPTO and the Pacific Trust facilitated an 'I Got Your Back' evening which targeted whānau in the sporting community and provided information on signs and symptoms of depression and suicide as well as promoting healthy lifestyle messages.
- **Bay of Plenty:** The 'Haka Up' campaign drew on many concepts and the mana of haka, which underpin some key protective factors of suicide, and it received an excellent response. Some important haka-related concepts were: wero – the challenge; cultural identity – whānau, language, marae, whenua, connectedness; the pride in one's self and that unique belonging; hard training in physical and mental stamina; and unity among brothers. Key messages of the campaign, which included a media launch, were: 'Haka up against suicide – Kotahi tātou – Kia mau to Māoritanga'; 'Stand/speak/challenge suicide ... Stand together ... Hold fast to your Māoritanga – your identity!' and 'I am more than ... I am whānau'.
- **Invercargill / Southland:** KPTO Coordinators developed *Choose Hauora Unlimited Rangatahi* (CHUR) as a multimedia project highlighting alcohol-related issues for Māori and Pacific youth. Ngā Kete Mātauranga collaborated with the Pacific Island Advisory Cultural Trust to develop a variety of multimedia resources including a DVD, a poster and a song. Another initiative was the 'Shout Out Southland' campaign aimed at youth, which recognised the role of youth, whānau and community in encouraging positive lifestyle choices and ongoing positive reinforcement. The 'Shout Out Southland' programme included a series of posters in which key sporting and musical role models encourage youth to *shout out*.

Engagement with Māori communities

- **Lakes District:** KPTO Coordinators led a marae-based wānanga initiative after whānau were exposed to suicides among their whānau, including an 11-year-old girl. The objective of the wānanga, attended by an average of 15–25 participants per four marae, was to enable people to talk more about suicide, rather than be fearful of doing so, and to move the community to a more strengths-based approach of empowerment and building champions. A marae tool box, tailored for each marae, included resources, a symptoms checklist and material to help whānau with coping strategies.
- **Hawke's Bay:** Coordinators conducted networking and engagement activities with organisations such as Waikaremoana Trust Board in Wairoa and Kahungunu Executive who all form part of the current Wairoa Community Network. A workshop was delivered to over 100 participants at Te Aranga Marae to raise awareness about suicidal tendencies. A resilience-building programme was developed for rangatahi with the community members of Flaxmere (Napier) and further programmes were being discussed for the future.
- **Bay of Plenty:** A Marae resilience plan initiative supported each marae, building on its strengths and developing its own resilience approaches. All marae in the Western Bay of Plenty region were contacted and supported to implement their plans – whatever these looked like to them. This ongoing initiative incorporated feedback from the communities of each marae.

Initiatives to reduce access to means of suicide

- **Whanganui:** KPTO Coordinators worked with partners and the local council to advocate for placing lights in areas of the city where suicides had been happening previously. A representative from Whanganui District Council's Safer Whanganui described the critical role KPTO staff played in the Safety and Wellbeing Steering Group. This forum implements actions from the Safety and Wellbeing Steering Group.
- **Invercargill / Southland:** With local pharmacies, KPTO Coordinators implemented a campaign promoting the safe storage and disposal of medicines and pills. Pharmacists provided clients with script pack inserts that contained information about safe storage and safe disposal of medication. In early 2012, KPTO ran the campaign again and included posters and media activity.

Resource development and distribution

- **Lakes District:** Some resources developed were: *Check it out* pocket resource; Suicide Assessment Tool for Lakes DHB; AEIOU tool; the marae toolkit and the media toolkit; and KPTO induction manual (supported by other regions).
- **Invercargill / Southland:** In August 2012, KPTO Coordinators, in partnership with the Southland Suicide Prevention Network, developed the *Worried that someone you care about may be suicidal* resource. The resource provides information about how to tell if someone is feeling suicidal, how to talk to someone who is suicidal, how to tell if the situation is serious and how to access professional help.

Establishing, participating in and maintaining stakeholder collaboration groups

- **Whanganui:** KPTO Coordinators participated in and contributed to: Removing Barriers Group with eight organisational members and families; Whanganui Prevention/Postvention Suicide Support team including Police, Victim Support, Child, Youth and Family, DHB mental health and public health for child and youth, and a variety of non-governmental organisations (NGOs); and Wellbeing and Suicide Prevention (WASP), which includes Strengthening Families, the district council, DHB, Te Oranganui and Balance Whanganui. Through these relationships, suicide prevention activity was prioritised across multiple agencies and community groups. Based on stakeholder responses, it was clear that KPTO Coordinators had a strong reputation and were considered key leaders across the suicide prevention landscape.
- **Northland Far North:** The Interagency Social Wellbeing Governance Group was established to more effectively respond to the challenges facing vulnerable children, youth and families in Northland Far North. The governance group comprised representatives from Northland DHB, Police, Ministry of Social Development, Ministry of Education, Te Puni Kōkiri, Tai Tokerau Iwi Chairs and the Whangarei Children's Team. With youth suicide as its strategic focus, it provided overall leadership and oversight to interagency responses and agreed strategies that impact on the social wellbeing of Northlanders. Its work led to the establishment of a Fusion Group to share intelligence daily on vulnerable children at risk, with the aims of mobilising crisis intervention at a local level (through local response teams) and informing the development of prevention strategies that enhance the social wellbeing of Northlanders.⁹ The KPTO Coordinator was a member of the Far North Local Response Team, which supported the Fusion Group's strategic focus.
- **Invercargill / Southland:** In 2011–2012 the KPTO team participated in and contributed to the design of strategy and policy regarding Southland's regional response to suicide prevention. For example, they contributed to the development of the Future Directions Southland Mental Health and Addictions Network Strategic Quality Plan and a traumatic response document, as well as participating in the Southland Mental Health Collaborative Promotion Group. This multi-agency collaboration around strategy and policy development helped to improve mental health services for Māori. In 2012 the KPTO team also worked with the Southland Suicide Prevention

⁹ Retrieved from Northland Intersectoral Forum website (www.nif.org.nz).

Network to develop a media engagement plan. The plan detailed media engagement activities and provided useful information to media stakeholders.

- **Northland Mid North:** Ngāti Hine Health Trust's KPTO and CAYAD teams (after consultation with rangatahi) launched the RAID Movement. Its purpose was to embed in the minds of all young people that support was available, 'RAID' the streets with information about suicide prevention, promote awareness of signs and symptoms of suicide, and strengthen and unite the voice of young people so that whānau and society would hear what was happening for young people. RAID provided an opportunity for agencies, providers and community organisations to listen in different and active ways to the voice of young people.
- **South Auckland:** Current KPTO staff were not employed during the evaluation period; however, the document review identified that the previous team had participated in the Māori caucus of the Injury Prevention Network of Aotearoa New Zealand and Counties Manukau DHB Interagency Steering Group, Mercer Netball Club, Te Wairua Sports Club, Te Matatini Waka Hourua advisory group and the iwi advisory forum. The KPTO team established and coordinated the Papakura High School Community Group to implement a leadership programme in the school as a direct response to a cluster of youth suicides.

PAPAKURA HIGH SCHOOL

A stakeholder praised the current KPTO team for its coordination of a KPTO-led community project in Papakura High School. In 2011 students were involved in a 'hangman' game in which rangatahi were getting texts on how to hang or choke yourself, which sadly resulted in two suicides and 17 hospitalisations (over the Christmas period). The KPTO team went into the community and organised a hui at Papakura Marae which involved NZ Police, Work and Income, the Families Commission and the Papakura Marae Society. It also organised a separate hui with parents and whānau. The hui resulted in a community action plan. A 'Leadership in School' peer support programme was put in place with the commitment and support of the community. Leaders (students) were identified within the school and the KPTO team coordinated appropriate training for them. These students wore wristbands to identify themselves as leaders. The short-term outcome was a reduction in risky behaviour. After three years, the leadership programme was still running and the original leaders were volunteering their time to Lifeline.

- **Lakes District:** Much of KPTO programme delivery was concerned with crisis prevention and working with government agencies to work with Māori more effectively. KPTO Coordinators' participation in relevant national advisory groups over the years was critical to keeping the KPTO agenda as a consistently high priority. Their participation included speaking at local and regional conferences. They were also strongly represented in key forums such as Ministry of Social Development, Suicide Prevention Information New Zealand (SPINZ), Mental Health Foundation, Taupo Injury Prevention Group, Te Rau Matatini, KPTO strategic planning team, media forums, Postvention Advisory group and Safer Communities Leadership Group. Previously KPTO staff participated in the now disestablished Ministry of Youth Development Postvention Group, Psychiatric Emergency Team Forum and the Rotorua Youth Resilience Centre.
- **Hawke's Bay:** KPTO Coordinators participated in and contributed to the Napier City Council Safer Community accreditation, which led them to establish an interagency Suicide Prevention Group (with members from the Hawke's Bay DHB, NZ Fire Service, Work and Income, Child, Youth and Family, mental health providers, schools and NGOs). The purpose of the group was to contribute towards achieving the Suicide Prevention Plan for the Hawke's Bay region.

- **Bay of Plenty:** KPTO staff participated in many interagency events: youth workers' hui; Te Pā Harakeke Māori networking hui; Ngāi Te Ahi Wānanga; Pirirakau hauora postvention hui; Barry Taylor training workshops; Mental Health Awareness Week; Western Bay of Plenty (WBOP) resilience planning hui; Te Ahi Kōmau hui; and Māori suicide prevention hui. KPTO Coordinators' participation in relevant advisory groups over the years has been critical to keeping the KPTO agenda as a consistently high priority. Such groups include: WBOP Māori suicide prevention advisory group; WBOP Community Response Team (established by the KPTO provider); CAYAD reference group; Midlands Mental Health Forum; Te Pā Harakeke; and RATS.

Media activity

- **Christchurch:** Activities included attendance at various community events such as FLAVA, HYPE Youth Weeks, media presentations, kapa haka, marae visits, rūnanga hui, Matariki celebrations, 'I Got Your Back' campaign, and presentations at secondary schools and interagency forums. In September 2012 the KPTO team coordinated a breakfast to which it invited media representatives to gain information about current suicide support and services throughout the South Island. Representatives attending were from Fairfax Media, the Press, the Christchurch Star, Tahu FM, New Zealand Doctor magazine, Hurunui News, Northern Outlook, Canterbury District Health Board Suicide Prevention Coordinator and Communications Advisor, Pasifika Health, He Oranga Pounamu of Canterbury University, Pacific Trust and Women's Refuge.
- **Invercargill / Southland:** Through the Southland Suicide Prevention Network, the KPTO provider established a media engagement plan to promote safe reporting of suicide in the media. Media representatives were provided with information that: clarified the prohibition under the Coroners Act 2006 on speculating on cause of death; reinforced current New Zealand guidelines of reporting on suicide and research behind the guidelines; and provided information and examples of reporting that facilitated learning and discussion while complying with evidence-based practice.

Capacity development

- **Northland Mid North:** KPTO Coordinators participated in the Ministry of Health's Gatekeeper (Question, Persuade and Refer)¹⁰ training and workshops in suicide prevention (delivered via Otago University) in the Northland DHB's catchment area.

NORTHLAND MID NORTH

The Whangarei Youth Space was particularly interested in developing a partnership with the RAID Movement as a positive way in which youth vitality could influence the organisation. In addition to KPTO Coordinator support, the RAID Movement had access to support from clinicians and supervisors. While RAID members (Raiders) had access to the RAID Movement Facebook website, Ngāti Hine Health Trust monitored and coordinated it. In 2013 a young person in the Wellington region mentioned on the Facebook page that she intended to take her own life. Young Raiders gathered intelligence and phoned Ngāti Hine Health Trust. Within 20 minutes of the Facebook post, the young person was in a meeting with her parents, school counsellor and child mental health services, discussing a plan to keep her safe. The RAID Movement contributed to her timely access to mental health support.

¹⁰ This training programme is a comprehensive first-level suicide screening method for individuals in the community and for organisations.

- **South Auckland:** KPTO staff participated in an induction and orientation programme. They considered that the KPTO induction manual (recently developed by Ngāti Pikiao) was beneficial and clarified definitions of roles. The development of the manual, however, was in its early stages and staff felt this process should be coordinated at a national level.
- **Hawke's Bay:** Staff confirmed that any training request was usually approved if it aligned closely with the objectives of the programme. Such training included a diploma in mental health, psychoactive substances training and pōwhiri poutama. One of the staff commented that, although each KPTO region tended to focus on its own capacity development, Te Whakauruora training had been a great vehicle to establish national capacity for KPTO staff. Another staff member commented that training around clinical perspectives on suicide response would be of benefit.
- **Bay of Plenty:** KPTO staff attended the Dr Candy Cookson Cox suicide prevention and intervention certificate course and the Māori leadership certification with Anamata. They were conversant with Te Whakauruora through their previous training experience and now supported its facilitation with external parties. One KPTO Coordinator commented that Te Whakauruora training should form part of the KPTO competencies of the programme. KPTO Coordinators also participated in training with Te Tāpenakara mo te Iwi Trust which specialised in healing and rongoā. Features of the training included using Māori models of practice, the spiritual aspects of suicide and understanding the difference between whakamomori and suicide.

Focus on high need / high risk communities

- **South Auckland:** Raukura Hauora o Tainui focused on locales of Papakura and Franklin that had been previously identified as priority areas and had experienced a suicide cluster in late 2010. Key activities included the successful implementation of an alcohol management policy with Franklin Sports Club; a training programme rollout out to Lifeline staff; engagement with the Papakura community with representation on the Papakura Council Social Services executive – an interagency body mandated to advocate on social services and community issues for Papakura; and a skills-building initiative targeting young mothers.

1.2 Impact evaluation themes

1.2.1 Community impact and alignment with objectives

Overall, the KPTO programme appears to have had a positive impact on the communities in which it has operated, in terms of encouraging a shared commitment to increase suicide prevention activity. This outcome was due largely to the strong multi-agency and community relationships that the KPTO programme initiated and maintained. It has benefitted not only suicide awareness, but crisis response, collaborative health promotion activity, and other services such as mental health, police response to incidents and school focus on bullying. Communities have become more aware of signs and symptoms of suicide and overall wellness, as evidenced by stakeholder and whānau responses.

Strengthening partner relationships: In most regions, KPTO Coordinators connected people from different government agencies, NGOs and Māori providers in a common cause. Among the results have been many stronger relationships, improved communications, better collaboration on joint projects or initiatives and a greater understanding of each other's roles, mandates and available resources. In many cases, the partners worked together on specific projects or initiatives as a result of this collaboration. Key examples are the RAID Movement in the Northland Mid North, the Fusion Group in Northland, WASP in Whanganui, the Kaikoura Networking Group in Canterbury, the Wairoa Community Group in Hawke's Bay and the Southland Suicide Prevention Network – all of which reinforced the success of a community response to community need. The Papakura High School project and the Kawerau project highlighted how efficiently and effectively KPTO Coordinators could bring together a community and respond to a community-based situation. Other regions had a KPTO

presence on advisory groups and/or external interagency networks and had likewise seen benefits arise from this participation such as joint policy development in the Lakes District. Both KPTO Coordinators and stakeholders reported that organisations were better positioned to address the varied and complex needs of their communities because their resources and information were shared and overall coordination was improved through the improved networking and communications.

Engaging Māori on suicide awareness: In all regions, stakeholders involved in the evaluation reported that the KPTO programme was important, particularly in relation to engaging with Māori in the area. Participants identified establishing, building and maintaining relationships among key stakeholders as critical elements and success factors for the KPTO programme. KPTO staff played a key advocacy role for suicide prevention at many Māori hui, gatherings and wānanga and they shared information with Māori on matters such as signs and symptoms and key contacts in a crisis, as well as sharing available resources which whānau found very useful (e.g. toolkit developed by Ngāti Pikiao). Over half of the stakeholder participants suggested that KPTO take an even greater role in building community resiliency and community spirit (e.g. community gardens, sports mentors) so that people in the community took more responsibility for promoting a safer, more caring community.

1.2.2 Examples of community impact and alignment with objectives

KPTO Coordinators undertook a wide variety of initiatives that aligned with the specific four objectives of the KPTO programme. The following examples represent a sample of the activities recognising that KPTO programme delivery was not limited to these examples.

Objective One: Promote mental health and wellbeing for Māori

- **Whanganui:** Through collaborative forums, KPTO staff and key stakeholders organised open public workshops and health promotion events to reduce the stigma surrounding suicide. Such forums included Waitangi Day, community concerts and Mental Health Awareness Week celebrations. While impacts of such activities were difficult to measure, stakeholders reported that they increased awareness of signs and symptoms of suicide and provided resources to increase access to support for whānau demonstrating 'at risk' behaviours.
- **Northland Far North:** Feedback from participants in programmes and workshops revealed that the majority of respondents (90 percent) felt more connected to the community and were empowered to make better life changes. In addition, 70 percent of respondents reported improved family relationships and 65 percent of respondents indicated improved self-esteem as a result of their participation.
- **Northland Mid North:** Between September 2012 and December 2013 the primary service activity was the RAID Movement. During stakeholder interviews, all respondents highlighted the success of the RAID Movement and the critical role it played across the youth suicide landscape. Key aspects of promotion that stakeholders identified included activities at Waitangi Day celebrations, community events and exerting an influence from within the Fusion Group.
- **South Auckland:** One stakeholder who was involved with the Papakura High School project praised the existing KPTO team for its critical role in leading and coordinating this community project. The team's work included providing leadership training and delivering positive messages to school students. The initiatives continued to be implemented.
- **Lakes District:** Stakeholders commented that KPTO staff were well connected within the community and regularly provided resource information. Marae wānanga, which were attended by 15–25 participants per four marae, were an effective forum for discussion with whānau about being less fearful of talking about suicide. KPTO Coordinators provided a safe place for koroua to discuss what they could help with, particularly with their knowledge and respect they hold with the next generation.

- **Christchurch:** Building strong community networks was critical to the success of the KPTO programme. One of the KPTO Coordinator's had a strong presence in the community and relied heavily on his existing networks to progress programme objectives. These networks created opportunities to further the reach of the KPTO programme into the Māori and Pacific rugby league community. During 2012–2013 the KPTO Coordinator's focused on building relationships with local marae. The presentations to marae introduced the KPTO programme and sought to strengthen cultural connections, build rūnanga confidence in KPTO and develop a plan for linking services. The presentations also promoted awareness of signs and symptoms of suicide and equipped participants with tools to better support whānau and friends. By the end of 2013 all marae in the Christchurch region had participated in KPTO presentations. One whānau interview participant mentioned that she had noticed an improvement in demystifying myths surrounding suicide.
- **Bay of Plenty:** The annual service plan was closely aligned to the All Age Suicide Programme Logic Model and Accountability Framework. There was evidence of activities across all of the four objectives. Stakeholders noted that KPTO played a critical role in bringing the agency arm and whānau together in Kawerau and respected the great work that KPTO staff had been doing in the community.
- **Invercargill / Southland:** In 2011–2012 the KPTO team contributed to the design of strategy and policy for Southland's regional response to suicide prevention. For example, they contributed to the development of the Future Directions Southland Mental Health and Addictions Network Strategic Quality Plan, the Southland Suicide Prevention Network Media Engagement Plan and a traumatic response document, as well as participating in the Southland Mental Health Collaborative Promotion Group. This focus on multi-agency collaboration around strategy and policy development helped to improve mental health services for Māori.

Objective Two: Reduce access to means of suicide

- **Whanganui:** The establishment of lighting within a high-suicide locale in the community was one specific initiative aimed at advancing this objective. A representative from Whanganui District Council's Safer Whanganui described the critical role KPTO staff played within the Safety and Wellbeing Steering Group and in effecting this initiative.
- **Hawke's Bay:** KPTO staff facilitated the coming together of a local community who had experienced several serious attempts and two suicides at a particular tree in a local park. To make the park safer for the community, the group removed the tree and enhanced lighting in the park.
- **Invercargill / Southland:** The KPTO reports showed KPTO staff were involved in building a wood barrier at the top of a cliff in Murihiku, recognised as a high-suicide locale. As the current KPTO team was not involved in this strategy, the evaluation team was unable to determine the outcome of the initiative.

Objective Three: Increase safe reporting of suicide by media

Four regions (Hawke's Bay, Bay of Plenty, Canterbury and Southland) specifically worked with media outlets to improve safe reporting on suicide. In Invercargill / Southland, for instance, the KPTO team used existing networks to provide presentations about safe reporting of suicide by media to journalism students at the Southern Institute of Technology. The KPTO team also worked with the Suicide Prevention Network to develop a media engagement plan. The plan detailed media engagement activities and provided useful information to media stakeholders, such as the Ministry of Health publication *Reporting Suicide: A resource for the media*.¹¹

¹¹ Media Roundtable (2011).

As there appeared to be no evidence of such activity in other regions, this is an area that will need improvement nationally.

Objective Four: Contribute to improved mental health services for Māori

- **Whanganui:** A representative from Whanganui District Council's Safer Whanganui described the critical role KPTO staff played in providing oversight of all suicide prevention activity of the Safety and Wellbeing Steering Group. With several partner organisations, KPTO established the WASP ki Whanganui forum to implement actions from the Safety and Wellbeing Steering Group. Through this partnership with key stakeholder organisations, including the Whanganui District Council, at least eight organisations agreed to increase support for prevention and postvention services and to increase the number of workshops in the community. One mental health stakeholder confirmed that the KPTO Coordinators influenced the development of their organisation's Māori health plan.
- **Northland Mid North:** He Tohu Rangatira was a marae-based whānau ora programme delivered to students and their whānau. Although it fell outside KPTO's health promotion focus, He Tohu Rangatira filled a critical service gap in the suicide prevention landscape through its focus on suicide prevention rather than intervention (or service delivery). To influence and improve services to Māori, the KPTO team developed key relationships with organisations such as Manaia Primary Health Organisation (PHO), Tai Tokerau PHO, Te Roopu Kimiora Adolescent Health Services at Northland District Health Board, Fusion Group and Whangarei Youth Space.
- **Whanganui:** Over the evaluation period, KPTO staff delivered educational workshops and presentations to mental health services, clients and community groups throughout the Whanganui and Rangitikei region. The workshops focused on recognising signs and symptoms of suicide and self-harm, along with wellness strategies. All workshops were tailored to suit the demographic of the specific community or group. Feedback from stakeholder groups indicated key KPTO campaigns were effective. Stakeholders specifically mentioned the 'Yeah Hard' and 'Got Your Back' campaigns as examples. A school reported that, in addition to talking about suicide, one male KPTO staff member engaged male students to speak about respecting women, anger management and self-harm. The school reported that a disproportionate number of students (mostly male) had been self-harming but this number had decreased following KPTO engagement. KPTO Coordinators clearly had a strong reputation among stakeholders. They were considered important leaders across the suicide prevention and postvention landscape and had considerable influence across the region. In 2011 they petitioned the Whanganui District Council, through the Safety and Wellbeing Steering Group, to reduce access to means of suicide by improving lighting and security cameras at sites of significance (high-suicide spots). Consequently, Whanganui District Council invested in better lighting and installed cameras at two high-suicide sites in the Whanganui area. Through the agency relationships that the KPTO team fostered, key suicide prevention and postvention groups with clear objectives were developed. In many cases, KPTO staff facilitated these groups and the current KPTO Coordinators are still represented on them. All stakeholders interviewed reported that KPTO staff were key influences in the suicide prevention and postvention landscape.
- **Northland Far North:** The five stakeholders interviewed were mixed in their views of the effectiveness of the KPTO programme. Four of these stakeholders reported strong relationships and involvement with the KPTO programme. KPTO staff provided critical support to agencies and community organisations during periods of crisis. These stakeholders reported that KPTO staff had strong community relationships and provided support to improve service access for Māori communities and local schools. In 2013 the KPTO Coordinator commenced a programme of working with marae and haukāinga to explore cultural imperatives in relation to suicide such as tangihanga, whānau pani, mihimihi and nehua. Workshop evaluations reported positive outcomes from the use of rongoā Māori, such as karakia, tikanga, hīkoi ngahere, moana and wai moana, as alternative remedies and healing solutions for suicide prevention. One stakeholder

commented that suicide prevention initiatives were part of their own role and they did not see the value of the KPTO programme in the region.

NORTHLAND FAR NORTH: TIHEI-WA MAURI ORA

In 2011–2012 Northland Far North experienced a cluster of youth suicides. Local responses ranged from deciding where to bury the young person to communities refusing provider and agency intervention. It was within this context that the KPTO programme operated. The nature of activities changed to include indigenous approaches. An important part of this change was to identify cultural best practice models relevant to Māori suicide prevention. KPTO developed and distributed the Tihei-wa Mauri Ora resource, which drew on Māori cultural understanding of the order of life and being and reflected life stages of being, divine potential, darkness and light. KPTO delivery focused on whānau ora and whānau wellbeing. Health promotion activities involved te ao Māori concepts such as manu aute (kite making and flying traditions). Manu aute activities were seen as connectors between the heavens and the earth. Traditionally they were used for light entertainment in significantly spiritual rituals. Children and adults made manu aute to practise whakawhanaungatanga, reinforce tikanga/kawa, commune with spiritual deities, produce artwork, perfect aerial movements and test their skills in competition. The KPTO team introduced manu aute and traditional techniques for making them to various schools in the Far North region. Through manu aute, rangatahi and children could express their feelings about suicide and the loss of whānau and friends and could begin the process of healing.

- **Northland Mid North:** Through the RAID Movement, the KPTO team had a strong presence in the youth community. Youth were empowered to lead their own programmes, with the support of supervisors and counsellors, and to positively influence their peers. All stakeholders interviewed reported that the RAID Movement contributed positively to the suicide prevention landscape. For example, it had a presence at Waitangi Day celebrations and community events promoting suicide prevention messages. The Fusion Group reinforced the success of a community response to the community need. Interview participants reported that organisations were better positioned to address the varied and complex community needs when they shared resources and overall coordination improved.
- **South Auckland:** The consensus among all stakeholders interviewed was that the KPTO programme was important, particularly in relation to engaging with Māori. Some identified that the resources available for providing suicide prevention services for Māori were limited because the region was so large. Feedback pointed clearly to the need for a stronger emphasis on increasing awareness and understanding of the KPTO programme in the region. Some stakeholders stated specifically that this area of activity should be managed by a regional or national body.
- **Lakes District:** KPTO staff had a strong presence on a significant number of advisory forums, iwi forums and regional and national steering committees. They consistently collaborated with key agencies, advocated at strategic levels and worked closely with whānau over the entire evaluation period. All stakeholders confirmed that KPTO Coordinators were well connected and therefore added value to the communities in the region. Another stakeholder complimented the KPTO staff for their innovative step of creating spaces where they could have a kōrero with individuals in the workplace.
- **Hawke's Bay:** The KPTO programme was effective at including stakeholders in Wairoa to ensure a comprehensive, regionally inclusive approach. One KPTO Coordinator focused on Napier and Wairoa while the other focused on Hastings and central Hawke's Bay so that they could cover the region. However, achieving full coverage was still a challenge because of travel distances.

- **Christchurch:** The general consensus among stakeholders was that the KPTO programme was an invaluable resource in the Christchurch region. One stakeholder felt the service specification and particularly the focus on health promotion did not align with the original intent of the programme. Another stakeholder commented that the programme would have a greater reach if it operated across both suicide prevention and intervention areas. Another comment from a few stakeholders was that, given kaupapa Māori provision supported direct whānau engagement, re-aligning the programme to a Māori worldview would add immense value to the KPTO programme. The team's relationship with the Canterbury DHB Suicide Prevention Coordinator was critical as it promoted collaboration, mutual respect and the exchange of knowledge and information.
- **Bay of Plenty:** Interviews provided evidence that Te Ao Hou Trust had a good reputation in the community as a service provider. Through key stakeholder relationships, KPTO staff encouraged others to prioritise suicide prevention and increase the number of related activities and programmes across the region. Their participation in relevant advisory groups, events, community engagement forums and training over the years was critical to keeping the KPTO agenda as a consistently high priority. Te Ao Hou Trust's strategy was to facilitate a whānau ora model of care, providing culturally appropriate support and developing a network of high-performing providers. The KPTO initiative had obvious synergy with the Government's Whānau Ora initiative, which could be harnessed to make real changes to engage and empower whānau in a well-coordinated approach to their journey to toiora – linking to the All Age Suicide Programme Logic Model.
- **Invercargill / Southland:** The evaluation found that during 2011–2012 the KPTO team made a significant contribution to suicide prevention initiatives across the region. The team, through its well-established networks, also contributed to key suicide prevention strategic and policy developments. Initiatives were well researched and enhanced through programme and activity evaluations. The team followed clear reflective practice to inform programme enhancements and grow service reach. A general consensus among stakeholders was that in 2012–2013 the suicide prevention message got lost within wider public health campaigns.

1.2.3 Value to the region and to the programme

Many KPTO staff were positioned as key leaders across the Māori suicide prevention landscape, and the KPTO programme played a critical role in raising suicide awareness in Māori communities (including schools). Interview participants reported that community organisations could address the varied and complex community needs more effectively when they shared their resources and overall coordination improved through the collaborations fostered by the KPTO programme (e.g. the RAID Movement). Establishing, building and maintaining relationships were identified as a critical element for the KPTO programme. Where the KPTO Coordinators worked proactively to collaborate and communicate, relationships and initiatives with partners were more successful and sustained.

Stakeholders interviewed confirmed that the KPTO programme contributed to and supported many positive local initiatives and made a difference for community members and whānau. This role was particularly evident where KPTO team's established different networks, held marae wānanga (and created safe spaces to discuss suicide without fear or stigma), created community action plans and worked with local authorities and DHBs on injury prevention and Safer Community initiatives.

These stakeholders also overwhelmingly reported that the KPTO programme played a **critical role** in the suicide prevention landscape. They specifically referenced improved access to Māori communities and schools as a result of their relationships with the KPTO team. In some regions, the KPTO team was identified as 'working well' and 'very successfully' with local councils and particularly Safer Community representatives, as well as DHB services in injury prevention and/or suicide prevention and mental health. As a result, those organisations often prioritised suicide prevention in

their plans (such as Māori health plans, local comprehensive community plans and DHB strategic service plans). In Christchurch, for instance, the KPTO team's relationship with the Canterbury DHB Suicide Prevention Coordinator was seen as 'critical' to coordinate regional approaches. In another example, the KPTO Coordinator in Southland was noted as 'instrumental' in forming the Southland Suicide Prevention Network, through which stakeholders could take a more coordinated regional response to planning initiatives and projects.

Those who responded to the online survey were mixed in their perceptions of the value and impact of the KPTO programme. Around half of these respondents indicated that the programme had a positive impact and provided value to the community through increasing the profile and awareness of suicide, developing the confidence of whānau and the wider community to talk about suicide, and more effectively coordinating efforts and resources around suicide prevention and intervention services.

Others felt that, while the principles and objectives underpinning the KPTO programme itself were sound, its implementation was deficient and therefore, in their view, it had limited or no impact on the community. A few respondents considered KPTO providers lacked the requisite skills and capacity to effectively deliver the programme, including content knowledge around suicide prevention and effective approaches to suicide prevention and intervention, teaching and facilitation skills and strategic planning and coordination. Other comments noted the lack of consistency in the scope and role of the KPTO programme: was the focus on prevention and intervention services for individuals and whānau, on strengthening the community-level coordination of multiple support and service agencies, or on influencing regional or national policy at the strategic level? The inconsistency in approach and focus was seen as limiting the KPTO programme's effectiveness and reducing the understanding of and confidence in it among community members and stakeholders.

Some of the barriers to a more effective KPTO programme that respondents identified were: the challenges around privacy and confidentiality requirements, which they saw as limiting information sharing and cross-agency coordination; the community's lack of knowledge and confidence to openly talk about suicide; fragmentation of funding where different provider services were seen to be in competition with each other, limiting integration of effective wrap-around prevention, intervention and postvention services; and a lack of evidence-informed practice to guide delivery approaches, particularly local research that identified contextually grounded approaches, strengths and assets.

1.2.4 Cultural competency of the programme

Some KPTO respondents felt the programme's four key objectives were too generic and did not reflect Māori views of suicide and suicide prevention. For this reason, key activities in the annual service plan did not reflect Māori models of care or Māori views on suicide and suicide prevention. They felt that the overarching framework against which the KPTO programme was being measured needed to be more Māori-specific.

Despite the above concerns, the evaluation team found evidence in all regions that the KPTO programme was being delivered in a culturally competent way by organisations committed to Māori development and to achieving the best outcomes for whānau. Many partners viewed the KPTO Coordinators as strong in kaupapa Māori approaches and respected and acknowledged their value in bringing Māori perspectives to interagency tables and initiatives. Although evaluation participants defined cultural competency in many ways, the common feature of almost all definitions was that competency recognises people and/or systems have the ability to apply their knowledge about culture to change or improve practices in ways that influence local health and wellbeing outcomes.

In other words, cultural competency is about having the knowledge and ability to respond to the unique needs of local Māori populations in tailoring programme design and delivery for them.

Most providers used te reo Māori in their programme delivery by employing fluent speakers as Coordinators or including kaumātua in their service delivery. All service providers used local and national iwi or Māori models to promote awareness of suicide prevention, and incorporated karakia, manaakitanga and whanaungatanga into their engagement processes. Most designed their own specific Māori initiatives (e.g. manu aute model) that were tailored to their area and its history and population. Because many providers were iwi-based (rūnanga), they used the tikanga of the local iwi, as espoused in their own iwi plans and processes, for their KPTO planning process. All stakeholders confirmed that the regional KPTO teams were 'well respected' for their knowledge of things Māori. One provider identified that they supported their KPTO Coordinators in Te Whakauruora training to help improve the competency of their programme delivery. Other providers stated that, due to changes in government policy, they could not access this training anymore which they saw as a loss of capacity-building opportunities.

All of the service providers used different kaupapa Māori approaches, with the choice often depending on the kaupapa of their own organisations (and how tikanga and te reo Māori were embedded strategically across all other programmes and services) and sometimes on Coordinators' competency and knowledge in relation to te ao Māori. The nature of activities changed to include indigenous approaches; for example, some activities identified cultural best practice models relevant to Māori suicide prevention. The Tihei-wa Mauri Ora resource was one example of a specific model developed in one region, which drew on Māori cultural understanding of the order of life and being and reflected life stages of being, divine potential, darkness and light. The evaluation found that the manu aute and rongoā activities increased the effectiveness of KPTO programmes in Māori communities. Te Whakauruora training as part of service delivery was seen as having a positive impact on health promotion activities, improving health and wellbeing for Māori, and increasing access to services.

1.2.5 Examples of cultural competency

The following are some examples of the activities by region that demonstrate the cultural competency of the KPTO teams.

- **Whanganui:** Stakeholders reported high cultural competency among KPTO staff. When asked to elaborate, the majority of stakeholders highlighted KPTO leadership with respect to tikanga during hui. Although KPTO staff attended Te Whakauruora training, there was little evidence that staff were supported to put this training into practice. Stakeholders commented that the organisational services were delivered in a culturally competent way through their commitment to tikanga Māori and Māori development. However, KPTO activities and campaigns did not necessarily reflect a Māori worldview, perhaps due to the collaborative initiatives that involved a whole-of-community approach rather than focusing on Māori exclusively.
- **Northland Far North:** The KPTO programme delivered by Te Rūnanga Hauora o Te Rarawa sought solutions to suicide prevention and postvention from within te ao Māori. This led to the delivery of programmes such as rongoā and manu aute throughout the Far North. The KPTO programme delivered by the Rūnanga, extends the reach of the overall KPTO programme objectives by working directly with whānau.
- **Northland Mid North:** The KPTO programme put whānau at the centre of its service delivery model. Through initiatives such as He Tohu Rangatira, Ngāti Hine Health Trust addressed the needs of the whole whānau while recognising the requirements of individual members. The programme focused on Māori frameworks and sourcing solutions to suicide prevention and postvention from within te ao Māori. Interviews and document reviews found that the Trust used Te Whakauruora training within service delivery. Where possible, it integrated the suicide

prevention contract with other health promotion activities in a deliberate attempt to promote health and wellbeing for Māori and increase access to services across the suite of its services.

- **South Auckland:** The provider is an iwi-based trust that is heavily underpinned by tikanga practices. Building the capacity of cultural competency both internally and externally was a key element of the organisation. As both KPTO Coordinators had recently joined the programme, the evaluation team was able to observe – during the pōwhiri, mihi and whanaungatanga process on the team's arrival – their tikanga practices and understanding of Raukura Hauora o Tainui that formed part of their induction process. Both Coordinators were fluent speakers of te reo Māori and one Coordinator facilitated a mau rākau programme with rangatahi. The KPTO Team Leader also explained the history of Raukura Hauora o Tainui at the beginning of the evaluation hui. Both KPTO Coordinators commented that these tikanga practices were essential in programme delivery.
- **Bay of Plenty:** KPTO staff commented that they had made a concerted effort to incorporate a strategic approach to bring back the rangatiratanga and mana to communities. One focus of the KPTO programme was that services should be attuned to whānau cultural norms and recognise the realities and opportunities in te ao Māori and in the wider society. The whānau group consulted agreed with this approach. KPTO staff worked hard to keep Māori and iwi involved in raising awareness of suicide prevention on a regular basis.
- **Lakes District:** Since the inception of the Te Rūnanga o Ngāti Pikiao Trust in 1987, its core business has been to support iwi, hapū and whānau of Te Arawa and Tūwharetoa, including Kaingaroa and Mangakino. The evaluation team found significant evidence of the programme's cultural competency, such as in the KPTO-led, marae-based wānanga and marae toolbox. Stakeholders' acknowledgement of and respect for this competency was also evident. A number of whānau initiatives, including the marae wānanga, received positive evaluations.
- **Hawke's Bay:** Staff commented that, while collaborations such as the interagency groups appeared to have some benefit, the stronger emphasis was on increasing networks within iwi, hapū and marae. These linkages provided an opportunity to work with people who could pass on sound advice in a different context and with the right cultural support. For example, the KPTO team delivered a positive workshop to over 100 participants at Te Aranga Marae, who were a great audience to raise awareness about suicidal tendencies. Cultural integration into all provider programmes was a key foundation for the provider.
- **Christchurch:** The programme was delivered by Māori for Māori. However, documentation and stakeholder responses offered little hard evidence that the programme used Māori frameworks or health models, even though staff had been trained in these areas. According to stakeholders, programme delivery was culturally competent and upheld tikanga Māori in hui and forums, and KPTO staff were highly culturally competent. One stakeholder commented that the KPTO programme influenced how his own organisation responded to Māori.
- **Invercargill / Southland:** Although monitoring reports described tikanga-based training opportunities, after a change in Ministry of Health policy in 2012 KPTO Coordinators were no longer able to access Te Whakauruora training. KPTO Coordinators felt that this change reduced their access to cultural competency training within the suicide prevention landscape. The KPTO programme over the evaluation period targeted whānau Māori but there was little evidence that Māori frameworks were used to influence service design and planning. The KPTO programme delivered by Ngā Kete Mātauranga in 2011–2012 was a generic suicide prevention programme. Then, from late 2012 and 2013, key suicide prevention messages delivered by KPTO were lost in the design and delivery of health promotion messages that were again generic in nature. Programme planning and design were influenced by the Ottawa Charter, which was clearly useful in terms of health promotion principles but stakeholders felt that the programme generally lacked a kaupapa Māori influence.

1.2.6 Strengths and opportunities for improvement

Competency in health promotion and partner collaboration: All providers used workshops, wānanga, community events and hui to promote suicide prevention in their regions. Some supported these activities with toolkits, hand-outs and other resources for families to take away. They also worked with key stakeholder groups to influence their engagement with Māori clients and in many cases they shared resourcing, undertook common planning, jointly developed and delivered initiatives at community events, and achieved tangible outcomes (e.g. lights installed in Whanganui and Hawke's Bay in areas known for high suicides).

Scope of KPTO: It was necessary to clarify the role (and limitations) of the KPTO programme in the intervention/postvention realm in order to address unrealistic expectations of it. This was an area of tension because some providers wanted to provide a seamless array of support from prevention to intervention to postvention, all under the auspices of the KPTO programme. In one area, the provider focused the KPTO programme solely on health promotion, but recommended its expansion to include intervention and postvention.

Awareness of KPTO mandate: As the stakeholder interviews and survey showed, in most regions awareness of the KPTO programme, its role and delivery elements were limited. In particular, many did not know whether they should expect KPTO staff to be involved in intervention processes.

Coordinated capacity development for Coordinators: Building the capability of KPTO Coordinators was identified as an area for improvement from a national perspective. Although various training solutions were identified, there was no central coordination of what would be of most value or critical in the KPTO role. All KPTO providers suggested that the Ministry of Health invest in developing a structured skills and knowledge training programme for staff that was specifically linked to the suicide prevention objectives (similar to the national BreastScreen Aotearoa coordinator training programme). Likewise, some KPTO Coordinators recommended developing nationally branded KPTO resources (again similar to BreastScreen Aotearoa's nationally branded resources) to give the programme a consistent national profile, especially in the media.

Among survey respondents' suggestions to strengthen the KPTO programme were to:

- focus more explicitly on delivering community-based education initiatives that empower whānau and community through knowledge, skill development and increased confidence to identify and respond to incidents relating to suicide
- improve the linkage and coordination between KPTO and specialist mental health and crisis support services to strengthen intervention and postvention support for clients and whānau to access these services
- develop a nationally consistent, locally contextualised communications strategy to increase the visibility, awareness and leadership around suicide, which would include a specific strategy around social media
- more strongly integrate culturally based initiatives that promote resiliency, identity and social connections to whānau, iwi and the wider community as a protective factor against suicide
- develop a community-wide planning framework to strengthen agency and provider collaboration and integration of services
- develop a stronger evidence base and dissemination strategy across the country to identify approaches that are working in this area, as well as make a greater investment in local research initiatives
- strengthen the KPTO monitoring framework so that indicators are more clearly able to measure the impact and value of the programme.

1.2.7 Examples of strengths and opportunities for improvement

- **Whanganui:** Due to the health promotion nature of the KPTO programme, it was very difficult to determine whether running workshops or having a presence at community events led specifically to positive changes for the community. Building strong networks was a critical element and a strength of the service. There was clear evidence of strong networks across multiple agencies and community organisations, which were further supported by the number of stakeholders who agreed to participate in this evaluation at short notice. The KPTO Coordinators had a strong presence in the community and among key stakeholder groupings. Service integration was seen as another positive aspect of the organisation. Staff believed that all services within Ngā Tai o Te Awa could refer clients on to other services and they did so frequently.
- **Northland Far North:** The strength of the KPTO programme of Te Rūnanga o Te Rarawa was that its activities and its solutions to suicide prevention were derived from te ao Māori. Resources produced by the KPTO Coordinator were used in the wider mental health sector and promoted by the Northland DHB. Activity and workshop evaluations reinforced the conclusion that the Rūnanga's approach to suicide prevention had positive outcomes. Given the nature of the suicide landscape, staff reported that the KPTO programme could extend its reach by encompassing suicide intervention and postvention as well as prevention.
- **Northland Mid North:** The KPTO programme had a strong health promotion focus but the organisation believed it would be more effective if it widened its focus to incorporate suicide intervention and postvention in addition to prevention. KPTO staff commented that KPTO involvement in postvention can support prevention.
- **Bay of Plenty:** Over the evaluation period, KPTO staff used innovative ways to promote wellbeing among Māori. In addition to delivering workshops and attending community events, KPTO staff worked with key stakeholder groups to influence their engagement with Māori clients. Their participation in relevant advisory groups, events, community engagement forums and training over the years was critical to keeping the KPTO agenda as a consistently high priority. KPTO Coordinators were able to demonstrate a number of effective engagement activities with iwi, hapū and whānau. The document review identified that it was critical to recognise the cultural distinctiveness of whānau, hapū and iwi in engagement activities. A KPTO principle is that services should be attuned to whānau cultural norms and recognise the realities and opportunities in te ao Māori and wider society. Among the findings, learnings and outcomes that came from the Kawerau cluster was that the KPTO programme could bridge the clinical gap and bring communities together. KPTO staff, who had been heavily involved in the programme for a number of years, commented that the programme was not strongly coordinated, with nine sites taking quite different approaches. Although they did not think the current arrangements were bad, the KPTO staff felt that a better-coordinated programme would make it easier to identify what was working and what was not. A national role or body would be able to provide induction services, disseminate important communications, connect KPTO providers with the Ministry of Health, fulfil an advocacy or advisory role, collate resources and highlight the ones that were working for Māori, and undertake general collaboration activities such as the national hui.
- **South Auckland:** In their interviews, stakeholders showed that they had limited awareness of the KPTO programme. Some of their comments indicated room for improvement in building the capability of KPTO Coordinators and in coordinating the programme. As both KPTO Coordinators had been in their role for less than three months, they were unable to contribute significant information on the evaluation period. However, they did wish to discuss their plans for improving or developing the KPTO programme. Activities that were to form part of their planning processes in the future include:
 - delivering a Māori suicide prevention campaign that is created and led by youth, which could include a performing arts initiative – *'Youth are so vulnerable these days and social media has had a big impact but our youth don't have the tools'*

- developing and implementing a kaupapa for manaaki whānau to understand their identity in terms of whakapapa, mātauranga and tikanga Māori
- implementing the RAID Movement as a nationwide strategy while appreciating that research evidence is required first
- supporting the key role of iwi, hapū and marae in promoting mental wellbeing with whānau, particularly by connecting kaumātua with rangatahi which was a need confirmed by one stakeholder
- developing a resource tool to educate whānau, hapū, iwi and hapori on suicide awareness and prevention. This could include a digital resource for schools – *‘ideally a tool on the cellphone like an AP’* – which would avoid the wastage of paper resources
- focusing on influence at a Government level – *‘We need a champion like [former] Minister Jim Anderton and [former] Minister Tariana Turia’*
- implementing a national body rather than having nine different ‘headships’, each with a different flavour. The national body could provide one heart, one mission and one vision, measure strategies and coordinate the ‘right’ flavour, which could be aligned to Whānau Ora outcomes
- building community champions to work in schools and build the capability of parents as educators.
- **Lakes District:** The document review confirmed that KPTO maintained strong relationships within the community and was well connected. KPTO staff also played a key advocacy role in the varying events and forums that they attended or participated in. One suggestion for improvement was to build resiliency in the community through community-based activities and initiatives that brought people together to work on them. Some stakeholders made comments surrounding possible alignment to Whānau Ora and Waka Hourua to ensure local and national alignment of strategies being implemented in Māori communities. Another suggestion was also for more national exposure of KPTO so that all regions of the country knew the programme was available in their respective region.
- **Christchurch:** As the document review and stakeholder interviews showed, the success of the KPTO programme relied on strong relationships with key stakeholder groups. These relationships enabled multiple organisations to share resources to promote suicide prevention messages. Stakeholders reported that collaborative activities had mutual benefits such as achievement of shared outcomes, wider community impact and coordinated planning. Clear opportunities existed to improve coordination among agencies and providers to enhance outcomes across the Christchurch population. If all members of the multi-agency suicide prevention forum used standardised forms such as evaluation tools, the group would gain enhanced knowledge about the collective impact of their efforts at a population level.
- **Invercargill / Southland:** Stakeholders interviewed commented on the health promotion focus of the KPTO programme, which felt was at odds with a kaupapa Māori approach or a Māori view of suicide prevention. KPTO staff considered that the programme would be substantially enhanced, with opportunities for more meaningful whānau engagement, if it was extended to include suicide intervention and postvention activities.

1.3 Assessment against KPTO Accountability Framework and All Age Suicide Programme Logic Model

This section offers an assessment of the overall evaluation findings against the KPTO Accountability Framework and All Age Suicide Programme Logic Model. Its focus is on the short-term programme outcomes developed in 2010 and outlined in the KPTO All Age Suicide Programme Logic Model. Each one is listed below (in bold) and findings are recorded against each of these objectives.

Māori have the opportunity to participate in mental health and wellbeing programmes

- The evaluation shows that many Māori individuals, families, hapū, marae and iwi as well as Māori service providers, schools (with high Māori student ratios) and rūnanga have been given extensive opportunities to participate in mental health and wellbeing programmes. This finding has been demonstrated through the wide variety of mental health promotion activities and interagency or collaborative partnerships and initiatives in which they have been able to participate.
- Improvements are needed to ensure equity of opportunity and access through reviewing providers that cover a large geographic region with a widely distributed Māori population, and ensuring KPTO programmes have the resources and capacity to reach all of these communities (specifically in Hawke's Bay, Canterbury and South Auckland).

Policies and strategies to reduce access to means of suicide are supported and encouraged

- The evaluation identified some good examples of strategies used to reduce access to means of suicide through work with schools and with local councils.
- There was a lack of evidence that the majority of KPTO programmes have developed specific approaches to addressing this objective in all regions.

Whānau are supported to reduce access to means of suicide

- As above, this evaluation found only a few specific examples where definitive action has been taken to address this objective. There was considerable room for improving the approach to this objective nationally.

Services and referral pathways for Māori are identified (across primary and secondary mental health services)

- The evaluation shows that through extensive interagency collaborations (especially with DHB mental health services, CAYAD teams, Police and others), the KPTO prevention programme's linkages with intervention and postvention services have been considerably strengthened. Some regions had formal protocols in place (e.g. Fusion Group) to ensure everyone can get help when they need it.
- In a few regions, KPTO Coordinators were being called on to become involved in suicide intervention and postvention with individual whānau, going beyond the scope of prevention and health promotion work. In some of these cases, the service providers suggested that the KPTO service could be improved by extending the scope of the programme to include intervention and postvention activities. Many stakeholders believed that, because KPTO focuses on suicide prevention, Coordinators could be called on as additional resource people in suicide incidents to support them as front-line responders and/or to support individuals and families. One reason for this expectation was that stakeholders lacked understanding of the purpose, scope and mandate of the KPTO programme.

Media and other organisations are engaged

- The evaluation shows that a few KPTO providers took proactive steps to work with their local media to focus on safe media reporting. Such activities were productive and useful.
- For the majority of KPTO programmes, there was no evidence that they had built strong relationships with local media to encourage safe media reporting.

Increased understanding of Māori appropriate service delivery models

- The evaluation shows that the majority of service providers were incorporating kaupapa Māori models and approaches into their programme design and delivery. Many used models such as Te Whare Tapa Whā or designed their initiatives with a foundation in te ao Māori (e.g. manu aute). This approach has been successful in helping the programme to reach the Māori community in an

appropriate way. Overall, stakeholders acknowledged and respected the skills and expertise of KPTO programmes to address Māori approaches and understandings of suicide in a Māori context.

- There was less evidence of specific improvements made to mental health services for Māori. However, all DHB mental health, public health, suicide and injury prevention stakeholders who participated in the evaluation were complimentary about their relationship with the KPTO programme and the value that this relationship brought to their work.

2. RECOMMENDATIONS

In light of evaluation findings, five recommendations are made for consideration in making decisions on the future of KPTO.

- 1) Review KPTO objectives and the scope of services to ensure that they are realistic and consistent with Māori cultural values and views of suicide. If the KPTO programme is intended to primarily support suicide prevention, then it should be made clear that agency requests to support emergency responses is not the preferred focus.
- 2) Communicate expectations of the KPTO programme more clearly to a wide range of stakeholders, through a variety of means that include news media and common messages.
- 3) Review the distribution of KPTO providers in terms of both geographical distribution and the appropriate size of the region covered by each provider.
- 4) Consider establishing a structured national leadership mechanism for the KPTO programme. National leadership could provide training for Coordinators, develop consistent resources and guidelines, develop a consistent communication plan and brand, share information across different providers to improve learning about what works under different circumstances, and coordinate programme delivery.
- 5) Review funding levels for KPTO providers to ensure that they are able to meet their objectives.



3. INDIVIDUAL SITE REPORTS

3.1 *Te Kupenga Hauora – Ahuriri: Hawke's Bay*

3.1.1 *Overview*

Kāhui Tautoko Consulting Ltd (KTCL) visited the site of Te Kupenga Hauora – Ahuriri (TKHA) on 2 and 3 July 2014 at its offices in Napier as well as visiting stakeholder offices in Wairoa. Careene Andrews and Arthur Selwyn from KTCL conducted this evaluation site visit, which comprised interviews with the Chief Executive Officer (CEO), the KPTO Service Manager and two KPTO Coordinators. KTCL interviewed all staff members involved in the KPTO programme.

The KPTO Coordinators provided contact details for key stakeholders involved in the programme during the evaluation period from 1 July 2010 to 31 December 2013. Of the stakeholders identified, six were available to participate in the evaluation: Te Taitimu Trust, Hastings (whānau); Hawke's Bay District Health Board – Suicide Postvention Coordinator; Wairoa College, including 13 students; Wairoa Ynot Trust; Wairoa Waikaremoana Trust; and Work and Income, Wairoa. KTCL was also scheduled to meet with Te Taiwhenua o Heretaunga in Hastings and Kahungunu Executive in Wairoa, but unfortunately the interviewees were unavailable.

The Ministry of Health provided documents relevant to the evaluation, including annual reports, previous reports, project plans and annual service plans. Documents were reviewed on site during the visit in July 2014. They included six-monthly reports (2010, 2011); three Integrated Contract Reports (2012/2013); KPTO Workforce Plan (2012/13); TKHA KPTO Service Plan 2012/13 (aligned to KPTO Provider Network Strategic Plan); Hawke's Bay DHB suicide support model paper; and Ministry of Health contract and service specification.

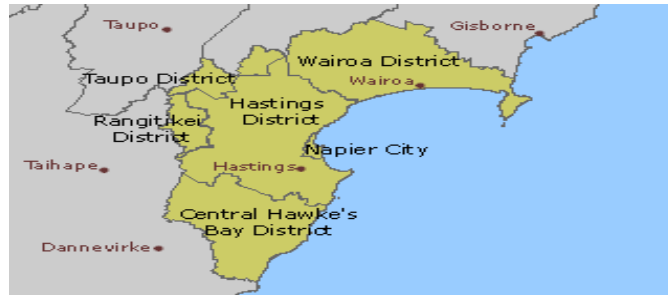
Limitations of the specific site evaluation

Of the two KPTO Coordinators interviewed, only one Coordinator was employed during the entire evaluation period, 1 July 2010 to 31 December 2013. The Hawke's Bay DHB Suicide Postvention Coordinator had a relatively low level of involvement with the KPTO programme due to their role of working in the postvention context. This stakeholder and the KPTO Coordinator who had recently started in the KPTO role were therefore unable to respond to all evaluation questions.

3.1.2 *Process evaluation findings*

Programme delivery and activities

Te Kupenga Hauora – Ahuriri is a charitable trust located in Napier that endeavours to deliver KPTO services across the Hawke's Bay DHB region. The large area lies between Takapau (central Hawke's Bay) in the south and Rongomaiwahine (Mahia) in the north. According to the 2013 census data, the total Māori population for Hawke's Bay was 33,555. The main concentrations of Māori were in Hastings, Wairoa and Flaxmere, Napier.



Although TKHA had two contracted KPTO Coordinators who worked together throughout the Hawke's Bay region, one Coordinator tended to focus on working with communities in Napier and Wairoa, while the other Coordinator focused on the area from Hastings to Central Hawke's Bay.

'We can't get to everyone. We'd always like to see more resources.' (KPTO staff)

'Wairoa definitely need their own KPTO Coordinator.' (Stakeholder)

KPTO Coordinators were asked about their health promotion and suicide prevention activities undertaken during 1 July 2010 and 31 December 2013. KPTO Coordinators stated that they provided mental health promotion through networking and engagement activities with organisations such as Waikaremoana Trust Board, Kahungunu Executive, Dove, Central Health, Birthright, HOPE and other providers and agencies. KPTO staff was also heavily involved in the Napier City Council Safer Community accreditation with key parties requesting KPTO staff to present at one of their major hui. The KPTO presentation was recognised and acknowledged as the best presentation on this topic. Health promotion hui were also conducted with organisations from Mahia and down to Takapau to raise the awareness of suicide prevention in the community. Staff commented that a number of their activities were prioritised around a calendar of events such as Iron Māori, Waitangi Day and Positive Living Te Iwi Māori in Wairoa.

'It's getting people to talk about it instead of brushing it under the carpet or treating it as a taboo subject like in the older days.' (KPTO staff)

'Māori speak more openly when they engage with Māori.' (KPTO staff)

KPTO programme reports identified the establishment of HOPE, an interagency suicide prevention group which included members from the Hawke's Bay DHB, New Zealand Fire Service, Work and Income, Child, Youth and Family, mental health providers, schools, iwi, whānau, hapū and non-governmental organisations. The purpose of the group was to contribute to the implementation of the Suicide Prevention Plan for the Hawke's Bay region. This collaboration enabled KPTO staff to give guidance to the group so that its members gained a better understanding of the KPTO kaupapa from a cultural perspective. While this input was positive, one of the KPTO Coordinator's indicated that the collaboration tended to be strongly focused on postvention and therefore the participants often had different agendas.

'There are no dedicated suicide prevention services in the Hawke's Bay and therefore there is no real connection with KPTO. This is a major concern for the Hawke's Bay region – we should be trying to prevent suicide, not react to it after the fact.' (KPTO staff)

KPTO Coordinators were asked about resource development, media initiatives and communications. They stated that their involvement in resource development for the programme was limited as they felt the nationwide resources were sufficient for their role. Although one KPTO Coordinator had worked on the development of the interagency group 'wallet card' resource, this work had lost momentum as it took over 18 months to be produced. The main reason for the length of time involved was seen as the lack of time available to dedicate to the project when other activities were of a higher priority.

'We need to brand Kia Piki Te Ora like we did with "Hui Up". It would be great to have resources like breast screening [national Breastscreen Aotearoa resources].' (KPTO staff)

KPTO programme reports highlighted media engagement activities with *Hawke's Bay Today*, Radio Kidnappers and Radio Kahungunu. Staff advised that they participated in a question-and-answer broadcasting programme at least three times a year. As KPTO reports identified, helpful developments for suicide prevention have been the uptake of social media and the growing ability among whānau to express their social conscience. KPTO Coordinators stated that they did not currently have a specific communications plan underpinning all this work; rather, communication was done as part of the overall strategic plan and service delivery. KPTO Coordinators participated in the KPTO teleconferences but confirmed that these could be coordinated better to make the most of the time dedicated to them.

Finally the evaluation looked at the infrastructure and human resource processes of the KPTO team. The KPTO team was well supported by the TKHA Human Resources team, as evidenced through the KPTO personal development and training plans. KPTO Coordinators confirmed that any training request was usually approved if it aligned closely with the objectives of the programme. One of the KPTO Coordinators advised that Te Whakauruora training had been a great vehicle in establishing national capacity for KPTO staff. The other KPTO Coordinator commented that training around clinical perspectives on suicide response would be of benefit.

Planning and monitoring

For the KPTO programme, TKHA originally had service specification contracts with the Ministry of Health until July 2011, in which the KPTO service formed part of an integrated contract along with Family Start, Social Workers in Schools and Aukati Kai Paipa. Like all TKHA services, an annual service plan had been developed for the delivery of the service aligned with the contract requirements, the KPTO Strategic Plan and the All Age Suicide Programme Logic Model and Accountability Framework. The service plan, along with an accompanying workforce development plan, was used to guide the implementation of the service. KPTO-related outcome measures in the service plan were aimed at promoting mental health and wellbeing for Māori, reducing access to the means of suicide, increasing the safe reporting of suicide by the media and improving mental health services for Māori. As set out in the plans, important methods to achieve these priorities included networking, engagement and maintaining key linkages with the community.

KPTO Coordinators were asked for their views on their annual service plans and whether they had an input into plan development. They replied that because the original annual service plan was already in place when they began working in the KPTO programme, they had no input into its original development. When they reviewed the annual service plan, however, they noted it was updated to reflect an approach focused on collaboration and prevention rather than on reaction and postvention.

'Our delivery is focused on strength based, rather than focusing on the dark place of self-harm or depression.' (KPTO staff)

'Community-led is the best evidence in Wairoa. Building their rangatiratanga and using high profile people.' (Stakeholder)

'There is a gap between clinical and KPTO (or non-clinical) collaboration and we need to bridge this gap.' (KPTO staff)

The document review conducted for this service showed that very effective service review and monitoring systems were in place. Two types of monitoring, including programme evaluations, were

identified. KPTO Coordinators advised that some improvements had been made based on feedback in the service evaluation forms from participants. For example, KPTO Coordinators found that clients who had attended workshops wanted the delivery to contain more cultural aspects, including tikanga and te reo Māori. KPTO Coordinators enhanced their programme delivery throughout their workshops. It was evident through the workshop evaluations that some clients attended because of these cultural elements.

Using the results of service monitoring, KPTO Coordinators provided management with monthly contract reports that outlined the outputs and outcomes achieved, reported back on the service objectives and contained a narrative component. Management reviewed these reports to ensure they aligned with contractual requirements.

3.1.3 Process evaluation conclusions

Programme delivery and activities

The KPTO programme was delivered by two KPTO Coordinators across the region. As it was a large region, not all areas were receiving support due to the limitations of resourcing and travel distances. The lack of resources (and therefore capacity) to cover this large area limited the reach of the programme. A relatively strong argument could be made for having a KPTO Coordinator dedicated to Wairoa, given that over 50 percent of its population is Māori and that it is a considerable distance from Napier.

As the KPTO programme was aimed at agencies in various sectors, its success for whānau or individuals could not be identified in this evaluation. Some local initiatives, however, were successful such as building awareness among the Wairoa community which, moreover, was now taking ownership through a core group of volunteers leading a support network. KPTO Coordinators were also involved in the Napier City Council's Safer Community accreditation by the World Health Organization, which provided a forum to promote the key messages of KPTO in that community. While these examples highlight some successes in working with various community agencies and providers, the involvement of iwi, hapū and marae cannot be underestimated. The workshop and hui held at Te Aranga Marae, with over 100 attendees, raised awareness of suicidal tendencies. One of the KPTO Coordinators said that Māori speak more openly when they engage with Māori.

Planning and monitoring

At the time that the current Coordinators were employed, an annual service plan and associated action plans for KPTO were already in place. These plans had been reviewed and adapted to more strongly emphasise collaboration and prevention activities. The plan was also enhanced to reflect more alignment to the goals of the KPTO contract and the programme's goals and objectives.

The KPTO programme was largely delivered on a needs basis across the large region of Hawke's Bay. The emphasis was on Wairoa, Hastings and Flaxmere, Napier as areas with high concentrations of Māori. KPTO Coordinators commented that they engaged less with other areas due to limited resourcing and travel distances. One stakeholder stated that Wairoa definitely needed its own KPTO Coordinator. Another significant concern identified from the evaluation was that Hawke's Bay had no or limited agencies dedicated to suicide prevention. Therefore it was difficult to work collaboratively with agencies working in a postvention-focused environment while the KPTO programme was focused on suicide prevention activities.

'It's too late to come to the party then in respect to postvention.' (KPTO staff)

'Whānau do not want to hear clinical jargon. Clinicians don't sit beside whānau; they stand over them.'
(KPTO staff)

KPTO Coordinators commented that the predominant approach was reactive and that agencies should be working together to prevent suicide. Similarly, they identified a gap between clinical and non-clinical (KPTO) services and they were conscious of the need to bridge this perceived gap.

3.1.4 Impact evaluation findings

Community impact and alignment with objectives

Stakeholder participants were asked for their views on the KPTO service and how it impacted on them. One participant did not know what the KPTO programme was actually contracted to deliver and was only made aware of the programme when they attended a Ministry of Education hui. This participant, however, was working in the postvention arena and therefore had a distinctly different role which meant they did not cross paths often with the KPTO team. The participant did comment that this type of programme should be by Māori for Māori.

*‘I think they seek to build community resilience and help them to develop community leadership.’
(Stakeholder)*

*‘If I’m still learning about what services are out there, then can you imagine how little the whānau know?’
(Stakeholder)*

Another stakeholder participant would like to see a change in programme delivery to invest in community volunteers or coordinators with a strong community focus. In contrast, the remaining participants saw significant value in the KPTO programme and Coordinators. These participants acknowledged the role that KPTO played in bringing communities together and setting the platform for community action.

‘KPTO know what they are doing and what’s going on in the community.’ (Stakeholder)

‘We are very appreciative of the work that KPTO does, but we are tired of getting visits from the Bay [Napier]. We can help support whānau straight away but we don’t have the funding.’ (Stakeholder)

Value to the region and the programme

KPTO Coordinators stated that the KPTO Strategic Plan focused on raising awareness, building community champions, leadership development, working in the education sector and strengthening the KPTO presence in the Wairoa district. Some of the many education engagement activities in Wairoa in 2010 were in Hinepu Kahurangi Te Kōhanga Reo, Te Wairoa Kōhanga Reo, Te Whānau o te Nuhaka, Tiaho Primary School, Te Kura Kaupapa Māori o Ngāti Kahungunu o Wairoa, Wairoa College and Nuhaka Primary School. As a result, the Coordinators had a secured agenda to present to Wairoa school principals twice a month. During the KTCL site visit, the research team observed one of the presentations aimed at raising suicide prevention awareness to 13 Wairoa College students. The local Wairoa initiative identified a positive outcome in Wairoa. It was noted that three years ago the KPTO programme had limited relationships with the community but now it was well embedded. The result is that the Wairoa community now has its own support network committed to promoting suicide prevention.

‘Three years ago there was no relationship in Wairoa but now we’re into action after establishing strong relationships and now we’re talking about it and more aware of it.’ (Stakeholder)

‘The community, with the help of KPTO, has established a core group of volunteers to lead a support network to address this need through a simple but effective phone service.’ (Stakeholder)

‘We are having difficulty with the Ministry of Education when trying to engage in schools.’ (KPTO staff)

Cultural competency

KPTO Coordinators commented that while collaborations such as the interagency groups produced some benefits, they were giving a stronger emphasis to increasing networks within iwi, hapū and marae. These linkages have provided an opportunity to work with people who can pass on sound advice in a different context and with the right cultural support. For example, the KPTO team delivered a Positive Living – Te Iwi Māori workshop to over 100 participants at Te Aranga Marae, which provided a vast audience to raise awareness about suicidal tendencies.

Strengths and opportunities for improvement

Some stakeholders had close connections with the programme, having known someone or known of someone in their community who had taken their own life. These participants were more interested in how they could provide further opportunities to reduce suicide statistics. One participant, with the support of the KPTO team, developed a community plan and included iwi in these hui. From this basis, they have worked together on community development initiatives such as keeping kids busy in activities like Iron Māori and a leadership hīkoi for rangatahi.

Additional comments from Wairoa stakeholders included the following.

‘A 0800 number in our rohe would be beneficial, and we could call it something like 0800 ASK AUNTY.’

‘There are a whole lot of people around for one at-risk girl. We need a navigator for a pathway as we are getting confused with too many services who don’t talk to each other.’

3.1.5 Impact evaluation conclusions

Community impact and alignment with objectives

Although TKHA was a well-established organisation with a relatively long history of providing this programme, some respondents were unsure of what the KPTO programme actually delivered or provided. It appeared that the KPTO Coordinators was being called on in many varying capacities, such as for postvention, cultural input and whānau engagement, thus causing some confusion among current and potential partners and participants. This uncertainty presented challenges for achieving the KPTO programme’s objectives in suicide prevention.

As the KPTO programme was delivered across a large region, not all areas were receiving support due to the limitations of resourcing and travel distances. The lack of service provision for suicide prevention in Hawke’s Bay also limited the reach of the programme as collaborative efforts were not a priority for some providers. However, KPTO staff described examples of two of TKHA’s initiatives where collaborative efforts have been successful.

‘Raureka community experienced several serious attempts and two suicides. The community sought out agencies to support them to make their community safer. The main means of attempts were hanging on a particular tree in the local park. With the support from KPTO the Raureka community met and set up their action plan. The main success was how the group discussed with Hawke’s Bay District Council to make the park safer for the community and to chop down the branches and light the park up. KPTO facilitated the coming together of the community at a local school and put the community in key roles to achieving the goals within.’

‘A web page that has taken on over 3000 friends was developed after a spate of four youth suicides. The page host worked on getting people to come and meet and share ideas on how to prevent suicide. They have a mantra of “One Love” and promote positive living. The page gives a vehicle to survivors (whānau)

of suicide to vent and offer support to those that may be thinking and needing support in difficult times. KPTO has been able to guide and support this kaupapa which resulted in the establishment of a support group called HOPE. We support in the administration of this group as it is made up of mostly volunteers.'

Value to the region and the programme

From the findings and analysis presented above, the programme has contributed and supported positive local initiatives and made a difference for community members and whānau. This was particularly evident with the establishment of the Wairoa support network, the raised awareness with local marae, the Raureka Community Action Plan and the contribution and support for the Napier City Council Safer Community accreditation. In addition, the engagement activities undertaken in the education environment were positive, while at the same time producing challenges when working with the Ministry of Education.

Some respondents stated that they were unsure of what the KPTO programme actually delivered and therefore of how to determine its value. It appeared that KPTO was being called on in many varying capacities, such as postvention, cultural input and whānau engagement, which was causing confusion and made it more difficult to achieve the KPTO programme's objectives in suicide prevention.

Cultural competency

Most respondents highlighted that suicide prevention should be a programme delivered by Māori for Māori. One participant commented that Māori speak more openly when they engage with Māori. Findings also highlighted that the KPTO team was called on regularly to provide cultural support or require services to engage with Māori whānau. In addition, the involvement of iwi, hapū and marae was not to be underestimated as an effective way of raising awareness about suicide prevention. Participants felt that a strong feature of delivery of KPTO by Te Kupenga Hauora – Ahuriri was that leadership from Coordinators and management was soundly based in tikanga and te reo Māori.

Strengths and opportunities for improvement

Although the KPTO programme was a well-established service with a relatively long history, awareness of it was fairly limited, particularly among agencies. Respondents agreed that this lack of awareness may have been due to the minimal number or absence of providers in Hawke's Bay who deliver suicide prevention services. The impact of the KPTO programme on community engagement was positive. Most of the respondents agreed that working with the KPTO programme had some value. One respondent, however, did feel that the programme should be changed to invest more in the community.

3.2 Ngā Tai o Te Awa: Whanganui

3.2.1 Overview

KTCL undertook the site visit to Ngā Tai o Te Awa (NTOTA) on 21–22 July 2014. Naomi Manu and Carla Te Hau from KTCL conducted this evaluation site visit and interviewed all current staff members involved with the KPTO programme, including the Service Manager, two KPTO Coordinators and the Board Chair. KTCL also attempted to interview former KPTO Coordinators who were employed during the pertinent evaluation period.

The KPTO Service Manager provided contact details for nine key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. Of these stakeholders, the following eight were available to participate in the evaluation: Pathways; Balance Whanganui; Whanganui DHB – Mental Health; Whanganui DHB – Public Health; Project Marton; Whanganui District

Council – Safer Community; Rangitikei College – Alternative Education Coordinator; and Te Oranganui Iwi Health Authority. All participants were from government organisations, non-governmental organisations, community providers or other Māori providers in the Whanganui and Rangitikei regions. Their positions in their respective organisations included social workers, support workers, health promotion personnel, mental health coronial liaison, programme coordinators and senior management.

The Ministry of Health provided documents relevant to the evaluation, including performance monitoring reports, project plans and service action plans. Documents were also analysed following site visits. They included: 'Got Your Back' campaign information; Prevention/Postvention Suicide Support Team terms of reference; Prevention/Postvention Suicide Support Team hui minutes (February–November 2011); KPTO Annual Service Plans (2010–2013); KPTO Annual Reports (2010–2013); KPTO six-monthly monitoring returns (2010–December 2013); notes and evaluation from community stakeholder/agency focus group feedback (2012); Removing Barriers Group terms of reference; Removing Barriers Group minutes (June–October 2013); Mental Health Awareness Week programme and evaluation (2013); Wellbeing and Suicide Prevention (WASP) ki Whanganui minutes (July–November 2013); WASP ki Whanganui Results Based Accountability (RBA) Scorecard; and Safer Whanganui RBA Summary Update (2013).

Limitations of the specific site evaluation

A significant limitation to this evaluation was the short time between the establishment of the KTCL contract with the Ministry of Health and the site evaluation. Due to this tight timeframe, Ngā Tai o Te Awa could not secure whānau and community member participation in the evaluation. Additionally, the evaluation team was unable to interview key KPTO staff that were employed throughout the evaluation period. Of the four staff employed during the evaluation period, only one was available to contribute to the evaluation. To minimise impact on the evaluation, the Board Chair was available during the evaluation and all programme documentation was provided to the evaluation team. It was clear during the evaluation that staff handover processes enabled current staff to comment on past KPTO activities.

3.2.2 Process evaluation findings

Programme delivery and activities

When asked what their roles as health promotion coordinators for KPTO involved, KPTO Coordinators stated that they provided mental health promotion within the Whanganui and Rangitikei regions. They outlined the four key objectives of the KPTO programme and appeared to have a good understanding of them.

KTCL asked staff to describe specific health promotion and suicide prevention activities that were delivered during the evaluation period. Although personnel had changed since the evaluation period, staff were able to comment on specific activities that were delivered and relationships that were established during the evaluation period. The following are examples of activities and campaigns.

MOOD FOODS

KPTO staff reported that many whānau struggled to talk openly about suicide and self-harm. In an effort to 'start the conversation' the KPTO Coordinators operated a stall at community events such as Rātana Pā celebrations, Marton Market Day, Mental Health Awareness Week celebrations and community open days. During such events, KPTO Coordinators ran a healthy fruit shake stall called Mood Foods. The mood foods gave staff the opportunity to talk with community members about the association of mood with food and the impact of healthy eating on both physical and mental wellbeing. Key to the success of these events was the opportunity to engage whānau in meaningful discussion while the fruit smoothie was being prepared.

'GOT YOUR BACK' CAMPAIGN

Following a spate of youth suicides in the Rangitikei area, KPTO Coordinators, alongside trained counsellors, presented the 'Got Your Back' campaign to student leaders in secondary schools in the Whanganui and Rangitikei region. The campaign sought to support students to create or identify a support network of people they could call on for advice on issues they might be struggling with in their lives. KPTO Coordinators explained that those on the support list did not necessarily have to be family members – they could be a mix of family, friends, classmates, teachers or anybody else they felt they could seek help from. After completing the list, students were invited to add contact details. They were also reminded that it was important to ask those they had identified if they were comfortable with being on that list and were willing to help if asked.

NTOTA developed strong partnerships with key community stakeholders. The KPTO service specification required NTOTA to develop and maintain effective and collaborative linkages with listed organisations in order to achieve maximum service effectiveness by reducing duplication of services. From the document review, staff and stakeholder interviews, it was clear that NTOTA had developed strong collaborative relationships with all organisations listed in the service specification.

In addition, the KPTO Coordinators occupied significant positions of authority and influence in key stakeholder collaborative groups, such as those listed in the table below.

Group name	Attendees	Position within group
<p>Removing Barriers Group</p> <p>Established: July 2013</p> <p>Purpose: Influence change in attitudes and behaviours with understanding and acceptance of people impacted by mental health and addictions in the Whanganui area</p> <p>Mental Health Awareness Week is the key health promotion activity for this group</p>	<p>Balance Whanganui (community mental health peer support organisation)</p> <p>Pathways (community mental health)</p> <p>Supporting families (family and whānau mental illness support organisation)</p> <p>Whanganui DHB – Public Health Centre</p> <p>Whanganui Community Living Trust (community-based support services for people with psychiatric disabilities)</p> <p>Mental Illness Survivor Team</p> <p>Whanganui DHB – Training Educator</p> <p>Te Oranganui Iwi Health Authority</p>	Chair
<p>Whanganui Prevention / Postvention Suicide Support Team</p> <p>Established: March 2011</p> <p>Purpose: A multi-agency networking forum on suicide prevention and self-harm</p>	<p>Police Māori Liaison Officer</p> <p>Victim Support Whanganui</p> <p>Child Adolescent and Family Mental Health Services</p> <p>Group Special Education</p> <p>Child, Youth and Family</p> <p>School Counsellor, Whanganui High School</p> <p>Youth Services Trust</p> <p>DHB Public Health Centre</p> <p>Women's Network</p> <p>Hinengaro Hauora</p> <p>Age Concern Whanganui</p>	Chair

Group name	Attendees	Position within group
	Project Marton	
Wellbeing and Suicide Prevention (WASP) ki Whanganui Established: August 2013 Purpose: Implement suicide prevention actions from the Safer Whanganui (run by Whanganui District Council) Results Based Accountability Scorecard	Whanganui District Council Whanganui DHB Fire Service Strengthening Families Balance Whanganui Support Families with Mental Illness Te Oranganui Iwi Health Board	Chair

As a result of these relationships, suicide prevention activity was prioritised across multiple agencies and community groups. Sections 3.2.4 and 3.2.5 discuss key outcomes of these relationships.

Planning and monitoring

The KPTO service specification required NTOTA to produce an annual service plan in consultation with key stakeholders. Over the evaluation period, NTOTA developed annual service plans that detailed key activities across the following four objectives:

- promote mental health and wellbeing for Māori
- reduce access to the means of suicide
- increase safe reporting of suicide by media
- contribute to improved mental health services for Māori.

These programme objectives represented four of the seven goals of the New Zealand Suicide Prevention Strategy 2006–2016 and the KPTO All Age Suicide Programme Logic Model. The plans highlighted key activities to achieve these objectives, along with anticipated short to long-term outcomes.

Key activities included identifying existing resources, whānau, individuals and agency support relevant to KPTO (including pharmacists, Whanganui District Council, Whanganui DHB, community mental health and other community organisations), establishing and maintaining relationships with key stakeholders, maintaining a presence at community events, and promoting and advocating suicide prevention.

KPTO Coordinators were asked for their views of the annual service plans and whether they had an input into plan development. Staff confirmed their involvement in developing and implementing the annual service plans. They reported that the Ministry of Health provided annual plan templates as well as six-monthly reporting templates that were aligned to them.

When asked how well the annual service plan reflected the directions in the All Age Suicide Programme Logic Model and Accountability Framework, staff reported the Ministry of Health's planning template reflected the All Age Suicide Programme Logic Model. Important activities aligned to several of the overall goals for the programme (Accountability Framework), including supporting Māori whānau to achieve their maximum health and wellbeing so they may experience physical, spiritual, mental and emotional health, and to have control over their own destinies. KPTO Coordinators reported that the annual planning process was upset by an inability to access relevant suicide data. They believed that access to suicide and attempted suicide data kept by Whanganui DHB would greatly assist the planning process.

Although NTOTA developed and implemented annual service plans throughout the evaluation period, KTCL was not provided with any documentation that evidenced the organisation's planning process, or main influences on the development of service plans or how activities were prioritised.

The document review process conducted for this service revealed little evidence that effective programme review and monitoring systems were in place. Staff reported that at the end of each health promotion session or workshop, each participant was asked to complete an evaluation form. Staff members were required to collect and collate the evaluation forms. With the exception of the Mental Health Awareness Week organised by the Removing Barriers Group, the evaluation team did not sight or review any further workshop or activity evaluations. Although NTOTA may use feedback on these evaluation forms to inform future planning and determine service improvements, the evaluation team did not sight or review any evidence of this practice.

Staff conducted service monitoring and presented the results in six-monthly progress reports to the Ministry of Health. These reports outlined the outputs and outcomes achieved, reported back on the service objectives and contained a narrative component, which included staff perspectives of how the activities were received and how they contributed to objectives of the programme. The reports also outlined how NTOTA believed its service met all requirements stipulated in the contract.

Staff performance monitoring was also conducted periodically. For KPTO Coordinators, it included staff development, which was linked to the KPTO staff workforce development requirements in the KPTO service specifications. It was clear that NTOTA prioritised workforce development for KPTO staff.

3.2.3 Process evaluation conclusions

Programme delivery and activities

The organisation was well known in the community as a reputable service provider, as evidenced in interviews with participants in the evaluation. Through key stakeholder relationships, KPTO staff encouraged others to prioritise suicide prevention and increase the number of related activities and programmes across the region.

Planning and monitoring

Many planning processes used in the service appeared ad hoc. However, the Ministry of Health planning and monitoring tools produced good results and many service objectives were achieved. The internal planning processes lacked direct contribution from key stakeholders and the community to which health promotion was targeted. In terms of building networks and extending relationships, it was clear that KPTO was a major influence in the suicide prevention and postvention landscape of the Whanganui region.

3.2.4 Impact evaluation findings

Community impact and alignment with objectives

Due to the health promotion aspect of the KPTO programme, it was difficult to determine whether results of workshops or a presence at community events led to positive changes for the community. Building strong networks was a critical element of the service and there was ample evidence of strong networks across multiple agencies and community organisations. The strength of these relationships was also reflected in the number of stakeholder participants agreeing to participate in this evaluation at short notice. The KPTO Coordinators had a notable presence in the community and among key stakeholder groupings. They chaired significant suicide prevention and postvention groups in the Whanganui region, including the Removing Barriers Group, the Whanganui

Postvention Support Team hui, WASP ki Whanganui, and the Safety and Wellbeing Steering Group (part of the Safer Whanganui group in Whanganui District Council).

Service integration was seen as another positive aspect of the organisation. KPTO Coordinators believed that all NTOTA services had the opportunity to refer clients on to other services and they did this frequently. A key example was the 'Yeah Hard' campaign, a positive social media campaign to promote healthy lifestyle options for people in the Whanganui region. The campaign, founded in June 2013, included collaboration between KPTO, Māori Problem Gambling and CAYAD.



Health promotion was about increasing awareness, knowledge and understanding of a specific topic and/or the impact of a health issue for an individual, whānau and the community. The evaluation found that, while the processes involved in the planning of the service were unclear, an annual service plan was always completed. While staff reported the community and stakeholders were involved in planning, there was no evidence of their direct involvement. It was clear, however, that indirect feedback from multi-agency forums influenced KPTO service planning. Some of the evidence for this link was that key actions in multi-agency forums aligned to annual service plans.

While the evaluation team did not sight planning systems and processes, it was evident that KPTO staff had strong community relationships and a robust understanding of community sensitivities surrounding suicide prevention. Some of the planned activities were designed to respond to community trauma (such as bullying or a spate of suicides and self-harm among rangatahi). Other activities, such as relationship management with key stakeholders, positioned KPTO staff as significant influences across the suicide prevention and postvention landscape of the Whanganui and Rangitikei region. As outlined in the six-monthly performance monitoring reports presented to the funders, many of the service objectives, goals or targets were achieved. All staff involved with the delivery of the KPTO health promotion had a good understanding of their role and what that role required – including a good understanding of the national strategy. KPTO Coordinators reported that stakeholder networks were a major strength for the service. A common consensus among stakeholders was that the organisation, specifically its KPTO programme, had an excellent reputation in the community.

Given time constraints the evaluation team was unable to meet whānau groups to find out about the impact of the service on them. However, when the evaluation team met with several key stakeholders (including government groups, community and non-governmental organisations), it enquired about their knowledge of the programme and invited them to describe what they perceived as the impacts of the KPTO programme. All participants engaged with the KPTO Coordinators to varying degrees. They overwhelmingly agreed that the KPTO programme was important, as was NTOTA's leadership in suicide prevention in the community. All stakeholders reported that the programme's performance and quality were high.

A representative from Whanganui District Council's Safer Whanganui described the critical role of the KPTO Coordinators in providing oversight of all suicide prevention activity on the Safety and Wellbeing Steering Group. With several partner organisations, KPTO established the WASP ki Whanganui forum to implement actions from the Safety and Wellbeing Steering Group. Following community hui in September 2013, KPTO staff and the Manager of Whanganui DHB Public Health services developed a Results Based Accountability Scorecard for suicide prevention activity. Through this partnership with key stakeholder organisations, including the Whanganui District Council, at least eight organisations agreed to increase support for prevention and postvention services and to

increase the number of workshops in the community. Through other collaborative forums, KPTO Coordinators and key stakeholders organised open public workshops to reduce the stigma surrounding suicide, as well as organising community concerts and Mental Health Awareness Week celebrations. Stakeholders reported that, while their impacts were difficult to measure, such activities increased awareness of signs and symptoms of suicide and provided resources to increase access to support for whānau demonstrating 'at risk' behaviours. One stakeholder interviewed reported that KPTO information and activities influenced the Māori health plan of their organisation.

Value to the region and the programme

From the document review, it was evident that many of the objectives outlined in the service specifications were achieved. However, face-to-face discussions with KPTO Coordinators made it clear that the six-monthly reports did not cover the breadth of activities led by KPTO Coordinators.

Over the evaluation period, KPTO Coordinators delivered educational workshops and presentations to mental health services, clients and community groups throughout the Whanganui and Rangitikei region. The workshops focused on recognising signs and symptoms of suicide and self-harm as well as wellness strategies. All workshops were tailored to suit the demographic of the specific community or group. Feedback from stakeholder groups was that key KPTO campaigns were effective. Stakeholders specifically mentioned the 'Yeah Hard' and 'Got Your Back' campaigns. Rangitikei College engaged KPTO Coordinators to deliver the 'Got Your Back' campaign in the school. The school reported that the campaign and workshops encouraged students to 'start the conversation' about suicide. It also reported that, in addition to talking about suicide, one male KPTO Coordinator engaged male students to speak about respecting women, anger management and self-harm. A disproportionate number of students (mostly male) had been self-harming but, the school reported, this number had decreased following KPTO engagement.

It was clear that KPTO Coordinators had an excellent reputation among stakeholders. The KPTO Coordinators were considered key leaders across the suicide prevention and postvention landscape and had considerable influence across the region. In a collaborative effort in 2012 KPTO staff and the Clinical Advisory Pharmacist / Pharmacist Facilitator began a campaign to engage key stakeholders to increase awareness around reducing access to medications through medication drops to pharmacies. A major barrier to the successful implementation of this campaign was the additional cost that pharmacies may incur for safe disposal of drugs, which led to some resistance from local pharmacies. However, some pharmacies now provide access to the safe disposal of drugs. In 2011 KPTO staff petitioned the Whanganui District Council, through the Safety and Wellbeing Steering Group, to reduce access to means of suicide by improving lighting and security cameras at sites of significance (high-suicide spots). As a result, the Whanganui District Council invested in better lighting and installed cameras at two high-suicide sites in the Whanganui area.

There was less evidence that the objective of increasing the safe reporting of suicide by the media had been achieved. However, the document review provided clear evidence of relationships between the KPTO team and Awa FM (the local Māori radio station). Engagement with Awa FM focused on encouraging whānau wellness. Although KPTO Coordinators identified opportunities to distribute suicide prevention information to the iwi via the radio station, lack of funding was a critical barrier. The 'Yeah Hard' campaign sought to provide positive messages around suicide prevention. A Facebook page was established to promote clear information on suicide and key signs and symptoms. The 'Yeah Hard' campaign also extended beyond suicide prevention to promote healthy lifestyle and wellness information for whānau in the Whanganui region.

Cultural competency

Although the evaluation sought to understand the cultural competency of the service, the only mention of responsiveness to Māori from this KPTO provider featured in the expressed intention to increase staff training to be more responsive to Māori. Stakeholders reported high cultural competency among KPTO Coordinators. When asked to elaborate, the majority of stakeholders acknowledged the KPTO leadership in tikanga during hui. KPTO Coordinators attended Te Whakauruora training but there was little evidence that they were supported to put this training into practice. Moreover, although NTOTA services were delivered in a culturally competent way through the team's commitment to tikanga Māori and Māori development, KPTO activities and campaigns did not necessarily reflect a Māori worldview. A possible reason may relate to the way the service specification was developed as the four key objectives for KPTO were generic rather than reflecting Māori views of suicide and suicide prevention.

Strengths and opportunities for improvement

The document review and stakeholder interviews reinforced the view that the KPTO Coordinators maintained strong relationships with key stakeholder groups. As a result of these relationships, key suicide prevention and postvention groups with clear objectives were developed. All stakeholders interviewed reported that KPTO Coordinators had a major influence on the suicide prevention and postvention landscape and, in many cases, facilitated or chaired the groups that were established in it. In one case in particular, the stakeholder reported that the KPTO programme influenced key activities in their organisation's Māori health plan.

3.2.5 *Impact evaluation conclusions*

Community impact and alignment with objectives

Overall the KPTO programme had a significant impact due largely to the strong multi-agency and community relationships. The organisation's services were seen as of high quality and respondents reported that KPTO Coordinators were accessible (beyond the 9 am to 5 pm traditional work day) and friendly. The promotion of the service, while good, needs to be improved as much of the information provided to clients was generic. The addition of information that was specific to the organisation or covered more kaupapa Māori aspects would be of benefit.

The majority of the service objectives were aimed at increasing community awareness about signs and symptoms of suicide and overall wellness. During the evaluation period, the KPTO programme influenced policy changes (including a Māori health plan), increased regional support for suicide prevention services, reduced access to means of suicide and delivered significant collaborative multi-agency/organisation activities. Because the four generic objectives for the KPTO programme did not reflect Māori views of suicide and suicide prevention, key activities in the annual service plan did not reflect Māori models of care or Māori views surrounding suicide and suicide prevention. Despite this concern, the KPTO programme was delivered in a culturally competent way by an organisation committed to Māori development and ensuring best outcomes for whānau.

Value to the region and to the programme

While KPTO Coordinators were positioned as significant leaders across the suicide prevention landscape, the annual service plan was not aligned to key suicide prevention documents such as the Safer Community Results Based Accountability Scorecard. Improved planning systems and processes will improve programme reach and effectiveness.

Cultural competency

The KPTO programme secured itself as a leader in the community around suicide prevention and postvention and, as such, had considerable influence in policy design and wider service delivery. More than eight organisations committed to increase suicide prevention activity, the District Council improved lighting and installed cameras at high-suicide spots and KPTO staff had a strong presence at community events.

Strengths and opportunities for improvement

Over the evaluation period, KPTO staff used innovative ways to promote mental health and wellbeing among Māori. In addition to delivering workshops and attending community events, KPTO Coordinators worked with key stakeholder groups to influence their engagement with Māori clients. One mental health provider reported that KPTO influenced the development of their organisation's Māori health plan.

3.3 Raukura Hauora o Tainui: South Auckland

3.3.1 Overview

KTCL undertook the Raukura Hauora o Tainui (RHOT) site visit on 30–31 July 2014. Careene Andrews and Arthur Selwyn from KTCL conducted this evaluation site visit and interviewed all staff members involved with the KPTO programme, including the Team Leader, two KPTO Coordinators and the Quality Coordinator.

The Quality Coordinator provided contact details for key stakeholders involved with the programme during the evaluation period, 1 July 2010–31 December 2013. Four of these stakeholders were available to participate in the evaluation: Te Wānanga o Aotearoa; Lifeline; Auckland DHB – Suicide Prevention Coordinator; and Community Action on Suicide Prevention Education and Research (CASPER). KTCL was also scheduled to meet with the Auckland City Council and Waitemata DHB but unfortunately interviewees were unavailable.

The Ministry of Health provided documents relevant to the evaluation, including annual reports, project plans and annual service plans. Documents reviewed on site during the visit in August 2014 included: Auckland DHB Suicide Prevention Coordinators Pilot Project – needs analysis report (2009); Ministry of Health Performance Monitoring Report (2011); three RHOT Annual Service Plans (2011/2012/2013/2014); Current Activities Report (2011/12); National KPTO Conference report (2012); RHOT Progress Report (2011); three Ministry of Health six-monthly feedback reports (2011, 2012, 2013); three RHOT progress reports (2012/2013); Mercer Netball Club Alcohol and Management paper; 18 supporting evaluations; multi-agency social inclusion action group minutes; and Papakura Council Social Services minutes (2012).

Limitations of the specific site evaluation

A significant limitation to this evaluation was the short time between the notification and commencement of the site evaluation. Originally the Northland KPTO providers were due to be evaluated in July, but unfortunately the flooding in the region made it necessary to change the evaluation logistical plan. RHOT was accommodating, rescheduling the site visit to an earlier date, but this meant time was insufficient to secure whānau participation in the evaluation.

Additionally, both KPTO Coordinators interviewed had not been employed during the entire evaluation period, 1 July 2010 to 31 December 2013. Therefore, neither could respond to all evaluation questions or respond in ways that were as meaningful as anticipated. KTCL did, however,

interview a former staff member who had unexpectedly popped in to the office and another KPTO Coordinator who had transferred from RHOT to another KPTO provider site. Nonetheless, process and service delivery information was limited for this evaluation.

3.3.2 Process evaluation findings

Programme delivery and activities

For the KPTO programme, RHOT had a service specification contract with the Ministry of Health. The 2011/12 KPTO Annual Plan had been developed with six objectives that aligned with the contract requirements of: developing policies to reduce harmful activities in the local community; delivering Māori suicide prevention training to community and mental health workers in Franklin and South Auckland; preventing mental health and wellbeing and prevent mental health problems; improving the care of people who were experiencing mental disorders associated with suicidal behaviour; reducing access to means of suicide; and undertaking a research project to improve the understanding of mental health behaviours. The 2011/12 current activities report provided evidence of progress towards the implementation of the action plan.

The 2011 RHOT progress report identified that the focus was on places in Papakura and Franklin communities that had been previously identified as priority areas after a suicide pandemic in the community in late 2010. In response, key activities included: the successful implementation of an alcohol management policy with Franklin Sports Club; a training programme rollout to Lifeline staff; engagement with the Papakura community with representation on the Papakura Council Social Services (PAPCOSS) executive – an interagency body mandated to advocate on social services and community issues for Papakura; and a skills-building initiative targeting young mothers.

PAPAKURA HIGH SCHOOL

A stakeholder praised the existing KPTO team on its coordination of a KPTO-led community project in Papakura High School. Students had been involved in a 'Hangman' game in which rangatahi were getting texts on how to hang or choke yourself, which sadly resulted in two suicides and 17 hospitalisations (over the Christmas period). KPTO staff went into the community and organised a hui at Papakura Marae which involved, among others, the New Zealand Police, Work and Income, Families Commission and Papakura Marae Society. KPTO staff also organised a separate hui with parents and whānau. The hui resulted in the development of a community action plan within three days and the Papakura community got involved. A 'Leadership in School' peer support programme was put in place with the commitment and support of the community. Leaders (students) were identified in the school and KPTO coordinated appropriate training for them. These students wore wristbands to identify themselves as leaders. The short-term outcome was a significant reduction in risky behaviour. After three years, the leadership programme was still running and the original leaders were volunteering their time to Lifeline. It should be noted that the wristband initiative was derived from the Kawerau Community Action Plan.

The 2013 RHOT progress report focused strongly on the report *Tihei Mauri Ora: Supporting whānau back to wellness*, along with continued engagement activities. The 2012/13 KPTO Annual Service Plan had been developed with key objectives that again aligned with the contract requirement: building Māori community capacity; delivering Māori suicide prevention training to whānau, hapū, iwi, hapori Māori and communities; establishing and maintaining strategic relationships with key stakeholders at local, regional and national levels; contributing to the development of Māori suicide prevention resources; attendance and participation at the youth mental health summit national conference; planning and implementing a performing arts initiative; involvement with social media; and undertaking a research project to improve the understanding of the content and effects of synthetic drugs. Interviews with former KPTO staff and document reviews confirmed that the annual service plans were used to guide the implementation of the KPTO programme, along with contract compliance.

Achievement of the KPTO programme outcomes, which were aimed at promoting mental health and wellbeing for Māori, was outlined in the annual service plan. When asked about their suicide prevention activities, KPTO Coordinators advised that the introduction of Whānau Ora had led to a broader focus on the wellbeing of Tainui people or people living in the area. While KPTO Coordinators concentrated on mental health and wellbeing, they also aligned other service contracts to provide a whānau ora service. KPTO Coordinators commented that their focus was on collaborations using existing services with RHOT, such as their addictions, youth justice and nutrition teams.

‘We do a lot of work with our CAYAD team and vice versa. There are a lot of synergies with both of our services.’ (KPTO staff)

Service partnerships

RHOT developed strong partnerships with key community stakeholders. The 2012 RHOT progress reports provided information on engagement with the Māori caucus of Injury Prevention Network of Aotearoa New Zealand (IPNANZ) and Counties Manukau DHB Interagency Steering Group, supporting the ‘What’s on your plate’ mental health project and the Wairua Netball Club. Staff interviews with former KPTO staff confirmed that agencies involved in engagement activities included IPNANZ, PACCOSS, Counties Manukau DHB, Manukau Police, Auckland City Council, Papakura High School, Mercer Netball Club, Te Wairua Sports Club, Māori Women’s Welfare League, Mental Health Foundation and SPINZ as well as other providers and agencies.

‘Noradean and Mariameno [former KPTO staff] raised good awareness through being on various advisory groups.’ (KPTO staff)

‘Would like a better relationship [for Lifeline] with KPTO; however, only 5–7 percent of Lifeline callers identify themselves as Māori.’ (Stakeholder)

In addition to the above groups, the KPTO Coordinators occupied significant positions of authority and influence in key stakeholder collaborative groups such as the Lifeline reference group, IPNANZ, PACCOSS, Te Matatini Waka Hourua advisory group and the iwi advisory forum.

Both current KPTO Coordinators have recently undergone an induction and orientation programme. They considered that the KPTO induction manual (recently developed by Ngāti Pikiao) was beneficial and clarified definitions of roles. The development of the manual, however, was in its early stages and staff felt this process should be coordinated at a national level.

‘Training should include the core values of the tanga’s. Media training on how to kōrero to media would also be of benefit.’ (KPTO staff)

‘While KPTO is called a suicide prevention service, our approach is about mental wellbeing (and stress preventers) and positive contribution to society.’ (KPTO staff)

‘The ASIST [Applied Suicide Intervention Skills Training] programme is a mainstream suicide prevention training programme purchased from a Canadian-owned company and is not suitable for Māori.’ (KPTO staff)

Planning and monitoring

As both KPTO Coordinators had been in their roles for less than three months, they had not been involved in any planning processes during the evaluation period. One of them did, however, contribute to the RAID Movement while working in the Northland KPTO team, which also informed the RHOT Annual Service Plan.

THE RAID MOVEMENT

One KPTO staff member was originally involved in the development of the RAID Movement that was presented to Tariana Turia, former Associate Minister of Health. The objective of RAID is to celebrate life and show why life is good – ‘Life over everything’. Its mission is to rid New Zealand of the issue of youth suicide. It aims to offer the support and comfort young people need to realise that life is the most important gift of all. A small group of young people promote the messages and are looking to change the world, one school at a time. The initiative promotes any and all ideas that come from youth.

Although the current KPTO Coordinators were also only in the early stages of planning activities for the current year, they did need to consider the coverage area in the review of their plan. Staff expressed concern that the population in Auckland and Tainui was 1.7 million (with no other KPTO provider sites in Auckland) while the Northland and Rotorua regions covered populations of 120,000 and 70,000 respectively.

‘Maybe Waka Hourua strategies that work could be merged into KPTO and activities can be identified to address the gaps in the regions that have no KPTO teams.’ (KPTO staff)

‘We are currently looking at developing a marae database for South Auckland.’ (KPTO staff)

‘As part of our whānau ora planning, we are currently working on a whānau reference group.’ (KPTO staff)

‘I would love to build the capacity of Māori men within the justice sector – including developing policies around tikanga.’ (KPTO staff)

In brief interviews, former KPTO Coordinators advised that research materials were used to inform planning activities. The impact experienced when eight people took their lives in Manurewa and Papakura also informed the planning activities. KPTO Coordinators commented that they were aware of community feedback evaluations being used for planning but no documentation could be reviewed to validate this practice. The document review process conducted for this service also revealed little evidence that effective programme review and monitoring systems were in place.

The Auckland DHB Suicide Prevention Coordinator commented that using the regional suicides trend report could add significant value to planning a coordinated approach with the KPTO programme. KPTO Coordinators similarly commented that there was no central point of reference for information, including ‘hands on’ statistics for KPTO as a national programme.

Staff conducted service monitoring, using the results in six-monthly progress reports to the Ministry of Health. These reports outlined the outputs and outcomes achieved, reported back on the service objectives and contained a narrative component. The Ministry feedback report confirmed that the RHOT progress reports were well written and had a structure that was easy to follow in identifying objectives achieved over each six-month period.

3.3.3 Process evaluation conclusions

Programme delivery and activities

The document review showed that the KPTO programme continued to meet service objectives, which appear to be driven by community and priority needs. A few of its activities have been in response to suicide pandemics. The Papakura High School project highlighted how efficiently and effectively the KPTO programme can bring together a community and respond to a suicide pandemic. The Kawerau project was an enabler that supported the Papakura High School project: as former KPTO Coordinators commented, learnings from such events helped inform future planning.

The former KPTO Coordinators occupied a number of significant positions of authority and influence in key stakeholder collaborative groups. This representation enabled the KPTO Coordinators to ensure that suicide prevention activities and messages were prioritised as key strategies with external stakeholder groups.

It is noteworthy that one of the KPTO Coordinators had been heavily involved in the RAID Movement while employed with Ngāti Hine Health Trust. Although the staff member downplayed their contribution, other provider site visits confirmed that their role in the establishment of RAID had been critical. Stakeholders in Northland commented that the RAID Movement was having a positive impact on youth.

Planning and monitoring

Both KPTO Coordinators interviewed had not been employed during the entire evaluation period so they could not describe the planning processes that had contributed to the development of RHOT's annual service plans. Although brief interviews with former KPTO Coordinators commented that programme evaluations and feedback contributed to planning and monitoring activities, KTCL were unable to sight evidence of this process.

3.3.4 Impact evaluation findings

Community impact and alignment with objectives

Given the time constraints, the evaluation team was unable to meet whānau groups to find out about the impact of the service on them. However, the evaluation team met with a few key stakeholders (including government groups, community and non-governmental organisations). Stakeholder participants were asked for their views on the KPTO service and its impact on them. One participant had not been aware of the KPTO service until KTCL had contacted them; another only heard about KPTO after speaking with SPINZ and was unsure of what the KPTO programme delivered. The remaining stakeholders were aware of KPTO, mainly due to a project in which both parties were involved. All of the following comments were expressed from the interviews with stakeholders.

'I originally did not know who they were until I had made contact with SPINZ a few years ago.'

'There doesn't appear to be any visibility [in the mainstream sector] of KPTO and what's been achieved or what are the learnings over the past 12 years.'

'Do they work with Māori?'

'I did some research on KPTO after receiving your [KTCL] phone call to organise the interview. Otherwise I was not aware of the service.'

'If they [the KPTO team] were to promote their service better, or in a more structured and cohesive way, that would be great. I suggest a national coordination service to produce a marketing strategy to improve service visibility, consistency in communicating key messages and sharing resources.'

'We need to build a brand like "It's not OK", maybe "You can talk to me".'

'Across the nine sites KPTO should have some type of practicality.'

One stakeholder who was involved with the Papakura High School project praised the existing KPTO team for its critical role in leading and coordinating this community project. KPTO had played a

critical role in leading this project. The initiatives continued to be implemented. Another stakeholder identified the Mercer Netball Team alcohol management policy as another positive project, although it was not exclusively developed as a KPTO-led initiative.

As an iwi charitable trust located in Manukau, Auckland, RHOT endeavours to deliver KPTO services across the Counties Manukau DHB boundaries. The large area lies between Kaiaua in the east, Port Waikato in the west, Pakuranga in the north and Manukau in South Auckland. According to 2013 census data, the total Māori population for Manukau City alone was 47,346, which was the largest Māori population size out of the 73 districts in New Zealand. The recently employed KPTO Coordinators commented that they were concerned about how much impact they could make in such a big region.



From the document review, it was evident that many of the objectives outlined in the service specifications were achieved. However, due to the limited stakeholder and KPTO Coordinator engagement during the evaluation, KTCL was unable to verify this.

Value to the region and the programme

The consensus among all participants was that the KPTO programme was important, particularly in relation to engaging with Māori. Some identified that the resources available for providing suicide prevention services for Māori was limited. However, there was clearly a need for a much stronger emphasis on increasing awareness and understanding of the KPTO programme in the region.

Both of the former KPTO Coordinator's occupied significant positions of authority and influence in key stakeholder collaborative groups such as the Lifeline reference group, IPNANZ, PAPCOSS, Te Matatini Waka Hourua advisory group, and the iwi advisory forum. The current KPTO Coordinator commented that this representation was vital in terms of raising the profile and implementing KPTO

programme activities. A representative from Lifeline stated that KPTO participation was valuable, strengthening the relationship between the two organisations and their collaborative activities.

Based on stakeholder feedback from the Northland KPTO evaluations, the RAID Movement had a positive impact on the community. One of the current KPTO Coordinators was heavily involved in the establishment of this initiative, which KTCL foresees as playing a major role in the KPTO programme in the future.

Cultural competency

RHOT is an iwi-based trust that is heavily underpinned by tikanga practices. Building the capacity of cultural competency both internally and externally is a key element of the organisation. Little evidence could be obtained about the cultural competency of the programme due to the limitations of the evaluation.

Strengths and opportunities for improvement

The stakeholder interviews showed that awareness of the KPTO service was limited. One participant, who worked for a nationwide programme, was not aware of the KPTO service until KTCL had made contact with them. After doing some research, this participant found a number of KPTO resources but only limited information on how KPTO was delivering outcomes. Another participant had only recently heard about KPTO after speaking with SPINZ.

In addition, the former KPTO Coordinator commented that the KPTO programme has undergone a number of changes since its inception, resulting in varying models of delivery and diluting the clarity of the original programme.

KPTO-led or community-led initiatives such as the Papakura High School project and the RAID Movement had the biggest impact on the community in terms of suicide prevention. In addition, the presence of KPTO staff on key groups and forums appeared to contribute strongly to achieving the objectives of the programme.

Some of the KPTO Coordinator comments below indicate there was room for improvement in building the capability of KPTO Coordinators and the coordination of the programme.

‘While KPTO is called a suicide prevention service, our approach is about mental wellbeing (and stress preventers) and positive contribution to society.’

‘The ASIST programme is a mainstream suicide prevention training programme purchased from a Canadian-owned company and is not suitable for Māori.’

‘The Ministry should bring all suicide prevention strategies together and [a] regional team should be established to bring all parties together.’

‘The KPTO national teleconference is not working – we can’t see each other.’

‘The Ministry of Health has been very good and accessible but we haven’t seenlately and he adds good value in understanding KPTO. It would be good if the Ministry were more than contract managers.’

As both KPTO Coordinators had been in their roles for less than three months, they could not contribute significant information on the evaluation period. However, they did wish to discuss their plans for improving or developing the KPTO programme. Activities that were to form part of their planning processes in the future included:

- delivering a Māori suicide campaign that is created and led by youth, which could include a performing arts initiative – *‘Youth are so vulnerable these days and social media has had a big impact but our youth don’t have the tools’*
- developing and implementing a kaupapa for manaaki whānau to understand their identity in terms of whakapapa, mātauranga and tikanga Māori
- implementing the RAID Movement as a nationwide strategy while appreciating that research evidence is required first
- supporting the key role of iwi, hapū and marae in promoting mental wellbeing with whānau, particularly by connecting kaumātua with rangatahi which was a need confirmed by one stakeholder
- developing a resource tool to educate whānau, hapū, iwi and hāpori on suicide awareness and prevention. This could include a digital resource for schools – *‘ideally a tool on the cellphone like an AP ... this saves throwing away paper resources’*
- focusing on influence at a Government level – *‘We need a champion like [former] Minister Jim Anderton and [former] Minister Tariana Turia’*
- implementing a national body rather than having nine different ‘headships’, each with its own different flavour. The national body could provide one heart, one mission and one vision, measure strategies and coordinate the ‘right’ flavour, which could be aligned to Whānau Ora outcomes
- building community champions to work in schools and build the capability of parents as educators.

3.3.5 Impact evaluation conclusions

Community impact and alignment with objectives

Although RHOT was a well-established service with a relatively long history, awareness and understanding of the KPTO programme were limited. One of the respondents agreed that the reasons for this may be the extensive area the service had to cover and the lack of understanding among stakeholders and the community of what the service was actually resourced to do. Two stakeholders also commented that the mainstream sector lacked clear information about KPTO service provision. After undertaking a considerable amount of online research, one stakeholder was unable to locate any information about the outcomes from the delivery of KPTO services. All respondents advised that the KPTO programme should increase its exposure through some type of national coordination.

Value to the region and the programme

The consensus among all participants was that the KPTO programme was important, particularly in relation to engaging with Māori. Establishing, building and maintaining relationships was identified as a critical element for KPTO. Previous KPTO Coordinators held roles on key advisory groups which raised awareness of suicide prevention and strengthened relationships.

Cultural competency

Little evidence could be obtained about the cultural competency of the programme due the limitations of the evaluation. Early planning activities for the new KPTO Coordinators were, however, strongly focused on marae and Māori engagement activities.

Strengths and opportunities for improvement

Localised community projects such as the Papakura High School collaboration highlighted how efficiently and effectively KPTO can bring together a community and respond to a situation. Due to

its limitations, the evaluation was unable to identify how the learnings from such projects can be aligned to the suicide prevention environment which could inform how postvention projects can move or transform into the prevention awareness efforts. Similarly, the RAID Movement was another project that successfully brought youth together with a focus on treasuring life.

The current KPTO Coordinators occupied a number of significant positions of authority and influence in key stakeholder collaborative groups which has strengthened relationships.

As the KPTO programme was delivered across a large region, not all areas were receiving support due to the limitations of resourcing and travel distances. The lack of service provision for suicide prevention in Auckland meant that the reach of the programme and awareness of the programme were limited.

Building the capability of KPTO Coordinators was identified as an area to improve on from a national perspective. Respondents offered various training solutions, but there was no central coordination of what would be of most value or critical in the KPTO role. It was suggested that the Ministry of Health invest in developing a structured skills and knowledge training programme for KPTO Coordinators that was specifically linked to the suicide prevention objectives.

3.4 Te Rūnanga o Ngāti Pikiao Trust: Lakes District

3.4.1 Overview

KTCL undertook the site visit of Te Rūnanga o Ngāti Pikiao Trust (TRONPT) on 4–5 August 2014. Careene Andrews and Duncan Andrews (kaumātua) from KTCL conducted this evaluation site visit and interviewed all staff members involved with the KPTO programme, including the General Manager, KPTO Project Leader and KPTO Coordinator.

The KPTO Project Leader provided contact details for key stakeholders involved in the programme during the evaluation period, 1 July 2010 – 31 December 2013. Six of these stakeholders were available to participate in the evaluation: Lakes District Health Board; Te Waariki Purea Trust – Safer Families Coordinator; Hinetitama Research Project; Tūwharetoa Whānau Ora; Turangi Safer Community; and a whānau member.

The Ministry of Health provided documents relevant to the evaluation, which included performance monitoring reports, project plans and service action plans. Documents reviewed on site included: *Te Whakauruora: Restoration of Health: Māori Suicide Prevention Resource*; Tihei-wa Mauri Ora resources, TRONPT Waka Hourua Project Plan (2014); Taupo and Reporoa community networking evaluation report (2014, in conjunction with Key to Life Charitable Trust); TRONPT KPTO induction manual; Community Action Plan Report (2012); Gifts from the Past (2014); 'Check it out' pocket resource and developmental material; Mental Health Services in the Lakes District Panui (2014); KPTO National Suicide Prevention Conference; KPTO Strategic Plan (2013–2016); document of the history of TRONPT; TRONPT KPTO Service Plan (2009/10); two TRONPT KPTO quarterly reports to Ministry of Health (2009/10); TRONPT Strategic Plan (2010–2015); KPTO Annual Plan (2010/11); five Ministry of Health feedback reports (2010–2014); TRONPT KPTO six-monthly reports to Ministry of Health (2010, 2011, 2012, 2013); TRONPT Annual Plan (2011/12, 2012/13 and 2013/14); and the AEIOU resource and supporting material.

Limitations of the specific site evaluation

Two scheduled interviews with whānau were sadly cancelled due to a tangihanga. However, these potential participants were provided with the link to the stakeholder survey which they could respond to if they wished at a later time.

3.4.2 Process evaluation findings

Programme delivery and activities

The KPTO Coordinators developed annual service plans in accordance with the contract service specifications, New Zealand Suicide Prevention Strategy, New Zealand Suicide Prevention Action Plan, *Te Whakauruora: Restoration of Health: Māori Suicide Prevention Resource* (2009) and the Whakamomori i a Ngāti Pikiao Scoping Project (2005). The document review provided evidence that linked activities to the KPTO strategic objectives. The Ministry of Health's feedback was that the KPTO programme continued to meet service objectives and achieve good outcomes with community groups and whānau.

The KPTO programme employed two full-time Coordinators, one of whom was one of the longest-serving KPTO Coordinators in the national KPTO programme and continually advocated nationally for KPTO. Both KPTO staff worked across the Lakes District, taking a flexible approach to split their resourcing across the Tūwharetoa rohe and Te Arawa rohe. This KPTO programme emphasised community development and community-driven actions.

'We try to work with champions or effective providers who are able to push our kaupapa best.' (KPTO staff)

The participation of KPTO staff in relevant national advisory groups over the years had been critical to keeping the KPTO agenda as a consistently high priority. For example, staff spoke at local and regional conferences and had strong representation on key committee groups such as Ministry of Social Development, SPINZ (although this was currently on hold), Mental Health Foundation, Te Rau Matatini, KPTO Strategic Planning team, media forums, postvention advisory group and Safer Communities Leadership Group. Some existing advisory groups such as the Ministry of Youth Development postvention group, Taupo injury prevention group, psychiatric emergency team forum and the Rotorua Youth resilience centre were disestablished. KPTO Coordinators commented that sitting on different groups was a more effective way of getting KPTO's key messages out to the community. Their participation in national advisory groups allowed a Māori voice to be heard at a national level and helped to bridge the gap between the mainstream sector and the KPTO programme. However, KPTO Coordinators were concerned that some participants around the table were merely ticking the 'Māori box'. The Ministry of Health documents commended TRONPT for its efforts and commitment to the kaupapa of KPTO. One of the Ministry's specific comments was: *'Collaborating with key agencies, advocating at strategic levels, and working closely with whānau has been consistently reported over the entire evaluation period which demonstrates service quality and consistency.'*

KPTO Coordinators commented that the relationship with the Lakes DHB Pou Whakarite Momori Suicide Prevention Coordinator was challenging due to high staff turnover and personality clashes. Irrespective of these challenges, both parties were passionate about the kaupapa and attempted to meet on a fortnightly basis. During the evaluation period, KPTO Coordinators had to re-establish this relationship four times.

'I feel sometimes that the mainstream system is failing Māori.' (KPTO staff)

KPTO Coordinators participated in and supported the following events: Te Arawa Men's Health Day managed by the Rūnanga, with messages around coping with depression; community awareness

wānanga delivered to various communities; Project Lighthouse in Taupo; RAID Movement; RATS; Kaingaroa provider community workshops; mental health forums; Te Rau Matatini hui; Mike King presentations; and sports events.

Another focus was on engagement with whānau, hapū and iwi in Te Arawa. KPTO staff led a marae-based wānanga initiative after people were exposed to suicides among their whānau, including an 11-year-old girl. The KPTO team obtained Ministry funding to deliver a programme that supported whānau, hapū, iwi and Māori communities in making decisions when working with communities at the time of death by either suicide or trauma. The objective of the wānanga, which were attended by 15–25 participants per four marae, was to enable whānau to talk more about suicide rather than be fearful of doing so. Another goal was to move the community to a more strengths-based approach of empowerment and building champions. A toolbox, tailored for each marae, included resources, a symptoms checklist and material to help whānau with coping strategies. The challenge for this initiative was that it was not well supported by mainstream partners, as KPTO Coordinators noted.

Other effective community events included the Kaingaroa Village Trust community project in workplace settings and the Reporoa Health Clinic resiliency programme. However there was a perceived gap when working with the Ministry of Education and Education Review office. The approach tended to focus reactively when traumatic incidents occurred, rather than proactive and preventative activity with young students.

KPTO Coordinators supported either the development of resources or the distribution of them in the community. These resources included ‘Check it out’ pocket resource, suicide assessment tool for Lakes DHB, AEIOU tool which included interest from Australia (a good, compact and available resource), marae toolkit and media toolkit. Although these were valuable resources, coordination was needed to collate them along with key strategic documents, to continue to distribute them and to renew them and maintain their validity.

In addition to service provision, TRONPT (with support from others) developed the KPTO induction manual, which was reviewed on site. The recently recruited KPTO Coordinators in Auckland commented that the induction manual was very useful. The manual explained public health versus personal health as well as the KPTO strategic objectives, annual planning and Māori models of health. KPTO Coordinators included the public health context in the induction manual as there appeared to be some confusion around why suicide prevention sits in the public health portfolio.

‘We are prevention focused but we sit in the public health context. Further clarity is required in terms of our role. We do strategies that reach the population but are not meant to be at the forefront.’ (KPTO staff)

When Te Whakauruora training was available, it was managed and delivered by Te Rau Matatini with the support of KPTO Coordinators. The training was reviewed by KPTO Coordinators to produce a reduced version for delivery to agencies, which included an explanation of how Māori see suicide differently from the mainstream view. KPTO Coordinators took part in radio interviews to promote information about the support available and the differences between clinical services and KPTO.

Among their general comments, KPTO staff noted the benefits of the KPTO national hui, as indicated by the increase in numbers attending. The change to allocating one day to community and one day to KPTO had proven to be successful. On the flipside, they saw the KPTO teleconference as ‘not an effective use of time’ as some did not participate or were selective about the ones they participated in. Finally staff considered that the programme’s relationship with the Ministry of Health was ‘good’ but it was more of a contract relationship than a well-developed collaborative process.

Planning and monitoring

KPTO Coordinators had effective planning and monitoring systems in place. They used recent data from the coroner to help inform planning activities. From this data, they could identify their local statistical information: their region had a population of 120,000, of which 35 percent were Māori. Māori suicides in the Lakes District fell from 17 in 2011 to two in 2012 and then three in 2013. KPTO staff access this data regularly, using it to plan and prioritise effectively. The programme would benefit from having someone in a coordination role to capture this data nationwide.

KPTO Coordinators advised that a needs analysis document was completed in April 2010 which was informed by an engagement hīkoi across the rohe. This identified trends and information to use in developing the annual service plan. KPTO Coordinators commented that the needs analysis showed awareness of KPTO and its activities was limited, as well as indicating that whānau did not know where to go for support. The evaluation team reviewed the 2012 Community Action Plan report, which was another document that informed the most recent annual service plan. The plan included recommendations to improve Māori suicide prevention. Also reviewed were two other evaluation reports on the Mike King presentations, as was community and school feedback to add value to community networking events. Sitting on numerous forums also helped to inform their planning processes. KPTO Coordinators had received Ministry of Health training in the All Age Suicide Programme Logic Model which links to the KPTO strategic plan.

The KPTO programme obtained funding from Te Puni Kōkiri to evaluate the three-day Māori suicide prevention wānanga in marae. The results of the evaluation were valuable, showing that it was well received overall. However, limited funding meant that a more in-depth analysis could not be made. An evaluation of the marae tool was also conducted and evidenced by the Ministry of Health through the document review.

3.4.3 *Process evaluation conclusions*

Programme delivery and activities

The KPTO programme met service objectives and achieved good health outcomes with community groups and whānau. It emphasised community development and community-driven actions. Much of its delivery was concerned with crisis prevention and working with government agencies to operate better with Māori. Important areas of focus for KPTO Coordinators were on collaborating with key agencies, advocating at strategic levels and working closely with whānau – an approach that demonstrated quality and consistency of service. A number of activities were undertaken to bridge the gap between mainstream agencies and KPTO.

It was critical that the engagement activities of the KPTO programme recognised the cultural distinctiveness of whānau, marae, hapū and iwi and this recognition was evidenced throughout the evaluation report. KPTO staff had taken a number of whānau engagement initiatives.

KPTO Coordinators were heavily involved in building the capability in the region as they conducted several training workshops, some of which were beyond the requirements of their role. They were also involved in or supported resource development, both regionally and nationally – such as in the development of the KPTO strategic plan and induction manual.

Being a well-established organisation with a relatively long history added strength to the KPTO kaupapa. However, according to some stakeholders interviewed, there was still some confusion about what the KPTO programme actually delivered given the extent of its activities.

Planning and monitoring

KPTO Coordinators had effective planning and monitoring systems in place as evidenced in their numerous evaluations, needs analysis, coroner data analysis and representation on various forums. A number of processes used in the service informed the development of the programme work plan. The Ministry of Health planning and monitoring reports were seen as useful and the programme could use them to determine that many service objectives had been achieved. Although key external stakeholders and the community did not contribute directly to internal planning processes, participants welcomed the opportunity for further engagement on this element of the KPTO plan.

The document review provided evidence that the service reports were well aligned to the national Accountability Framework and All Age Suicide Programme Logic Model.

3.4.4 Impact evaluation findings

Community impact and alignment with objectives

Much of the KPTO programme's delivery concerned crisis prevention and working with government agencies to better operate with Māori. All stakeholders confirmed that they were aware of KPTO staff but there appeared to be confusion about what those staff actually deliver. Although two respondents commented that KPTO staff were well connected with the community, what this connectedness looked like needed to be clarified. Another stakeholder advised that KPTO staff regularly provided valuable resource information but that further collaborations were needed to ensure that their networks were aware of the support that was available from the KPTO programme. Some of the network members only knew of KPTO because the DHB told them about it.

'I have never seen information on what the KPTO role is.' (Stakeholder)

'I don't understand what they do. Are they about strategy and not prevention? It appears the messages are more strategic messages.' (Stakeholder)

'What do they do and where do people go?' (Stakeholder)

Four stakeholders made similar comments that the profile of KPTO was missing and that it needed a formalised structure as it did not seem to sit anywhere, particularly regionally. A whānau member also was not aware of the KPTO programme but knew one of the KPTO Coordinators. One stakeholder commented that attendance from the KPTO Coordinators at their own forums was fairly limited and that they were keen to work collaboratively as the KPTO programme had a similar agenda to the stakeholder's organisation. During interviews, KPTO Coordinators acknowledged that awareness of the programme was mixed but that this trend was evident at all levels (including the Ministry of Health).

'Is it [the KPTO programme] sitting in the right structure? Should KPTO sit inside a hapū organisation and is that the right thing for the hapū?' (Stakeholder)

'The marae initiative was very valuable and the concept of the wānanga was fantastic to be able to talk openly about suicide.' (Stakeholder)

One stakeholder identified the need to increase their own capability to better support bereaved whānau. As a result of KPTO training for staff and community groups, 10 facilitators were now qualified to deliver the training. However, during the training a stakeholder observed that some of the facts in the presentations were incorrect and that it was essential to present accurate information. KPTO Coordinators also provided training to their own general practitioners and nurses on trends in Māori suicidal behaviour. Comments suggested that a number of KPTO activities went

beyond the Coordinators' roles and these activities should be acknowledged. Two stakeholders commented that KPTO leadership went beyond its programme contract obligations and funding parameters.

Without being prompted, two stakeholders commented on possible alignment to Whānau Ora and Waka Hourua. One stakeholder noted that suicide prevention objectives would be better achieved if KPTO and Waka Hourua were interwoven. The other identified definite synergies between KPTO and Whānau Ora.

'We need to build on the learnings from the past and focus on the right things that make the biggest difference.' (Stakeholder)

'KPTO needs to dovetail into Waka Hourua as it needs a home.' (Stakeholder)

Value to the region and the programme

KPTO staff had strong representation on a significant number of advisory forums, iwi forums and regional and national steering committees, as evidenced in the document and stakeholder interviews. They consistently collaborated with key agencies, advocated at strategic levels and worked closely with whānau over the entire evaluation period. All stakeholders confirmed that KPTO Coordinators were well connected and therefore were adding value to the communities in the region. One stakeholder complimented the KPTO staff on their innovative step of 'creating spaces to have a kōrero' with individuals in the workplace.

Another stakeholder felt that the KPTO programme should focus on building resilience such as through keeping community gardens and developing community neighbourhoods to strengthen local communities so that they can take care of themselves. One stakeholder thought there must be gaps around the country that the KPTO programme could fill as a colleague of theirs in another region felt they could benefit from it and did not know it was a national programme. The stakeholder suggested that a national body could support getting the word out about KPTO in all regions. One stakeholder commented that 'KPTO empower you to come up with your own initiatives' and also shared the following whakaaro:

'They share concepts and resources to help you on your way, and they let you adapt things to fit your area. Like they gave a whole lot of their resources for free! They gave opportunities to learn more about whakamomori. The best thing about it – they came from a kaupapa Māori perspective. Before them, it was mostly the DHB coming in and "ticking the box", or taking more out – e.g. what can we do for them, more than giving – e.g. what can you [the DHB] do for whānau here in our rohe?'

Cultural competency

Since the inception of the Rūnanga in 1987, its core business has been to support iwi, hapū and whānau of Te Arawa and Tūwharetoa, including Kaingaroa and Mangakino. The evaluation found significant evidence that the KPTO staff were culturally competent in their service provision and that external stakeholders working with them acknowledged and respected this.

Another focus has been on engagement with whānau, hapū and iwi in Te Arawa. KPTO staff led a marae-based wānanga initiative after people were exposed to suicides among their whānau. They developed a marae toolbox, which was tailored for each marae and included resources, a symptoms checklist and material to help whānau with coping strategies.

'Our key point of difference is working with Māori.' (KPTO staff)

One stakeholder shared their own whakaaro in relation to this evaluation finding:

'Whakamomori – focus should be on aroha and light, instead of dwelling on the dark places [rom Ngāti Pikiao]. Te Takinga used the following analogy, based around marae fortifications and their job – defending the whānau of the marae. Traditionally the whare was built on top of the maunga, not at the bottom. So for whakamomori, we needed a change of thinking. Remove the shame and the stigma traditionally associated with whakamomori – “No, they’re not lying on the marae or going to the urupā. They didn’t want to live with us, they don’t deserve to be buried with us.” Or, “It’s the family’s fault. Where were you?” Whatever happened, the whānau pani need to be supported. Instead of climbing up from the bottom, put them at the safest place, the marae up the top of the maunga. The maunga is the base. Build some fences, fortifications around it – this is done by talking about it instead of hiding or smothering it like it never happened.'

Strengths and opportunities for improvement

The document review confirmed that the KPTO team maintained strong relationships within the community and was well connected. KPTO Coordinators also played a key advocacy role in the range of events and forums they attended or participated in. One suggestion for improvement was for the programme to build resiliency in the community through community-based activities and initiatives that brought people together to work on them. Two stakeholders suggested that the KPTO programme might align with Whānau Ora and Waka Hourua so that local and national strategies being implemented in Māori communities could work together. Another suggestion was for more national exposure of KPTO so that all regions of the country knew the programme was available in their own region.

3.4.5 Impact evaluation conclusions

Community impact and alignment with objectives

Overall the KPTO programme had a significant impact due largely to the longevity of staff members and the strong multi-agency and community relationships. The promotion of the service, while good, would benefit more if information provided was more than at a strategic level. Some stakeholders commented that more emphasis could be placed on building community resilience.

Building and maintaining strong relationships in the community has been a critical element to programme delivery for TRONPT which aligns well to the objectives of the programme. The KPTO Coordinators had a notable presence and connectedness with the community and this was seen as a particular strength. The service had a relatively substantial impact due largely to the strong marae-based relationships but there was room for improvement in profiling the programme among agencies and ensuring everyone understood the role of the KPTO programme.

Value to the region and the programme

KPTO Coordinators were positioned as significant strategic leaders across the suicide prevention landscape and therefore adding value to the communities in the region. While holding strong representation on a number of advisory forums, iwi forums and regional and national steering committees, KPTO Coordinators were also key drivers of raising the profile and creating opportunities for the future development of the KPTO programme.

The KPTO Coordinators regularly provided resource information and the marae toolkits for wānanga which, according to two stakeholders, were highly valued. The document review and two stakeholders confirmed that KPTO Coordinators undertook regular training for the benefit of the

programme. Some stakeholders commented that their activities went beyond their programme contract obligations and funding parameters.

Cultural competency

The evaluation provided significant evidence that KPTO staff were culturally competent in their service provision and that their knowledge, expertise and competence were acknowledged and respected. As a well-established and well-connected organisation in the region, the KPTO programme had significant strength and ability to reach into the Māori community. However, it was noted that KPTO is not a front-line service based on individual clients, which often caused confusion among external stakeholders about what it was expected to achieve.

Strengths and opportunities for improvement

Over the evaluation period, KPTO Coordinators used innovative ways to promote mental health and wellbeing for and among Māori. The document review and stakeholders confirmed that the KPTO programme maintained strong relationships within the community and was well connected. Some stakeholders felt that KPTO Coordinators' connectedness with the community was a particular strength. However building the resiliency of the community could be a key focus for the programme in the future.

KPTO have regularly provided had input into key KPTO strategic discussions, documents and resources. In addition to this, KPTO Coordinators also provided training to the community, all of which goes beyond their role. Through conducting training workshops, KPTO Coordinators were heavily involved in building community capability in suicide prevention in the region. They seemed to complete some of these workshops beyond the requirements of their role.

KPTO staff of TRONPT had been involved in or supported the development of key KPTO strategic and orientation documents. They therefore shared their whakaaro on what an effective KPTO programme structure could look like. In particular, they considered that it would involve:

- identifying, establishing and maintaining effective relationships that encourage collaborative projects to raise awareness of suicide prevention
- maintaining representation on key advisory forums to ensure the KPTO agenda was well exposed both regionally and nationally
- maintaining the KPTO programme profile through increased exposure while also emphasising what the programme was actually contracted to provide, such as by involving the Ministry of Health in promoting its aims, expected activities and position within the wider suicide prevention sector
- aligning to Whānau Ora philosophies and values where whānau were engaged and empowered with a focus on building resiliency
- taking a coordinated national approach to building the capability of KPTO Coordinators and raising the profile of the KPTO programme
- involving and emphasising the importance of iwi, hapū, marae and Māori whānau in a culturally distinctive context.

3.5 Ngāti Hine Health Trust: Northland Mid North

3.5.1 Overview

KTCL undertook the site visit of the Ngāti Hine Health Trust (NHHT) on 5–6 August 2014. Naomi Manu and Carla Te Hau from KTCL conducted this evaluation site visit, which comprised interviews with all staff members involved with the KPTO programme: the General Manager, Line Manager, KPTO Coordinators, Quality Manager and a former KPTO Coordinator.

The KPTO General Manager provided contact details for nine key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. Of these stakeholders, six were available to participate in the evaluation, including: Northland Police Superintendent; Northland DHB Suicide Prevention Coordinator; RAID Movement founding members; Whangarei Youth Space Coordinator; and two whānau focus groups (comprising eight individuals).

The Ministry of Health provided documents relevant to the evaluation, including annual reports, project plans and annual service plans. Documents reviewed on site during the visit in August 2014 included: *Te Whakauruora: Restoration of Health: Māori Suicide Prevention Resource*; KPTO Workforce Development Plans (2010–2011); Ngāti Hine Health Pro Māori Attitudes Survey(2011); *A Youth Approach to Youth Suicide Awareness in Northland* (2012); Fusion Group terms of reference; Local Response Team terms of reference; RAID Movement Waitangi Day Event Plan; and RAID Movement Waitangi Day Survey results (2013).

Limitations of the specific site evaluation

A key limitation of this evaluation was the short time between the establishment of the KTCL contract with the Ministry of Health and commencement of the site evaluation. Due to this tight timeframe, Ngāti Hine Health Trust could not secure expanded participation of whānau and community members in the evaluation.

3.5.2 Process evaluation findings

Programme delivery and activities

KTCL asked KPTO staff to describe specific health promotion and suicide prevention activities that were delivered during the evaluation period. KPTO Coordinators and NHHT management reported that their approach involved programmes that addressed the holistic needs of whānau. In 2011 NHHT reviewed *Te Whakauruora: Restoration of Health: Māori Suicide Prevention Resource* in an effort to reorient service delivery to better reflect philosophies of te ao Māori. *Te Whakauruora* described Māori cultural protective factors as including:

- an understanding of Māori concepts such as mana atua, mana tūpuna, mana tangata, taha wahine, taha tāne, mana motuhake, mana whenua, utu, hara, tapu, noa, muru, maungarongo and whakamā
- strengthening of cultural identity including te reo Māori me ngā tikanga Māori.

Following this review NHHT delivered He Tohu Rangatira to Te Kura Kaupapa Māori o Taumarere and Motatau School. He Tohu Rangatira was the flagship programme in the organisation's healthy lifestyles campaign and sought to encourage participation in Māori cultural activities among whānau and marae. Each school worked in conjunction with its own marae and kōhanga reo. While the programme did not speak directly to suicide prevention, staff reported that the use of Māori models of hauora were supported by *Te Whakauruora*: 'Access to Māori cultural resources – tohunga, koroua, kuia, te reo Māori, whenua, Marae, tikanga, whakapapa – can help healing' (p. 26). Wāhanga Tuatoru of *Te Whakauruora* also states, 'ongoing education programmes are in place for whānau and their whānau member and whānau proactively seeking and maintaining wellbeing' (p. 36) because important health gains can be achieved through access to services that are culturally relevant and include the whole whānau. He Tohu Rangatira catered for the whole whānau as well as nurturing the differing needs of individual whānau members based on the rationale that this approach would strengthen community and whānau cohesion and develop personal and community resilience to poverty, deprivation, unemployment and harm caused by alcohol and drugs.

In early 2012 NHHT identified significant concern in secondary schools and community groups about the risk of a suicide contagion. Its KPTO and CAYAD teams sought direct consultation with rangatahi to determine an appropriate response. In September 2012 NHHT launched the Respond to All In Distress (RAID) Movement, which sought to 'raid' the minds of all young people, 'raid' the streets with information about suicide prevention, promote awareness of suicide signs and symptoms, and strengthen and unite the voice of young people so that whānau and society would hear what was happening for young people. RAID provided an opportunity for agencies, providers and community organisations to listen in different and active ways to the voice of young people.

NHHT had strong relationships with key stakeholder agencies, community organisations and whānau, as evidenced through monitoring reports and stakeholder interviews. In July 2010 the Ministry of Health commissioned Otago University to deliver Gatekeeper (Question, Persuade, Refer) training and workshops in suicide prevention in the Northland DHB catchment area through to June 2012. KPTO staff worked alongside Otago University researchers to deliver workshops and training, which included a Māori perspective, to both Māori and mainstream groups.

In 2012 an interagency social wellbeing governance group was established to more effectively respond to the challenges facing vulnerable children, youth and families in Northland. Comprising representatives from Northland DHB, Police, Ministry of Social Development, Ministry of Education, Te Puni Kōkiri, Tai Tokerau Iwi Chairs and the Whangarei Children's Team, the group provided overall leadership and oversight to interagency responses and agreed strategies that impact on the social wellbeing of Northlanders. Its strategic focus was youth suicide prevention.

Within this framework, a Fusion Group shared intelligence on a daily basis and was responsible for collating and analysing information on youth and families that present a high vulnerability and risk. This information was used to mobilise crisis intervention at a local level (through local response teams) and inform the development of prevention strategies that enhance the social wellbeing of Northlanders. NHHT chairs the Fusion Group.

Planning and monitoring

The KPTO service specification required NHHT to produce an annual service plan in consultation with key stakeholders. Over the evaluation period, NHHT developed annual service plans that detailed key activities across the following four objectives:

- promote mental health and wellbeing for Māori
- reduce access to the means of suicide
- increase safe reporting of suicide by media
- contribute to improved mental health services for Māori.

These four programme objectives represented four of the seven goals of the New Zealand Suicide Prevention Strategy 2006–2016 and KPTO All Age Suicide Programme Logic Model. The plans highlighted key activities to achieve these objectives, and anticipated short- to long-term outcomes. Key activities included developing healthy lifestyles campaigns for Māori that address the holistic needs of the whānau, strengthening relationships with marae and schools, facilitating opportunities for whānau and community representatives to complete Gatekeeper (Question, Persuade, Refer) training, and strengthening relationships with like-minded organisations to address community needs.

Staff reported that a major influence on annual service planning was intelligence from stakeholder groupings. Plans aligned to community needs with a particular focus on improved access to Māori models of care and whānau ora. Stakeholder relationships and alignment to collaborative activities were also prioritised during the planning phase. A key example was the Fusion Group (chaired by NHHT: see above) which developed a Suicide Prevention Plan for Northland.

Plans aligned closely to the Programme Accountability Framework and planning templates used good intervention logic, including performance measures and data sources. NHHT actively evaluated programmes and activities. Evaluation forms were provided to workshop and training participants and their feedback was used for service improvements. This was particularly evident with the RAID Movement. The review of documents confirmed that information from regular environmental impact scans (government policy and local needs) was used in future planning and service enhancements.

On 1 January 2013 NHHT entered into a high trust Integrated Outcomes Agreement, which included the KPTO programme, with the Ministry of Social Development, Ministry of Health, Ministry of Justice and Te Puni Kōkiri. There were no changes to the existing service specification. However, the Integrated Outcomes Agreement moved from outputs-related reporting to outcomes reporting through the Results Based Accountability Framework.

Both prior to and following the Integrated Outcomes Agreement, staff conducted service monitoring and included the results in six-monthly progress reports to the Ministry of Health. The reports detailed outputs and outcomes achieved, reported back on the service objectives and provided narrative about implementation of service programmes such as He Tohu Rangatira and the RAID Movement. The Integrated Outcomes Agreement reported specific performance measures based on the RBA measures of how much, how well and are whānau better off.

3.5.3 Process evaluation conclusions

Programme delivery and activities

KPTO Programme delivery and activities during the evaluation period were primarily focused on the RAID Movement with youth as well as utilising a kaupapa Māori approach for service provision. For example, KPTO programme delivery utilised cultural best practice models including Te Whare Tapa Whā and the Pōwhiri Poutama.

The RAID Movement is a health promotion youth initiative, primarily delivered by youth. The KPTO programme supported, coordinated and co-facilitated the RAID initiative and activities. Overwhelming evidence and stakeholder feedback validated the success of the RAID Movement programme.

KPTO reinforced the success of a community response to a community need with their involvement with the Fusion Group, established in 2012. This group shared intelligence on a daily basis and was responsible for collating and analysing information on youth and families that present a high vulnerability and risk. The information was used to mobilise crisis intervention and inform the development of prevention strategies.

Planning and monitoring

NHHT had effective planning and monitoring processes utilising local information, from both agencies and community hui, in developing and prioritising activities within its annual service plans. Plans aligned to community needs with a particular focus on improved access to Māori models of care and whānau ora, as well as being strongly aligned to the Programme Accountability Framework. Programmes and initiatives, particularly the RAID Movement, were well researched and evaluated for programme improvement.

3.5.4 *Impact evaluation findings*

Community impact and alignment with objectives

From the document review, it was evident that many of the objectives outlined in the service specifications were achieved. Between September 2012 and December 2013 the primary service activity was the RAID Movement. During stakeholder interviews, all respondents highlighted its success and its critical role across the youth suicide landscape. NHHT engaged RAID representatives as KPTO Coordinators.

Objective One: Promote mental health and wellbeing for Māori

Over the evaluation period, NHHT used Māori frameworks to promote mental health and wellbeing for Māori. He Tohu Rangatira was a health promotion initiative that focused on nurturing Māori identity (through a range of activities) within the taitamariki population, while strengthening community responses to circumstances that impact on the mental health and wellbeing for taitamariki services delivered to students and their whānau. He Tohu Rangatira identified a critical service gap in the suicide prevention landscape in that it was focused on suicide prevention rather than intervention (or service delivery).

The RAID Movement was a particular focus for NHHT during 2012 and 2013. RAID promoted mental health and wellbeing with a strong presence both in the community and online. In 2013 the RAID Movement facilitated the NHHT presence at Waitangi Day. The event recruited 198 new RAID members. These youth committed to the following four principles of the RAID Movement Treaty:

- provide support and aid to all
- reach out for help if you need it
- believe in what the RAID Movement stands for
- always promote the motto 'Life over everything'.

Objective Two: Reduce access to means of suicide

The Northland Police Superintendent commented that KPTO involvement in the Fusion Group may have contributed to a decline in suicide in the Northland region. The Fusion Group received real-time intelligence from the police and mental health sectors and was able to respond accordingly. Through its networks in the Māori community, NHHT contributed directly to whānau crisis engagement and in some cases provided support that other providers were unable to. The Police Superintendent reported that the RAID Movement played a critical role in reducing youth suicide across the Northland region.

Objective Three: Increase safe reporting of suicide by media

Reports and discussions provided little evidence that the KPTO programme had any direct influence on the media's safe reporting of suicide.

Objective Four: Contribute to improved mental health services for Māori

KPTO staff developed key relationships with organisations such as Manaia PHO, Tai Tokerau PHO, Te Roopu Kimiora Adolescent Health Services at Northland DHB, Fusion Group and Whangarei Youth Space. The strategic intent was to influence an improvement in services for Māori. The KPTO team met regularly with these stakeholders. The Whangarei Youth Space was particularly interested in developing a partnership with the RAID Movement as a positive way in which youth vitality could influence the organisation.

In addition to KPTO Coordinator support, the RAID Movement had access to support from clinicians and supervisors. While RAID members (Raiders) had access to the RAID movement Facebook website, NHHT monitored and coordinated it. In 2013 a young person in the Wellington region mentioned on the Facebook page that she intended to commit suicide. Young Raiders gathered intelligence and phoned NHHT. Within 20 minutes of the Facebook post, the young person was in a meeting with her parents, school counsellor and child mental health services, discussing a plan to keep her safe. The RAID Movement contributed to timely access to mental health support for this young person.

Value to the region and the programme

Through the RAID Movement, the KPTO programme had a strong presence in the community. Youth were empowered to lead their own programmes, with the support of supervisors and counsellors, and positively influence their peers. All stakeholders interviewed during the evaluation reported that the RAID Movement contributed positively to the suicide prevention landscape. Following discussion with RAID volunteers, Raiders reported that membership of the Movement required a high level of commitment to its values and further that these values ought to be 'lived' values. When asked how Raiders managed information from vulnerable youth, interviewees reported that youth:

- shared these feelings freely with their peers, which Raiders were now trained to manage
- had access to a team of experts at Ngāti Hine Health Trust who more appropriately managed support for vulnerable youth. It was the Raiders primary responsibility to promote 'Life over everything' and refer youth on to expert advice and support.

Cultural competency

NHHT delivery of the KPTO programme largely put whānau at its centre. Through initiatives such as He Tohu Rangatira, NHHT addressed the needs of the whole whānau while recognising the requirement of individual members. The programme focused on Māori frameworks and sourcing solutions to suicide prevention and postvention from within te ao Māori.

Interviews and document reviews provided evidence that NHHT used Te Whakauruora training in service delivery. Where possible, it integrated the suicide prevention contract with other health promotion activities in a deliberate attempt to promote health and wellbeing for Māori, and improve access to the suite of NHHT health services.

Strengths and opportunities for improvement

Currently the nationwide KPTO programme has a health promotion focus. Given the nature of the suicide landscape, staff reported that the KPTO programme would have a greater reach if it widened its focus to include suicide prevention, intervention and postvention. NHHT delivered the KPTO programme in this way, which helped to achieve key Programme Accountability Framework objectives.

3.5.5 *Impact evaluation conclusions*

Community impact and alignment with objectives

Overall the KPTO programme identified key activities that aligned to the KPTO programme objectives. This was particularly evident with the RAID Movement initiative and coordinating change and promoting positive messages with youth. There was unanimous feedback from stakeholders that this was a positive suicide prevention approach.

The focus on tikanga practices and kaupapa Māori models of care in service provision also had a positive impact on the community. As these were locally developed and approaches were adapted to local needs, there was stronger buy-in and engagement from the community.

KPTO involvement in the Fusion Group helped to improve information sharing and policy development both at a strategic level as well as at a community level.

Value to the region and the programme

As the KPTO strategy promotes, successful outcomes were achieved through the RAID Movement and Fusion Group as KPTO Coordinators focused strongly on collaborating with key agencies in the region. The KPTO programme was able to demonstrate its value through these types of collaborative efforts.

The Fusion Group reinforced the success of a community response to the community need. Interview participants reported that organisations were better positioned to address the varied and complex community needs when they shared resources and overall coordination improved.

Cultural competency of the programme

There were many examples of culturally based, best-practice models relevant to suicide prevention, particularly those that applied a connectedness to the local environment and history. The KPTO programme was delivered in a culturally competent way through the organisation's commitment to tikanga Māori and Māori development.

Strengths and opportunities for improvement

The KPTO programme adopted and tailored three main localised approaches for service provision. Of which all have provided evidence-based models for successful KPTO service provision. Some of these approaches may be limited in terms of age groups or forming only parts of the suicide prevention spectrum however further investment could utilise components that have worked well.

NHHT identified opportunities in its annual service plans to develop strong relationships with local media to promote safe reporting of suicide. However, there was little evidence that these relationships had been developed.

3.6 Te Ao Hou Trust: Bay of Plenty

3.6.1 Overview

KTCL undertook the site visit of Te Ao Hou Trust (TAHT) on 7–8 August 2014. Careene Andrews and Duncan Andrews (kaumātua) from KTCL conducted this evaluation site visit and interviewed all staff members involved with this service, including the Manager and two KPTO Coordinators.

The KPTO Coordinators provided contact details for key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. Seven of these stakeholders were available to participate in the evaluation including: Te Kupenga mo Kawerau; Tūwharetoa ki Kawerau; Te Tāpenakara mo te Iwi Trust; Western Bay of Plenty PHO; Ministry of Education; Bay of Plenty District Health Board; and a whānau group.

The Ministry of Health provided documents relevant to the evaluation, including performance monitoring reports, project plans and service action plans. Reviewed documents included: five TAHT

six-monthly reports 5 (2010, 2011, 2012, 2013); six Ministry of Health feedback reports (2010, 2011, 2012, 2013); three TAHT annual service plans (2010-2011, 2011-2012, 2012-2013); KPTO Strategic Plan; the TAHT 2013–2015 Strategic and Annual Plan; workforce development plans; Western Bay of Plenty suicide resilience planning hui – He Aumangea (2012); Kawerau Suicide Prevention Action Plan – Te Kupenga mo Kawerau (The Kawerau Support Net) (2013–2016); Te Ahi Komau Report (2013); Ngāi Te Ahi Hapū Management Plan (2013); Western Bay of Plenty Suicide Intervention Plan (2014–2016); and the Ministry of Education Preventing and Responding to Suicide resource kit for schools.

Limitations of the site specific evaluation

TAHT provided an extensive list of stakeholders to engage with. However due to the limited on-site time allocated to the evaluation, not all stakeholders were interviewed. The stakeholder survey provided a forum for all stakeholders to provide their feedback if they wished to.

3.6.2 Process evaluation findings

Programme delivery and activities

TAHT employed two KPTO Coordinators, who allocated their resources across Eastern Bay of Plenty (EBOP) – which was a rural area consisting of Kawerau, Whakatane, Opotiki and Murupara and surrounding towns – and Western Bay of Plenty (WBOP), which was more urban with a rapidly growing infrastructure, including Katikati to Otamarakau. Both KPTO Coordinators had been employed for the entire duration of the evaluation period, one having been involved with the programme since early in its inception.

The KPTO Coordinator who worked in WBOP had three main goals in their strategic approach:

- autonomy – community engagement, driven and ownership
- skilled – training, education, services, information and resources
- nurture – to take care of and support each other, with strong and appropriate referral pathways.

The EBOP KPTO Coordinator had a slightly different focus, particularly with a heavy involvement in Kawerau and building relationships at key forums.

The document review provided evidence that the KPTO programme's service objectives aligned to the KPTO strategic objectives. Specifically, the service objectives were to:

1. maximise sector relationships to improve service knowledge for delivery to Māori in the Bay of Plenty
2. develop training and workshops to increase awareness and understanding of suicide through information and accessibility to support services for Māori in the Bay of Plenty
3. increase the knowledge and awareness of current trends for Māori suicidal behaviour in the Bay of Plenty
4. develop a media communication plan that contributes to achieving the KPTO objectives
5. attend Te Whakauruora training for continued support and professional growth in delivering a public health approach to suicide prevention (this objective was replaced in 2013 with a combined skills and knowledge objective).

The 2011–2015 annual service plans, which incorporated the above objectives, were reviewed regularly. One recent result of this review process was that a stronger focus was placed on supporting whānau, hapū, marae, iwi, hapori Māori and communities to help reduce suicide and the impact of suicide. Throughout the documentation there was a strong link to the philosophies of the Whānau Ora initiative led by Te Puni Kōkiri.

TAHT's strategy was to facilitate a whānau ora model of care, providing culturally appropriate support and developing a network of high performing community health and social providers. It had an obvious synergy with the Government's Whānau Ora initiative, which could be harnessed to make real changes to engage and empower whānau in a well-coordinated approach to their journey to toiora – linking to the All Age Suicide Programme Logic Model.

'KPTO values need to align to Whānau Ora instead of things being done to them.' (Stakeholder)

'The philosophy of Whānau Ora sits behind KPTO.' (Stakeholder)

'KPTO needs a korowai.' (KPTO staff)

The following are only a sample of the numerous engagement activities that KPTO Coordinators undertook over the past few years.

KAWERAU

Many lessons can be learnt from the 18-month youth suicide cluster in Kawerau. According to the Kawerau Suicide Prevention Action Plan, the community of Kawerau, with 60 percent Māori in its population, had undergone significant changes with the restructuring of certain industries which resulted in low employment and a relatively large, unskilled workforce. These developments were a significant concern for the Kawerau community. While quite a number of parties were involved in the Kawerau cluster, all stakeholders interviewed felt that KPTO played a critical role in bringing the community together. One stakeholder said that the response was initially focused on primary mental health but, through hui with the bereaved whānau, a Kawerau Implementation Team was established. KPTO staff were on this team and played a vital role in bringing clinical and non-clinical personnel together.

'I couldn't understand why clinical and non-clinical weren't working together like [this] across the country.'

By working together, this variety of stakeholders was able to gather information in a coordinated approach to cover the whole spectrum of suicide prevention and intervention, as the stakeholder above noted.

The 2011 and 2012 TAHT documentation identified that over 32 hui associated with the response to the suicide pandemic were held in the Bay of Plenty. KPTO staff commented that while it was wonderful to play a major part in the delivery and implementation of the Kawerau Suicide Prevention Action Plan, it had been taxing with the extra hui and time it had involved. The voluntary involvement of some members, including bereaved whānau, itself had its own dynamics and challenges in repeatedly bringing such a sensitive issue to the fore.

Among the range of findings, learnings and outcomes from this community approach, the most successful has been that no suicides occurred in 12 months following its introduction.

'KPTO was able to bring the agency language into a voice that whānau could better understand.'

'I am grateful for the support given and especially working with KPTO.'

HAKA UP

The 'Haka Up' campaign drew on many concepts and the mana of haka, which underpin the protective factors of suicide, and it received an excellent response. Some important concepts related to suicide were: wero – the challenge; cultural identity – whānau, language, marae, whenua, connectedness; the pride in one's self and that unique belonging; hard physical and mental stamina training; unity among brothers. It was also an auspicious time leading into the Rugby World Cup, with Māori featuring prominently in the opening ceremony. Key messages of the campaign, which included a media launch, were: 'Haka up against suicide – Kotahi tātou – Kia mau to Māoritanga'; 'Stand/speak/challenge suicide ... Stand together ... Hold fast to your Māoritanga – Your Identity!' and 'I am more than ... I am whānau'.

KPTO played a key role in the overall development and coordination of this campaign.

The KPTO programme implemented an initiative involving marae resilience plans as a pathway for stakeholder engagement. The concept was about engaging marae to identify their strengths and build their own resilience plans. Through the response plan evaluation, 94 percent of marae in WBOP had indicated their support for the plans. The 2013 Annual Service Plan identified champions to lead response plans which incorporated three EBOP Māori community provider groups and eight hapū or community groups. All 36 of the marae in the WBOP region had received a marae resource and information pack. KPTO staff commented that the initiative hit a stumbling block in 2014 in relation to implementing the plans.

‘When delivering KPTO to whānau, it helps if you are from the rohe.’ (KPTO staff)

‘We need to continue to build up our whānau.’ (KPTO staff)

‘There is still a lot of pearls of wisdom from our kaumātua to help with suicide prevention.’ (Stakeholder)

In addition to the above activities, KPTO Coordinators participated in the following events: youth workers’ hui; Te Pā Harakeke Māori networking hui; Ngāi Te Ahi Wānanga; Pirirakau Hauora postvention hui; Barry Taylor training workshops; Tauranga Tangata Festival; Regional Schools Kapa Haka; Matariki; World Suicide Prevention Day; Mental Health Awareness Week; WBOP resilience planning hui; and Te Ahi Kōmau hui Māori suicide prevention hui.

KPTO Coordinator interviews and documentation provided evidence that participants in a number of community hui included, but were not limited to: Ngā Matapuna Oranga PHO, Tauranga; Western Bay of Plenty Primary Health Organisation, Tauranga; Strengthening Communities, Tauranga; Māori providers; Group Special Education Trauma Incident Team; Poutiri Trust; CASPER; Clinical Advisory Services, Otago University; Tūwharetoa ki Kawerau Hauora Education & Social Services; Te Hūinga Social Services; Te Tāpenakara mo te Iwi: Pou Whakaaro; Richmond New Zealand; Compassionate Friends Bereaved Parents’ Support Group; Te Kaokao o Takapau; Waikirikiri Marae Social Services; Te Toi Huarewa; Tūhoe Hauora; Te Ao Mārama Whānau Ora collective; and Opotiki Mental Health Service.

The participation of KPTO staff in relevant advisory groups over the years has been critical to keeping the KPTO agenda as a consistently high priority. These groups include: WBOP Māori Suicide Prevention Advisory Group; Tangata Whenua Collective, WBOP Community Response Team; CAYAD reference group; Midlands Mental Health Forum; Te Pā Harakeke; and RATS. While continuing to focus on increasing the knowledge and awareness of trends for Māori suicidal behaviour in Bay of Plenty, the KPTO staff supported the development of the New Zealand Suicide Prevention Action Plan 2013–2016, the Community Action Group 2013–2018 Strategic Plan and the KPTO 2013–2016 Strategic Plan.

In addition, KPTO Coordinators felt that the KPTO teleconference showed inconsistencies in relationships. In their view, the Ministry of Health needed to collate and provide feedback on reports to promote unity among the nine different KPTO sites, as their comments below indicate.

‘We need to capture the essence of KPTO.’ (KPTO staff)

‘There is a lack of leadership within the Ministry for KPTO. Looking forward to working with from the Ministry of Health as previously I only saw ... twice over five years.’ (KPTO staff)

KPTO Coordinators were also heavily involved in numerous training activities including Dr Candy Cookson Cox’s Anamata Suicide Prevention and Intervention Certificate Course; Māori Leadership, Anamata; and Te Whakauruora.

Media campaigns have been another key feature of KPTO service provision, particularly ‘Haka Up’, ‘The Big Dump’, ‘Make my day sucker’ and ‘There is always hope!’ Little Tui Creations communication services provided media training and media toolkits with the launch of each of these initiatives and advisory plans were developed in each case. In addition, the ‘Take notice, take TIME, take a breath, take notice’ campaign provided a forum to co-facilitate hui presentations. The document review also highlighted that KPTO staff had engaged with over 20 media providers.

The KPTO Coordinators, who had been heavily involved with the programme for a number of years, commented that the KPTO programme was not strongly coordinated, with the nine sites taking different approaches. Although they did not think the current arrangements were bad, they felt a better-coordinated programme would make it easier to identify what was working and what was not.

‘We need to have resources like CAYAD and then we wouldn’t feel so isolated.’ (KPTO staff)

Planning and monitoring

There was overwhelming information and evidence that the KPTO programme had effective planning and monitoring systems in place. The 2010/11 TAHT Annual Plan details that the Bay of Plenty region has the fifth-highest suicide rate in New Zealand, with a particular concern for Māori men aged 15–24 years. It also highlights that the region has a high Māori population and the social demographics related to a higher risk and incidence of suicide. The KPTO programme received regular coroner statistics which it used to prioritise its mahi.

The following is a sample of planning and monitoring activities. The 2012 TAHT report continued to highlight the connection with building resilient whānau, hapū and iwi under the concept of prevention within Whānau Ora. The Te Whakauruora Wānanga workshop evaluations were reviewed, taking an RBA view of the outcomes to consider ‘What did we do?’ and ‘How well did we do it?’ The overall outcomes from these evaluations highlighted that 100 percent of participants felt that the training was one of the most powerful and effective forums for communicating and interacting with and building knowledge for our communities. The review of the WBOP suicide resilience planning hui – He Aumangea (2012) document identified a comprehensive planning process involved in establishing this marae resilience project. Advisory plans were made for each media campaign to ensure community input. The annual service plan highlighted the evaluation information gained after each campaign as well as the number of resources distributed.

3.6.3 Process evaluation conclusions

Programme delivery and activities

KTCL acknowledges that this was one of the few sites where both Coordinators were able to provide evidence covering the entire evaluation period, which highlights the high level of staff turnover in some other KPTO provider sites.

The unique allocation of service provision for the KPTO programme validated that different but localised approaches could still achieve the same outcome. This was evident with one Coordinator focusing more on community and Māori resilience, and the other on strategic collaborations. There was also an obvious synergy with the Government’s Whānau Ora initiative, promoting whānau empowerment and self-determination.

A key focus for one of the KPTO Coordinators was participation, support and coordination of the Kawerau suicide pandemic. One of the key strengths of the KPTO programme was the ability to bring whānau and agencies together and discuss strategies that all parties understood and

contributed to. The other KPTO Coordinator provided strong evidence surrounding a Marae resilience project, where 'all' Marae contributed to community resilience plans. Both of these activities, while positive, were quite arduous in terms of resource distribution.

Media campaigns have been another key feature of KPTO service provision and extensive material was sighted that promoted key messages and community input into resource development.

Planning and monitoring

There was overwhelming information and evidence that KPTO had effective planning and monitoring systems in place that were well aligned to the national framework and All Age Suicide Programme Logic Model. This was evidenced in the various evaluation documents, which demonstrated communities and whānau contribution to the planning hui and feedback processes.

3.6.4 Impact evaluation findings

Community impact and alignment with objectives

Building strong networks both with stakeholders and the community was a critical element of the service and there was ample evidence of strong networks across multiple agencies, community organisations and iwi, hapū and Marae. The strength of these relationships was also reflected in the number of stakeholder participants agreeing to participate in this evaluation. The KPTO Coordinators had a notable presence in the community. All stakeholders who had involvement with the Kawerau collaboration, commented that KPTO played a key role in these hui.

The document review provided numerous evaluations from workshop participants that provided information for future development of the KPTO programme. One evaluation provided a 100% response to improved awareness of suicide prevention. Another provided commentary from participants that Māori concepts were having a positive effect on the community.

Given time constraints and an unexpected tangihana, the evaluation team was unable to meet with as many stakeholders as scheduled to find out about the impact of the service on them. However all those who were interviewed agreed that the KPTO programme was important and the quality of programme delivery was effective.

Value to the region and the programme

Substantial evidence identified activities that added value to the region and the programme. The WBOP marae resiliency project proved to be a successful model in enabling whānau to start talking about suicide prevention. The whānau group commented on the work of the KPTO Coordinators that enabled strong discussion around suicide prevention and building resilience. Two stakeholders involved in the Kawerau project noted that KPTO staff played a critical role in bringing the agency arm and whānau together. In interviews, all stakeholder and whānau participants acknowledged and respected the great work that KPTO staff had been doing in the community and that they were committed to supporting each other.

The evaluations of Te Whakauruora Wānanga workshops highlighted that the training managed by KPTO staff was one of the most powerful and effective forums of communicating and interacting with and building knowledge for our communities. One stakeholder confirmed that the KPTO team did a great job, particularly in explaining the difference between whakamorimori and suicide and what it means to them.

One stakeholder was involved with the Ministry of Education traumatic response team which allowed for a better-coordinated approach when working with the KPTO programme.

Cultural competency

KPTO Coordinators commented that they had made a concerted effort to incorporate into their work a strategic approach that strengthened the rangatiratanga and mana of communities. The document review identified that it was critical to recognise the cultural distinctiveness of whānau, hapū and iwi in engagement activities. One focus of this KPTO programme was that services should be attuned to whānau cultural norms and recognise the realities and opportunities in te ao Māori and in the wider society. The whānau group consulted agreed with this approach.

‘The KPTO tohu is that you need to acknowledge the needs of Māori.’ (KPTO staff)

‘We need to incorporate a mauri ora programme [in]to KPTO.’ (Stakeholder)

The WBOP ‘Marae throughout WBOP engaged with their community’ initiative gained good traction. Two whānau stakeholders commented on their involvement in the development of the plan and how their marae were starting to talk about suicide prevention.

‘We know we are in a system and dependent on agency but we need to connect whānau back to the land and teach them the history, tikanga and kawa of the land.’ (Stakeholder)

KPTO Coordinators made a concerted effort to regularly involve Māori and iwi in raising the awareness around suicide prevention. The document review highlighted the various engagement activities with rūnanga.

The 2013 Annual Service Plan strengthened the focus on supporting whānau, hapū, marae, iwi, hāpori Māori and communities to help reduce suicide and its impact. It also set out related objectives along with activities to achieve these objectives. KPTO Coordinators mentioned that, although a clinical role was involved, the KPTO programme belonged instead in a cultural aspect of wellbeing.

‘There is a place for a psychologist and a place for a nanny.’ (Stakeholder)

With the implementation of the various media campaigns, over 15 whānau groups advocated safe practices in the removal of access to means of suicide by hanging. These included: Ngāi Te Ahi Ngāti He Kaumatua Roopu; Ngāi Te Ahi Ngāti He Mana Pēpi Roopu; Whānau Rangatahi Roopu; Mangatawa Rangatahi Alternative Learning Centre, Te Pā Harakeke ki Tauranga Moana; Whāioranga Kaumatua Roopu; Hei Whānau Roopu (Te Puke); Rangataua Sports Club; Waipu Hauora Whānau; Tamapahore Marae committee; Te Huinga Social Services, Te Huinga Kāhui Pakeke; Tūwharetoa Hauora Education Social Services; He Whānau Kotahi Tātou Rangatahi; Te Waimana Kaaku Executive; Te Pārihi o Hato Hemi, Rāhiri Marae Committee and Waimana; and Kawerau implementation team.

Strengths and opportunities for improvement

Both KPTO Coordinators had been employed in the KPTO programme for the entire duration of the evaluation period, with one being involved since early in its inception. KTCL acknowledges that this was one of the few sites that both Coordinators could provide evidence covering the entire evaluation period, which highlights the high level of staff turnover at some other KPTO sites.

TAHT’s strategy was to facilitate a whānau ora model of care, providing culturally appropriate support and developing a network of high-performing providers. It had an obvious synergy with the Government’s Whānau Ora initiative, which could be harnessed to make real changes to engage and encourage whānau in a well-coordinated approach to their journey to toiora – linking to the All Age Suicide Programme Logic Model.

‘KPTO values need to align to Whānau Ora instead of things being done to them.’ (KPTO staff)

‘The philosophy of Whānau Ora sits behind KPTO.’ (KPTO staff)

‘KPTO needs a korowai.’ (KPTO staff)

A number of findings, learnings and outcomes came from the Kawerau cluster. A key factor was that KPTO staff were able to bridge the clinical gap and bring communities together. The KPTO programme demonstrated a number of effective engagement activities with iwi, hapū and whānau. The document review identified that it was critical to recognise the cultural distinctiveness of whānau, hapū and iwi in engagement activities. One focus of the KPTO was that services should be attuned to whānau cultural norms and recognise the realities and opportunities in te ao Māori and in the wider society.

The participation of KPTO staff in relevant advisory groups, events, community engagement forums and training over the years was critical to keeping the KPTO agenda as a consistently high priority. While continuing to focus on increasing the knowledge and awareness of trends for Māori suicidal behaviour in the Bay of Plenty, the KPTO staff also supported the development of the New Zealand Suicide Prevention Action Plan 2013–2016, the Community Action Group 2013–2018 Strategic Plan and the KPTO 2013–2016 Strategic Plan.

KPTO Coordinators, who had been heavily involved in the programme for a number of years, commented that the KPTO programme was not strongly coordinated, with the nine sites taking different approaches.

A national role or body was recommended to provide induction services, disseminate important communications, connect KPTO with the Ministry of Health, fulfil an advocacy or advisory role, collate resources and highlight the ones that were working for Māori, and undertake general collaboration activities such as the national hui.

3.6.5 Impact evaluation conclusions

Community impact and alignment with objectives

The organisation was well known in the community as reputable service provider, as evidenced by interviews with participants in the evaluation. The evaluation found consistent evidence of activities to achieve all of its strategic objectives. Two stakeholders involved in the Kawerau project noted that KPTO played a critical role in bringing the agency arm and whānau together.

There was overwhelming evidence that the KPTO Coordinators were a good conduit between whānau, hapū, iwi and marae and agencies. KPTO Coordinators were able to facilitate conversations in the community to address suicide issues in culturally appropriate ways.

Value to the region and the programme

All stakeholder and whānau participants acknowledged and respected the great work that KPTO staff had been doing in the community and that they were committed to supporting each other. KPTO Coordinators were positioned as significant strategic leaders across the suicide prevention landscape and therefore adding value to the communities in the region. While holding strong representation on a number of advisory forums, iwi forums and regional and national steering committees, KPTO Coordinators were also key drivers of raising the profile and creating opportunities for the future development of the KPTO programme.

The KPTO Coordinators regularly provided training, resource information and marketing collateral. A few stakeholders complimented the KPTO Coordinators for their innovative ways of promoting suicide prevention.

Cultural competency

KPTO Coordinators commented that they had made a concerted effort to incorporate into their work a strategic approach that brought back the rangatiratanga and mana to communities. One focus of the KPTO programme was that services should be attuned to whānau cultural norms and recognise the realities and opportunities in te ao Māori and in the wider society. The whānau group consulted agreed with this approach. KPTO Coordinators also emphasised regularly involving Māori and iwi in raising the awareness around suicide prevention.

Strengths and opportunities for improvement

Over the evaluation period, KPTO Coordinators used innovative ways to promote wellbeing among Māori. In addition to delivering suicide prevention workshops and attending community events, they worked with key stakeholder groups to influence their engagement with Māori clients. Their participation in relevant advisory groups, events, community engagement forums and training over the years was critical to keeping the KPTO agenda as a consistently high priority. In addition, among the many findings, learnings and outcomes from the Kawerau cluster was that KPTO staff were able to bridge the clinical gap and bring communities together.

KPTO Coordinators, who had been heavily involved in the programme for a number of years, commented that the KPTO programme is not strongly coordinated, with its nine sites using different approaches. One result was to create confusion about the mandate and purpose of the programme. KPTO Coordinators felt a better-coordinated programme would make it easier to identify what was working and what was not. A national role or body would be able to provide induction services, disseminate important communications, connect KPTO providers with the Ministry of Health, fulfil an advocacy or advisory role, collate resources and highlight the ones that were working for Māori, and undertake general collaboration activities such as the national hui.

The continuity and longevity of KPTO staff provided benefits in terms of extensive community knowledge and engagement. In addition, their input into varying KPTO improvement could not be underestimated.

3.7 He Waka Tapu: Christchurch

3.7.1 Overview

KTCL undertook the site visit of He Waka Tapu (HWT) on 11–12 August 2014. Careene Andrews and Naomi Manu conducted this evaluation site visit and interviewed all staff members involved with the KPTO programme: the Service Manager, KPTO Coordinators, a former KPTO Coordinator and the CEO.

The He Waka Tapu Service Manager provided contact details for seven key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. All of these stakeholders were available to participate in the evaluation: Christchurch City Council; Arowhenua Whānau Services; Canterbury DHB Suicide Prevention Coordinator; Waimakariri District Council Injury Prevention Coordinator; Aranui Community Trust Incorporated Society; He Oranga Pounamu; and Pacific Trust. Three whānau members also agreed to participate in the evaluation.

The Ministry of Health provided documents relevant to the evaluation, including performance monitoring reports, project plans and service action plans. Documents were also analysed following site visits. These documents included: Media Breakfast Plan, Programme and Report (September–October 2012); KPTO internal monthly reports (August–December 2013); KPTO PowerPoint presentation (2013); training evaluation forms (September 2013); ‘I Got Your Back’ Campaign Plan (2013); and ‘I Got Your Back’ Health Evening evaluation (November 2013).

Limitations of the specific site evaluation

One of the KPTO Coordinators commenced employment with the programme in July 2014. Although present for some of the site visit, this Coordinator was unable to respond fully to the evaluation questions.

A further limitation to this evaluation was that all 2010–2011 documentation was destroyed as a result of the February 2011 Canterbury earthquake.

3.7.2 Process evaluation findings

Programme delivery and activities

KTCL asked Coordinators to describe specific health promotion and suicide prevention activities that were delivered during the evaluation period. Although personnel had changed from those employed during that time, staff were able to comment on either specific activities that were delivered or relationships that were established during the evaluation period. Activities included attendance at various community events such as FLAVA, HYPE Youth Weeks, media presentations, kapa haka, marae visits, rūnanga hui, Matariki celebrations, ‘I Got Your Back’ campaign, and presentations at secondary schools and interagency forums.

In September 2012 the KPTO Coordinators invited media representatives to attend a breakfast and listen to information about current suicide support and services throughout the South Island. The document review identified participants included representatives from Fairfax Media, the *Press*, the *Christchurch Star*, Tahu FM, *New Zealand Doctor* magazine, *Hurunui News*, *Northern Outlook*, Canterbury DHB Suicide Prevention Coordinator and Communications Advisor, Pasifika Health, He Oranga Pounamu of Canterbury University, Pacific Trust and Women’s Refuge.

In August 2013 the KPTO programme in partnership with Pacific Health developed the ‘I Got Your Back’ campaign, which sought to encourage positive behaviour including support and understanding. HWT and Pacific Trust launched the campaign at the annual Bro’s v Uso’s rugby league event, the largest Māori and Pacific event in the South Island, which drew over 5000 spectators. The event organisers supported the promotion of a message based on community strengths. Event participants reported that the event was community run and community owned, increasing interest in the ‘I Got Your Back’ campaign and the messages against domestic violence, bullying, alcohol and drugs, on-field and off-field violence, and suicide.

In November 2013 KPTO staff and Pacific Trust facilitated an ‘I Got Your Back’ evening. It targeted whānau in the sporting community and raised awareness of signs and symptoms of depression and suicide as well as promoting healthy lifestyle messages. The evening also included information about access to services and support. Eighty-eight percent of participants thought the session was useful. Some shared experiences of asking for help and receiving support.

Key to the success of the KPTO programme in Christchurch was the need to build and sustain meaningful stakeholder relationships. The evaluation found that KPTO had a strong presence in the community and among marae, agencies and non-governmental organisations.

Planning and monitoring

The KPTO service specification required HWT to produce an annual service plan in consultation with key stakeholders. Over the evaluation period, HWT developed annual service plans that detailed key activities across the following four objectives:

- promote mental health and wellbeing for Māori
- reduce access to the means of suicide
- increase safe reporting of suicide by media
- contribute to improved mental health services for Māori.

These four programme objectives represented four of the seven goals of the New Zealand Suicide Prevention Strategy 2006–2016 and KPTO All Age Suicide Programme Logic Model. The plans highlight key activities to achieve these objectives, and anticipated short- to long-term outcomes.

KPTO Coordinators were invited to comment on the annual service plans and whether they had an input into plan development. Staff confirmed their involvement in the implementation of the annual service plans. Although annual service plans aligned to the All Age Suicide Programme Logic Model and Accountability Framework, the evaluation team did not sight HWT planning systems and processes. The document review revealed that annual service plans identified key activities across the four programme objectives, tasks, expected outcomes, performance measures and data sources. There was also some alignment to HWT strategic documents. Annual service plans identified key stakeholders and monitoring reports detailed engagement activities.

KPTO Coordinators invited programme and workshop participants to complete evaluation forms at the conclusion of each session. Information from the evaluations was collated and reported back to the team. Key feedback influenced programme improvements and this process demonstrated strong reflective practice. HWT also used evaluation feedback as evidence of the impact of its activities.

KPTO Coordinators furnished six-monthly monitoring reports to the Ministry of Health in accordance with the KPTO service specification. The monitoring reports evidenced achievement of KPTO activities and described their contribution to KPTO programme objectives. The narrative section of the reports provided a good level of information about community engagement activities and findings from programme and workshop evaluations.

3.7.3 *Process evaluation conclusions*

Programme delivery and activities

KPTO Coordinators participated and contributed to numerous events within the region to raise awareness of the KPTO objectives. A number of these were community events with high participation and attendance. Presentations were a key focus at these events and the KPTO Coordinator's nature encouraged strong engagement. It was difficult however to determine the specific outcomes in terms of KPTO programme delivery.

KPTO Coordinators, in partnership with Pacific Health, developed two unique campaigns which sought to encourage positive behaviour, particularly within the sporting community. KPTO Coordinators were able to provide information on signs and symptoms of depression, suicide and promoting healthy lifestyle messages. The development of localised approaches is well supported within this community.

Planning and monitoring

At the time the KPTO Coordinators were employed, the Annual service plans were already in place. Through the document review, the Annual service plans aligned to the All Age Suicide Programme

Logic Model and Accountability Framework. The document review revealed that annual service plans identified key activities across the four programme objectives, tasks, expected outcomes, performance measures and data sources.

3.7.4 Impact evaluation findings

Community impact and alignment with objectives

From the document review, it was evident that many of the objectives outlined in the service specifications were achieved. Building strong community networks was critical to the success of the KPTO programme. One of the KPTO Coordinator's had a strong presence in the community and relied heavily on his existing networks to progress programme objectives. These networks created opportunities to further the reach of the KPTO programme into the Māori and Pacific rugby league community. Through the Bro's v Usos league event, KPTO staff could distribute health promotion messages to over 5000 spectators. Event coordinators actively participated in spreading health promotion messages. League players, together with their families, attended health evenings.

In 2012 KPTO staff organised a media breakfast to provide information about safe reporting of suicide. All major local newspapers and representatives from radio stations attended and they received information packs about the safe reporting of suicide in media pamphlets and the KPTO programme. This informative and influential breakfast potentially could be used as a model in other KPTO sites.

During 2012–2013 the KPTO Coordinators focused on building relationships with local marae. The presentations to marae introduced the KPTO programme and sought to strengthen cultural connections, build rūnanga confidence in KPTO and develop a plan for linking services. The presentations also promoted awareness of signs and symptoms of suicide and equipped participants with tools to better support whānau and friends. By the end of 2013 all marae in the Christchurch region had participated in KPTO presentations. One whānau interview participant mentioned that she had noticed an improvement in demystifying myths surrounding suicide.

'Listening to conversations around whānau is different than it was 10 years ago. People are starting to talk about it whereas we always thought if we talked about it we would encourage it.' (KPTO staff)

Value to the region and to the programme

The general consensus among stakeholders was that the KPTO programme was an invaluable resource in the Christchurch region. One stakeholder commented that she felt the service specification and particularly the focus on health promotion did not align with the original intent of the programme. She considered that KPTO would have a greater reach if the programme operated across the suicide prevention and intervention areas. In her view, given that kaupapa Māori provision supported direct whānau engagement, re-aligning the programme to a Māori worldview would add immense value to the KPTO programme.

The KPTO team's relationship with the Canterbury DHB Suicide Prevention Coordinator was critical. It promoted collaboration and mutual respect for exchanging knowledge and information. The nature of the relationship was such that the Suicide Prevention Coordinator relied on KPTO intelligence to determine how to best distribute resources.

Cultural competency

Although the evaluation sought to understand the cultural competency of the service, the programme's only point of difference from mainstream services was that it was delivered by Māori

for Māori. There was little evidence that the programme used Māori frameworks or health models even though staff had been trained in these areas. Programme delivery was culturally competent and upheld tikanga Māori within hui and forums.

Stakeholders reported high cultural competency among KPTO Coordinators. When asked to elaborate, the majority acknowledged KPTO leadership with respect to tikanga during hui. One stakeholder commented that KPTO influenced how his organisation responded to Māori.

KPTO activities and campaigns did not reflect a Māori worldview. One reason may relate to the way the service specification was developed as the four key KPTO objectives were generic rather than facilitating the use of or reflecting Māori views of suicide and suicide prevention.

Strengths and opportunities for improvement

The document review and stakeholder interviews found that the success of the KPTO programme relied on strong relationships with key stakeholder groups. These relationships enabled multiple organisations to share resources to promote suicide prevention messages. Stakeholders reported that collaborative activities had mutual benefits in terms of achievement of shared outcomes, wider community impact and coordinated planning.

Clear opportunities existed to improve coordination among agencies and providers to enhance outcomes across the Christchurch population. If parties to the current multi-agency suicide prevention forum used standardised forms, such as evaluation tools, the collective would gain enhanced knowledge about the collective impact of their efforts at a population level.

3.7.5 Impact evaluation conclusions

Community impact and alignment with objectives

Based on the two localised events within the community, one stakeholder praised the work that the KPTO Coordinators provided. These events were well attended and key suicide prevention messages were presented to varying audiences. One KPTO Coordinator was able to utilise his existing networks to promote the objectives of the programme.

Value to the region and the programme

The general consensus among stakeholders was that the KPTO programme was an invaluable resource in the Christchurch region. Its relationship with the Canterbury DHB Suicide Prevention Coordinator was critical in that it promoted collaboration, mutual respect and the exchange of knowledge and information. The nature of the relationship was such that the Suicide Prevention Coordinator relied on KPTO intelligence to determine how to best distribute resources.

One stakeholder commented that a greater emphasis on Māori approaches and views of suicide prevention would add immense value to the programme.

Cultural competency

Stakeholders reported high cultural competency among KPTO Coordinators. When asked to elaborate, the majority acknowledged KPTO leadership with respect to tikanga during hui. One stakeholder commented that KPTO influenced how his organisation responded to Māori.

KPTO activities and campaigns did not reflect a Māori worldview. One possible reason may relate to the way the service specification was developed as the four key KPTO objectives were generic rather than facilitating the use of or reflecting Māori views of suicide and suicide prevention.

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Clear opportunities existed to improve coordination among agencies and providers to enhance outcomes across the Christchurch population. If parties to the current multi-agency suicide prevention forum used standardised forms, such as evaluation tools, the collective would gain enhanced knowledge of the collective impact of their efforts at a population level.

3.8 Ngā Kete Mātauranga Pounamu Charitable Trust: Invercargill / Southland

3.8.1 Overview

KTCL undertook the site visit of Ngā Kete Mātauranga Pounamu Charitable Trust (NKMPT) on 13–14 August 2014. NKMPT is the newest provider, joining the programme in 2011. Careene Andrews and Naomi Manu from KTCL conducted this evaluation site visit and interviewed the KPTO Service Manager, KPTO Coordinator, a former KPTO Coordinator and the Acting Chief Executive.

The KPTO Service Manager provided contact details for 10 key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. Of these stakeholders, six were available to participate in the evaluation: Southern DHB Kimiora Trust Suicide Intervention; Southern Mental Health Promotion Collaborative – Southland Suicide Prevention Network; Interagency Suicide Prevention Initiatives; Choose Hauora Unlimited Rangatahi (CHUR); He Pataka Oranga; and He Waka Tapu.

The Ministry of Health provided documents relevant to the evaluation, including performance monitoring reports, project plans and service action plans. The document review assisted the evaluators to further refine their knowledge and understanding of the KPTO programme delivered by Ngā Kete Mātauranga. Documents were also analysed on site and following the site visit. Reviewed documents included: NKMPT six-monthly reports; Ministry of Health feedback reports; NKMPT Strategic Plan; NKMPT workforce development plans; safe storage and safe disposal of medication campaign material; Suicide Prevention Resource documentation; MKMPT Quality Management documents; Shout Out Southland production material; and CHUR campaign documentation.

3.8.2 Process evaluation findings

Programme delivery and activities

In 2011 and 2012 the KPTO programme prioritised stakeholder engagement. Over this period the KPTO Coordinators regularly met with organisations and providers such as Child, Youth and Family, Youth Justice, Public Health South, health and disability advocate, youth mental health, pharmacies, Police, Awarua Health and Social Services, local secondary schools and tertiary institutions, Community Care Trust, mental health organisations, Pacific Island Advisory and Cultural Trust and Strengthening Families. The KPTO Coordinators clearly understood that stakeholder relationships were critical to the achievement of programme objectives.

During 2011–2012 the KPTO Coordinators delivered an average of two KPTO workshops or presentations each month. The aim of the presentations was to increase understanding and awareness of the KPTO programme in the Murihiku/Southland region.

Stakeholder relationships contributed to the success of the following activities.

Medication safe storage and safe disposal

In 2011 KPTO staff and local pharmacies implemented the safe storage and safe disposal of medication campaign. Pharmacists provided clients with script pack inserts with information about safe storage and safe disposal of medication. In early 2012 KPTO ran the campaign again and included posters and media activity.

Suicide prevention resource - Worried that someone you care about may be suicidal?

In August 2012, in partnership with the Southland Suicide Prevention Network, the KPTO team developed the 'Worried that someone you care about may be suicidal?' resource. The resource provided information about how to tell if someone was feeling suicidal, how to talk to someone who is suicidal, how to tell if the situation is serious and how to access professional help.

Southland Suicide Prevention Network – media engagement plan

In July 2012, through the Southland Suicide Prevention Network, the KPTO team established a media engagement plan to promote safe reporting of suicide. Media representatives were provided with information that:

- clarified the prohibition under the Coroners Act 2006 on speculating on cause of death
- reinforced current New Zealand guidelines of reporting on suicide and the research behind the guidelines
- provided information and examples of reporting that facilitated learning and discussion while complying with evidence-based practice.

In November 2012 the KPTO programme transitioned into Ngā Kete Mātauranga's Health Promotion team, which gave it a Māori health promotion and public health focus. Two KPTO staff were employed to deliver the programme, one as a KPTO Coordinator and the other as the Health Promotion Service Manager providing KPTO service provision and oversight. The evaluation found that throughout 2013 KPTO activity largely transitioned from a focus on stakeholder engagement and collaboration to health promotion campaigns primarily through resource development. The following were two key KPTO activities in 2013.

- **Choose Hauora Unlimited Rangatahi (CHUR)** was a multimedia project highlighting alcohol-related issues for Māori and Pacific youth. Ngā Kete Mātauranga collaborated with the Pacific Island Advisory and Cultural Trust to develop a variety of multimedia resources including a DVD, poster and a song.
- The **'Shout Out Southland' campaign** was aimed at youth and recognised the role of youth, whānau and community in encouraging positive lifestyle choices and ongoing positive reinforcement. The 'Shout Out Southland' programme included a series of posters in which key sporting and musical role models encouraged youth to *shout out*.

Planning and monitoring

The KPTO service specification required Ngā Kete Mātauranga to produce an annual service plan in consultation with key stakeholders. Over the evaluation period, the evaluation team only sighted the annual service plans for 2012 and 2013.

Ngā Kete Mātauranga's annual service plans aligned closely to the Accountability Framework and All Age Suicide Programme Logic Model. Programme activities were largely evidence based and well researched. For example, in 2011 KPTO research identified medication overdose as a primary means of suicide. In response, the KPTO Coordinators implemented a safe storage campaign and worked with pharmacists to improve knowledge and awareness of safe storage and safe disposal of

medications. Ngā Kete Mātauranga evaluated the campaign and made improvements before running the campaign with accompanying media activity in March 2012.

Plans identified key activities, associated tasks or actions, short-term outcomes and performance measures. Over the evaluation period, key activities focused on: youth, their whānau and building relationships with youth-centred services; safe storage and disposal of medication; gun safety; and developing and managing relationships with key stakeholders across the suicide prevention and postvention landscape.

In 2011 and 2012 the KPTO Coordinators furnished monthly reports to the KPTO Service Manager. These reports detailed key activities across the four programme objectives, networking activities, and training and development. They evidenced a well-structured, well-planned and well-established programme in the Murihiku/Southland region. Of particular interest was that each month the KPTO Coordinators reported networking activities and described newly created networks. It was clear that KPTO staff used these networks to extend the reach of the KPTO programme's messages.

In November 2012, following the transition of the KPTO programme to Ngā Kete Mātauranga's health promotion team, Ngā Kete Mātauranga integrated KPTO activity with wider health promotion activity including youth alcohol, parenting programmes and early childhood programmes. Activities promoted mental health and wellbeing among whānau in the Murihiku/Southland region.

Service monitoring during 2011–2012 focused primarily on the use of monthly reports and activity evaluations. It was clear that evaluations and reflective practice enhanced the programme, as did the KPTO team's use of its vast networks. Ngā Kete Mātauranga furnished six-monthly monitoring reports in line with service specifications.

3.8.3 Process evaluation conclusions

Programme delivery and activities

In 2011 and 2012 the KPTO programme prioritised stakeholder engagement. For much of the evaluation period, the KPTO Coordinators clearly understood that stakeholder relationships were critical to the achievement of programme objectives. Presentations to stakeholders increased understanding and awareness of the KPTO programme in the Murihiku/Southland region.

In November 2012 the KPTO programme transitioned into Ngā Kete Mātauranga's Health Promotion team, giving it a Māori health promotion and a public health focus. The evaluation found that throughout 2013 KPTO activity transitioned from a focus on stakeholder engagement and collaboration to health promotion campaigns run largely through resource development. Service integration was seen as a positive aspect in this approach.

Planning and monitoring

Ngā Kete Mātauranga's annual service plans aligned closely with the Accountability Framework and All Age Suicide Programme Logic Model. Programme activities were largely evidence based and well researched. Service monitoring during 2011–2012 focused primarily on the use of monthly reports and activity evaluations. It was clear that evaluations and reflective practice enhanced the programme, as did the KPTO team's use of its vast networks. Ngā Kete Mātauranga furnished six-monthly monitoring reports in line with service specifications.

3.8.4 *Impact evaluation findings*

Community impact and alignment with objectives

Throughout the evaluation period, Ngā Kete Mātauranga largely met KPTO programme objectives. In 2011 it began a campaign to improve awareness of the safe storage and disposal of medications. In May 2011 safe disposal script pack inserts were printed and distributed to all pharmacies in the Murihiku/Southland region.

In 2011–2012 the KPTO team contributed to the design of strategy and policy for Southland’s regional response to suicide prevention. For example, they contributed to the development of the Future Directions Southland Mental Health and Addictions Network Strategic Quality Plan, the Southland Suicide Prevention Network Media Engagement Plan and a traumatic response document, as well as participating in the Southland Mental Health Collaborative Promotion Group. This focus on multi-agency collaboration around strategy and policy development helped to improve mental health services for Māori.

In 2012 KPTO staff used existing networks to make presentations about safe reporting of suicide by media to journalism students at the Southern Institute of Technology. The KPTO Coordinators also worked with the Southland Suicide Prevention Network to develop a media engagement plan, which detailed media engagement activities and provided useful information to media stakeholders.

There was little evidence to suggest that the KPTO programme’s shift to the Public Health team in Ngā Kete Hauora improved its service reach. Monitoring reports suggested a decline in evaluation- and evidence-based approaches to suicide prevention activity. Stakeholders interviewed also reported a decline in networking and collaborative engagement efforts across the region.

Value to the region and to the programme

The evaluation found that during 2011 and 2012 the KPTO Coordinators contributed significantly to suicide prevention initiatives across the region. The team, through its well-established networks, also contributed to key suicide prevention strategic and policy developments. Initiatives were well researched and enhanced using feedback from programme and activity evaluations. The team engaged in clear reflective practice to inform programme enhancements and grow service reach. The general consensus among stakeholders was that in 2012 and 2013 the suicide prevention message got lost within wider public health campaigns.

Cultural competency

Although monitoring reports described tikanga-based training opportunities, after a change in Ministry of Health policy in 2012, KPTO Coordinators were no longer able to access Te Whakauruora training. The KPTO programme over the evaluation period targeted whānau Māori but there was little evidence that Māori frameworks were used to influence service design and planning. The KPTO programme delivered by Ngā Kete Mātauranga in 2011–2012 was a generic suicide prevention programme. From late 2012 and 2013, key suicide prevention messages were lost in the design and delivery of generic health promotion messages. Programme planning and design were influenced by the Ottawa Charter, which was clearly useful in terms of health promotion principles but the programme generally lacked a kaupapa Māori influence. Nonetheless, observation confirmed that the KPTO Coordinators are culturally competent and fully conversant with tikanga practices.

Strengths and opportunities for improvement

Stakeholders interviewed felt that the health promotion focus of the KPTO programme was at odds with a kaupapa Māori approach or a Māori view of suicide prevention. KPTO staff agreed that a significant enhancement for the programme would be to extend it to include suicide prevention,

intervention and postvention activities. This would provide opportunities for more meaningful whānau engagement.

3.8.5 Impact evaluation conclusions

Community impact and alignment with objectives

Ngā Kete Mātauranga was appointed as a KPTO provider in 2011 and has undertaken numerous and varied activities that largely meet the KPTO programme objectives. During the evaluation period, a key focus for the KPTO team has included networking and relationship building. However stakeholders interviewed reported a decline in networking and collaborative engagement efforts across the region.

The majority of the service objectives were aimed at increasing community awareness and building community resilience with a health promotion focus.

Value to the region and to the programme

The evaluation found that during 2011 and 2012, the KPTO Coordinators made a significant contribution to suicide prevention initiatives across the region. The team, through its well-established networks, also contributed to key suicide prevention strategic and policy developments. Initiatives were well researched and enhanced using feedback from programme and activity evaluations. The team engaged in clear reflective practice to inform programme enhancements and grow service reach.

Cultural competency

Although the KPTO programme over the evaluation period targeted whānau Māori, there was little evidence that Māori frameworks were used to influence service design and planning. The KPTO programme delivered by Ngā Kete Mātauranga in 2011 and 2012 was a generic suicide prevention programme. From late 2012 and 2013, key suicide prevention messages were lost in the design and delivery of generic health promotion messages. Nevertheless, the KPTO programme was delivered in a culturally competent way by Coordinators who were committed to Māori development and best outcomes for whānau.

Strengths and opportunities for improvement

Stakeholders interviewed felt that the health promotion focus of the KPTO programme was at odds with a kaupapa Māori approach or a Māori view of suicide prevention. It was suggested that the overall KPTO framework should be reconsidered within the Māori cultural context.

KPTO staff agreed that a significant enhancement for the programme would be to extend it to include suicide prevention, intervention and postvention activities.

3.9 Te Rūnanga o Te Rarawa: Northland Far North

3.9.1 Overview

KTCL undertook the site visit of Te Rūnanga o Te Rarawa (TROTR) on 19–20 August 2014. Naomi Manu and Careene Andrews from KTCL conducted this evaluation site visit and interviewed all staff members involved with the programme: the CEO, the Principal Advisor, Service Delivery, the KPTO Service Manager and the KPTO Coordinator.

TROTR provided contact details for key stakeholders involved with the programme during the evaluation period, 1 July 2010 – 31 December 2013. Of these stakeholders, seven were available to

participate in the evaluation: two whānau focus groups; Te Hauora o Te Hiku o Te Ika; Taipa Area School; adult mental health services; Te Roopu Kimiora Youth Mental Health Services; and the Suicide Prevention Coordinator at Northland DHB (interviewed on the Northland Mid North site visit).

The Ministry of Health provided documents relevant to the evaluation, including annual reports, project plans and annual service plans. Documents reviewed on site included the Northland DHB Annual Plan 2013/14; Northland DHB Māori Health Annual Plan 2013/14; Northland DHB Health Services Plan 2012–2017; and the Long Term Plan for Whānau, Hapū and Iwi o Te Rarawa 2013.

Limitations of the site specific evaluation

A key limitation to this evaluation was the short time between establishment of the KTCL contract with the Ministry of Health and commencement of the site evaluation. In this tight timeframe, Te Rūnanga o Te Rarawa could not secure expanded whānau and community member participation in the evaluation.

3.9.2 Process evaluation findings

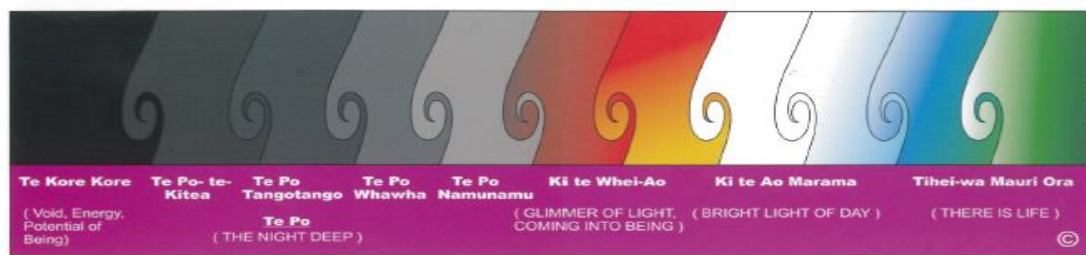
Programme delivery and activities

During 2010 and 2011 the KPTO programme focused on health promotion. One of its initiatives was to promote positive texting in schools in response to considerable cyber-bullying and suicidal ideation during that period. Initially schools were reluctant to engage KPTO staff to deliver the programme as they considered it might glorify suicide. The KPTO Coordinator and TROTR staff strengthened relationships with schools to enable successful programme delivery. The programme enhanced awareness of cyber-bullying and its impact on some peers of students.

In 2011 KPTO staff sought to establish a Kāhui Kaumātua group to support the programme. TROTR staff reported that kaumātua expressed resistance to discussing suicide and suicide prevention initiatives. The two main foundations for their views were, first, some Christian perspectives of suicide and, second, a general misunderstanding that discussing suicide glorifies it. In 2011–2012 the Northland Far North experienced a cluster of youth suicides. Local responses to the suicides ranged from deciding where to bury the young person to communities refusing provider and agency intervention. It was within this context that the KPTO programme needed to operate.

In response, KPTO staff changed the nature of activities to include indigenous approaches such as identifying cultural best practice models relevant to Māori suicide prevention. They developed and distributed the Tihei-wa Mauri Ora resource, which used Māori cultural understanding of the order of life and being and reflected life stages of being, divine potential, darkness and light.

TIHEI-WA MAURI ORA



Vivienne Body & Teina Piripi

TE RUNANGA O TE RARAWA

Tihei-wa Mauri Ora is an indigenous resource based in Maori cultural understandings of the creative order of life and being. All life goes through these stages of being, darkness, and light as life grows. These stages are eternal and cyclic.

There are different realms of life development beginning with Te Korekore, ki Te Po, ki Te Whei-Ao, ki Te Ao Marama, Tihei-wa Mauri Ora!

Te korekore (pitch black) the vast mass of potential being, imbued with divine essences (conception).

Te Po realms (various shades of black) darkness and night stages of growth and development
(Child grows within the mother's womb).

Te Whei-Ao (reds/orange) the realm of coming into being, critical changes and transition, glimmer of light
(Mother goes into labour in process of birthing).

Ki Te Ao Marama (white/light blue) the realm of light and being, this world, mortality (child is born into the world of light).

Tihei-wa Mauri Ora! (Blue/green) the living breath of life.

We can liken these stages 'of being' to represent different things like how we feel, our relationships, health and wellbeing, any aspect of our lives can be metaphorically represented within Maori cultural understandings of growth, development, and being.

KPTO delivery focused on whānau ora and whānau wellbeing. Through the programme, health promotion activities involved te ao Māori concepts such as manu aute (kite making and flying traditions). Manu aute activities were seen as connecting the heavens and the earth. Traditionally the use of manu aute ranged from light entertainment to significantly spiritual rituals. Children and adults made manu aute to practise whakawhanaungatanga, reinforce tikanga/kawa, commune with spiritual deities, produce artwork, perfect aerial movements and test skills in competition.

The KPTO team introduced manu aute and traditional techniques for making them to various schools in the Northland Far North region. Through manu aute, rangatahi and children could express their feelings about suicide and the loss of whānau and friends and could begin the process of healing.

In 2012 KPTO staff also introduced rongoā practice to the community and offered workshops and training sessions. The rongoā programme was a way for community and whānau to access healing in te ao Māori.

Also in 2012 an interagency social wellbeing governance group was established to more effectively respond to the challenges facing vulnerable children, youth and families in Te Tai Tokerau. The governance group (comprising representatives from Northland DHB, Police, Ministry of Social Development, Ministry of Education, Te Puni Kōkiri, Tai Tokerau Iwi Chairs and the Whangarei Children's Team) provided overall leadership and oversight of interagency responses and agreed strategies that impacted on the social wellbeing of Northlanders. The strategic focus was youth suicide.

Within this framework, a Fusion Group shared intelligence on a daily basis and was responsible for collating and analysing information on youth and families that present high vulnerability and risk. This information was used to mobilise crisis intervention at a local level (through local response teams) and inform the development of prevention strategies that enhance the social wellbeing of

Northlanders.¹² The KPTO Coordinator was a member of the Far North Local Response Team, which was responsible for:

- providing a coordinated local response that minimised the risk to others when a young person suicides, which included preparing and maintaining a local risk register
- sharing information with relevant providers in the area who were able to contribute to postvention and/or suicide prevention strategies
- developing agreed action plans including responsibilities and accountabilities of the participating agencies' groups for postvention
- providing support to whānau and/or communities affected by suicide
- providing input into the development of interagency suicide prevention strategies and implementing these strategies once they were approved by Governance Group.

Planning and monitoring

The KPTO service specification required TROTR to produce an annual service plan in consultation with key stakeholders. TROTR developed annual service plans that detailed key activities across the following four objectives:

- promote mental health and wellbeing for Māori
- reduce access to the means of suicide
- increase safe reporting of suicide by media
- contribute to improved mental health services for Māori.

These four programme objectives represented four of the seven goals of the New Zealand Suicide Prevention Strategy 2006–2016 and KPTO All Age Suicide Programme Logic Model. The plans highlighted key activities to achieve these objectives and anticipated short- to long-term outcomes.

TROTR was cognisant of community vulnerabilities in developing its annual service plans. Throughout 2011–2013 the KPTO programme was required to operate in communities where youth remained vulnerable following at least five high-profile sexual abuse investigations and associated convictions. It was against this backdrop, including a growing number of youth suicides, that TROTR was required to deliver the KPTO programme. The difficulty for the KPTO Coordinators was that the community crises required a shift from the strategic intent of the contracted service to the direct response needed in the community.

The plans reflected a Māori worldview and attempted to develop programmes and initiatives to support whānau access solutions within te ao Māori. Other activities included resource development, relationship management with key stakeholders, interagency meetings and activities, attendance at community events, training and workshops with local school students and teachers, and hosting youth suicide prevention days.

Annual service plans aligned to the Accountability Framework and All Age Suicide Programme Logic Model and included activities, short-term to long-term outcomes, performance measures and data collection methods. The results of monitoring were reported in six-monthly performance returns to the Ministry of Health and monthly reports from the KPTO Coordinator to the Service Manager. Reports included key highlights for the period, difficulties or barriers to implementation of the KPTO programme and opportunities for improving its implementation.

The evaluation team sighted workshop and training evaluations. TROTR used feedback from these evaluations to inform programme enhancements and identify other activities.

¹² Retrieved from Northland Intersectoral Forum website (www.nif.org.nz).

3.9.3 Process evaluation conclusions

Programme delivery and activities

KPTO activities incorporated indigenous approaches that identified cultural best-practice models relevant to Māori suicide prevention. KPTO delivery focused on whānau ora and whānau wellbeing. Through the programme, health promotion activities involved te ao Māori concepts such as manu aute and rongoā. These programmes enabled communities and whānau to access solutions and healing within te ao Māori.

KPTO reinforced the success of a community response to a community need with their involvement with the Fusion Group, established in 2012. This group shared intelligence on a daily basis and was responsible for collating and analysing information on youth and families that present a high vulnerability and risk. The information was used to mobilise crisis intervention and inform the development of prevention strategies.

Planning and monitoring

Annual service plans aligned to the Accountability Framework and All Age Suicide Programme Logic Model. They included activities, short-term to long-term outcomes, performance measures and data collection methods. The results of monitoring were reported in six-monthly performance returns to the Ministry of Health and monthly reports from the KPTO Coordinators to the Service Manager. Reports identified key highlights for the period, difficulties with or barriers to implementation of the KPTO programme and opportunities for improving its implementation. The evaluation team sighted workshop and training evaluations. TROTR used feedback from workshop evaluations to inform programme enhancements.

3.9.4 Impact evaluation findings

Community impact and alignment with objectives

TROTR used Māori models to promote awareness of suicide prevention. Evaluations of its rongoā and manu aute activities found that as a result of programme and workshop attendance, the majority of respondents (90 percent) felt that they were more connected to the community and empowered to make better life changes. In addition, 70 percent of respondents reported improved family relationships and 65 percent indicated improved self-esteem as a result of their participation.

In 2012, following a spate of youth suicides, the Fusion Group decided to support a road show of the play *Matanui*, a two-hour production that included content relating to some of the key challenges young Northland people face such as alcohol, teen pregnancy, sexual abuse and suicide. *Matanui* aimed to empower youth and their communities in order to build community resilience. Fusion Group and Local Response Group members accompanied the road show and were introduced to the audience. Their involvement enhanced visibility of the KPTO programme and evidenced the collective impact of community collaborations to address community concerns.

The KPTO team promoted suicide prevention information and awareness in TROTR's quarterly periodical *Te Kukupa*, which was distributed to over 3000 people. Information was also circulated via Facebook and the local radio station. In addition, KPTO delivered workshops with secondary school students, focusing on anti-bullying messages and promoting positive texting in schools.

Value to the region and to the programme

The five stakeholders interviewed were mixed in their views of the effectiveness of the KPTO programme. Four reported strong relationships and involvement with the KPTO programme. One stakeholder reported that they used the Tihei-wa Mauri Ora resource in the mental health sector and that Māori clients used the resource to articulate how they were feeling.

KPTO Coordinators provided critical support to agencies and community organisations during periods of crisis. Stakeholders reported that KPTO staff had strong community relationships and provided support to improve access to services for Māori communities and local schools.

In 2013 the KPTO Coordinators began a programme of working with marae and haukāinga to explore cultural imperatives in relation to suicide such as tangihanga, whānau pani, mihimihi and nehua. Workshop evaluations reported positive outcomes from the use of rongoā Māori, such as karakia, tikanga, hīkoi ngahere, moana and wai moana, as alternative therapies for suicide prevention.

Cultural competency

The KPTO programme delivered by TROTR sought solutions to suicide prevention and postvention from within te ao Māori. This led to the delivery of programmes such as rongoā and manu aute throughout the Northland Far North. The KPTO programme, as delivered by TROTR, extended the reach of the overall programme objectives by working directly with whānau.

While whānau intervention does not strictly meet the intent of the KPTO as a health promotion programme, evidence suggests that the rongoā and manu aute activities made the KPTO programmes more effective in Māori communities. One whānau interview participant reflected on the importance of the workshops delivered by KPTO in the following way.

‘Not only do we learn a skill, but it is the kōrero that sits behind that. Like, for example, we might make a whare out of cardboard boxes, we are reminded that our whare needs four pou and when our four pou are in alignment, the whare stands. So too is it with us ... We must balance our four pou. Through these workshops we discover healing within te ao Māori.’

Strengths and opportunities for improvement

The strength of TROTR’s KPTO programme is that its suicide prevention activities were derived from within te ao Māori – and it was the only provider to do so. Resources produced by the KPTO Coordinator were used in the wider mental health sector and promoted by the Northland DHB. Activity and workshop evaluations reinforced the view that the TROTR approach to suicide prevention had positive outcomes.

Staff reported that, given the nature of the suicide landscape, the KPTO programme would have a greater reach by widening its focus to include suicide prevention, intervention and postvention.

3.9.5 Impact evaluation conclusions

Community impact and alignment with objectives

Overall the KPTO programme identified key activities that aligned to the KPTO programme objectives. The focus on tikanga practices and kaupapa Māori models of care in service provision also had a positive impact on the community. As these were locally developed and approaches were adapted to local needs, there was stronger buy-in and engagement from the community.

KPTO involvement in the Fusion Group helped to improve information sharing and policy development both at a strategic level as well as at a community level.

Value to the region and the programme

Stakeholders interviewed reported that the KPTO programme played a critical role in the suicide prevention landscape. They specifically referenced improved access to Māori communities and schools as a result of their relationships with KPTO.

Participation in the Fusion Group reinforced the success of a community response to community needs. Interview participants reported that organisations were better positioned to address the varied and complex community needs when they shared resources and overall coordination improved.

Cultural competency

The nature of activities changed to include indigenous approaches, such as identifying cultural best-practice models relevant to Māori suicide prevention. The KPTO programme delivered by TROTR sought solutions to suicide prevention and postvention from within te ao Māori, which led to the delivery of programmes such as rongoā and manu aute throughout the Northland Far North. KPTO staff also developed and distributed Tihei-wa Mauri Ora, a resource that used Māori cultural understanding of the cultural order of life and being. The resource and reflected life stages of being, divine potential, darkness and light. The evaluation found that the manu aute and rongoā activities extended the effectiveness of the KPTO programmes within Māori communities.

Strengths and opportunities for improvement

The strength of TROTR's KPTO programme was that its activities were derived from within te ao Māori— and it was the only provider to do so. Resources produced by the KPTO Coordinator were used in the wider mental health sector and promoted by the Northland DHB. Activity and workshop evaluations reinforced the conclusion that the TROTR approach to suicide prevention had positive outcomes.

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Appendix 1: Evaluation overview and methodology

Evaluation objectives

The evaluation commissioned by the Ministry of Health sought to determine:

At a process level

- how service activities were determined, designed, planned, delivered and monitored by each of the service providers to align with the Programme Accountability Framework and the All Age Suicide Programme Logic Model
- what was delivered by the programme, including how and with whom (service partnerships) the programme was delivered as a whole and how it was being delivered by each service provider

At an impact level

- the impact of the programme on the communities and the extent to which it is meeting each provider's service planning objectives
- the value the programme added to Māori suicide prevention in communities within each district health board region, and how it contributed to the wider suicide prevention sector in New Zealand
- the cultural competency of the programme
- the strengths and opportunities for improvement of the programme.

Methodology

KTCL used underlying principles of kaupapa Māori research to shape the approach to this evaluation. These principles included appropriately expressing tikanga and kaupapa, emphasising whakawhanaungatanga (making and renewing relationships), promoting kanohi ki te kanohi (face-to-face) methods of inquiry and recognising the importance of collective benefit and reciprocity, as well as giving prominence to the voices of Māori participants. Methods included:

6. **evaluation planning** in May 2014 after contract signed
7. **tool development** (interview and focus group tools and consent forms) for interviews with KPTO / service provider staff, stakeholders and whānau; participant notification letters sent in June 2014
8. **pre-site visit document review** (documents provided by the Ministry of Health) such as performance monitoring reports, project plans and service action plans
9. **site visits** conducted July and August 2014, which included on-site document reviews and staff and stakeholder interviews. See Tables 1 and 2 below for details of representation and number of participants in the interview process
10. **stakeholder online survey**, which was available for those who could not attend or who were unable to be interviewed during site visits. In August 2014, an online survey was distributed to 48 stakeholders.
11. **analysis of findings** against the six evaluation questions (two process and four impact questions)
12. drafting of nine individual reports and a summary report and submitting them to the Ministry of Health along with personal presentation; editing of draft reports and production of final report.

Table 1: Provider participation in the KPTO programme evaluation

Region of provider	Board	CEO/ Management	KPTO Coordinators	Others (internal to provider)
Whanganui	✓	✓	✓ (2)	
Hawke's Bay	x	✓	✓ (2)	Service Manager
Northland Far North	x	✓	✓ (1)	(2) Principal Advisor and Service Manager
Northland Mid North	x	✓	✓ (2 current + 1 former)	(2) Quality Manager and Line Manager
South Auckland	x	✓	✓ (2)	Quality Coordinator
Bay of Plenty	x	✓	✓ (2)	-
Lakes District	x	✓	✓ (2)	
Christchurch	x	✓	✓ (2 current + 1 former)	Service Manager
Invercargill / Southland	x	✓	✓ (2 current + 1 former)	

In total, 34 people participated from the nine organisations, excluding the three former KPTO Coordinators interviewed. All of the KPTO Coordinators who were employed at the time of the site visits participated.

Table 2: Stakeholders who participated face-to-face in the KPTO programme evaluation (excluding stakeholders who completed online survey)

Region	District health boards – public health, mental health	Local authorities (e.g. Safer Community)	Social development – Child Family Services; Work & Income	Iwi, hapū, marae, Māori providers, Māori community	Justice – Police, Courts	Education sector – schools	Other NGOs	Total
Whanganui	1	1	–	1	–	1	3	7
Hawke's Bay	1	1	1	1	–	1	1	6
Northland Far North	2	–	–	3	–	1	–	6
Northland Mid North	1	–	–	1	1	–	2	5
South Auckland	1	–	–	–	–	1	2	4
Bay of Plenty	1	1	–	1	–	1	1	5
Lakes District	1	1	–	1	–	–	1	4
Christchurch	1	2	–	3	–	1	1	8
Invercargill / Southland	2	–	–	2	–	–	2	6
Total	11	6	1	13	1	6	13	51

In total, 51 people were interviewed from the different target sectors. The majority were representatives from district health boards, the Māori community and other non-governmental organisations.

While the participation of 51 stakeholder participants was viewed as substantial given the short timeframe, and representation from the health sector, Māori community and community NGO was strong, there were identified gaps in participation of the justice, education, social development and local authority sectors. Aiming to bridge this gap and gain perspectives from stakeholders in these sectors, in August 2014 KTCL sought and received approval from the Ministry of Health to undertake an online survey with external stakeholders. External stakeholders who could not be personally interviewed at site visits were invited to complete an online survey (Figure 1), giving their perspectives of the effectiveness of the processes and activities of the KPTO programme, its impact on and value to the community, barriers inhibiting its successful implementation and suggested improvements. KTCL distributed the survey to 48 stakeholders across the nine KPTO regions, of which 20 respondents completed this survey. Stakeholders included whānau and clients, as well as representatives from DHBs, Māori providers, New Zealand Police, social service providers and other NGO groups.

The goal of the survey was to try to gain perspectives from all seven identified stakeholder sectors for each of the nine regions, or approximately 60–65 stakeholder perspectives. The range of online survey linkages that were disseminated is demonstrated in Table 3 below.

Table 3: Breakdown of stakeholders who were sent the online survey for completion

Region	District health boards – public health, mental health	Local authorities (e.g. Safer Community)	Social development – Child Family Services; Work & Income	Iwi, hapū, marae, Māori providers, Māori community	Justice – Police, Courts	Education sector – schools	Other – NGOs	Total
Whanganui	–	–	–	–	–	–	–	0
Hawke's Bay	5	1	1	2	1	1	1	12
Northland Far North	–	–	1	–	–	1	–	2
Northland Mid North	–	–	–	–	–	–	–	0
South Auckland	2	1	1	1	1	–	–	6
Bay of Plenty	2	1	1	1	1	1	1	8
Lakes District	1	1	–	–	1	1	–	4
Christchurch	–	–	1	2	2	–	–	5
Invercargill / Southland	2	2	1	2	2	1	1	11
Total	12	6	6	8	8	5	3	48

Among the 20 responses received, some did not identify their stakeholder type (nine responses) or their region (three responses). Therefore the results of the online survey were aggregated for the summary report only. They were not included in the individual reports so that individual regional findings were not skewed.

The need to take an aggregated approach was disappointing for the evaluation because the addition of 20 online responses to the 51 face-to-face responses would have provided perspectives from 71 stakeholder participants. If identifiers were available, the target stakeholder participant profile of around seven stakeholders for each of the nine regions might have been achieved.

Figure 1: Stakeholder survey

Evaluation of Kia Piki Te Ora

The Ministry of Health has commissioned Kāhui Tautoko Consulting Ltd (KTCL) to evaluate the Kia Piki Te Ora Suicide Prevention Programme (the Programme). The focus of the following questions seeks to i) assess the impact and value of the Programme on Māori suicide prevention in your community; and ii) identify strengths and opportunities for improvement of the Programme.

The Ministry of Health will use the evaluation to inform future decision-making about the Programme and provide evidence about the effectiveness of the Programme for the communities supported.

* 1. What do you think of, or what do you know of the Kia Piki Te Ora Suicide Prevention Programme?

* 2. If you are aware of the Programme, what kind of impact and/or value has it added to the area of suicide prevention in your community?

3. If you have worked collaboratively with Kia Piki Te Ora, how effective was this collaboration in terms of suicide prevention in your community?

4. What can the Community, Whanau, and/or agencies 'best' do to prevent suicide?

* 5. What kind of barriers are there to successful suicide prevention activities?

* 6. If you were to develop a suicide prevention programme that aims to promote mental health and wellbeing for Maori, what would an effective programme look like (e.g. what has worked or what could work)?

* 7. Are there any other issues/information that you want to share about the Programme that have not been covered?

8. I consent to the evaluation including my views and comments (without identifying me personally)

☐ Yes
☐ No

9. Name & Region

Analysis and reporting

Because interview and survey questions were aligned to the six evaluation questions, KTCL analysed data from document reviews and responses from participants into themes for each evaluation question. Where appropriate, the following terms were used to describe the quantity of staff or stakeholder responses to various questions in the evaluation, for ease of reading:

- 'the majority' of participants – 75 percent or more made or affirmed this statement or finding
- 'most' or 'many' of the participants – 50–75 percent made or affirmed this statement or finding
- 'some' of the participants – 25–50 percent made or affirmed this statement or finding
- 'a few' of the participants – 25 percent or less made or affirmed this statement or finding.

This report presents a summary of the findings of the individual site-specific process and impact evaluations of the KPTO programme delivered by the nine regional contracted service providers. An individual summary report was prepared for each service provider and KTCL was asked to incorporate these into this report rather than produce them separately. This report therefore includes the nine individual reports (Section 3), along with a summary of key themes drawn from them (Section 1) and a number of recommendations to improve the programme (Section 2).

Limitations

The primary limitation of this evaluation was that interviews could be conducted with only five of the 17 KPTO Coordinators who had been employed during the entire evaluation period (1 July 2010 to 31 December 2013) and a further two who had been employed for a portion of that period. In many regions, therefore, KTCL was unable to obtain accurate or informed responses from KPTO Coordinators about process and service delivery for the evaluation period. As a consequence, KTCL had to rely mostly on its review of whatever documentation was available for that time.

In addition, where KPTO Coordinators lacked knowledge of the evaluation period, it was more difficult to identify stakeholders who were involved with KPTO or who may have been involved in activities during the evaluation period. Wherever possible, stakeholder names and agencies were identified from the document review in order to cover a sufficient range of stakeholder perspectives.

To overcome these limitations and reach those who could not be interviewed face-to-face, KTCL sought approval from three providers to contact former KPTO staff and sought approval from the Ministry of Health to undertake the online stakeholder survey.

Finally KTCL sought to reach a cross-section of external stakeholders from seven sectors (education, health, local government, social development, non-government community, justice/police and Māori community) in the nine regions. Its target was to gain this representation from around 60–65 stakeholder participants. Regrettably some stakeholders responding to the online survey did not identify their region and/or their stakeholder type, so a detailed breakdown of region and stakeholder type for all 71 participants (51 face-to-face interviewees and 20 online survey respondents) could not be made. Consequently, comprehensive stakeholder perspectives could not be included in the individual regional reports. Data and information from the face-to-face interviews were included in individual reports while those from the online survey respondents were only included in the national summary report.

Appendix 2: Glossary of Māori terms

Hapori	Section of kinship group, family, society or community
Hapū	Sub-tribe
Hauora	Wellbeing
Hīkoi	Walk or march
Hui	Gathering or meeting
Iwi	Māori tribe
Kanohi ki te kanohi	Face to face
Kapa Haka	Māori cultural or performing group
Karakia	Prayer
Kaumātua	Elder
Kaupapa Māori	Māori approach, Māori topic
Kōrero	Speak or talk
Mahi	Work
Mana	Prestige, authority or spiritual power
Manaakitanga	Hospitality, kindness or generosity
Manu aute	Kite flying
Marae	Meeting house
Mātauranga	Learning
Rangatiratanga	Chieftainship
Rohe	Boundary or district
Rongoā	Remedy or medicine
Rūnanga	Council
Taitamariki	Youth or adolescent
Te ao Māori	The Māori world
Te reo Māori	Māori language
Te Whakauruora	A Māori suicide prevention resource
Tikanga	Māori customs and protocols
Wānanga	To meet and discuss; a seminar
Whākaaro	A thought, opinion or understanding
Whakamomori	To commit a desperate act
Whakapapa	Genealogy or lineage
Whānau	Family
Whānau ora	Family wellbeing
Whanaungatanga	Relationship

Appendix 3: Summary of suicide data

Source: Ministry of Health. 2011. *Suicide Facts: Deaths and intentional self-harm hospitalisations*. Wellington: Ministry of Health.

- In 2011, the total Māori suicide rate was 16.8 per 100,000 Māori population; 1.8 times higher than the non-Māori rate (9.1 per 100,000 non-Māori population).
- Between 1996 and 2011, non-Māori male suicide rates trended downwards, while the trend for Māori male suicide rates was less pronounced. No obvious trend was evident for either Māori or non-Māori females.
- In 2011, the Māori youth suicide rate (36.4 per 100,000 Māori youth population) was 2.4 times higher than the equivalent rate for non-Māori youth (15.1 per 100,000 non-Māori youth population).
- Youth rates for non-Māori are trending downwards over time, but Māori rates show no such trend.
- There were 24 suicide deaths among Pacific people and 28 suicide deaths among Asian people in 2011.
- Rates for Pacific and Asian people have not been calculated because the small number of suicides means rates are variable and may be misleading.

Table 5: Suicide deaths, by ethnicity, age and sex, 2011

Ethnicity	Sex	Total	Age group (years)															
			10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85+
Māori	Total	108	2	28	18	20	13	5	6	7	7	2	0	0	0	0	0	0
	Male	80	2	21	11	14	10	4	5	6	5	2	0	0	0	0	0	0
	Female	28	0	7	7	6	3	1	1	1	2	0	0	0	0	0	0	0
Pacific	Total	24	1	7	5	3	2	3	0	1	2	0	0	0	0	0	0	0
	Male	15	0	4	3	2	2	2	0	1	1	0	0	0	0	0	0	0
	Female	9	1	3	2	1	0	1	0	0	1	0	0	0	0	0	0	0
Asian	Total	28	0	4	3	3	2	3	1	3	2	2	1	1	0	1	0	2
	Male	20	0	3	3	2	2	2	1	3	1	2	1	0	0	0	0	0
	Female	8	0	1	0	1	0	1	0	0	1	0	0	1	0	1	0	2
Other	Total	318	0	15	44	24	22	26	28	40	27	28	25	9	6	7	10	7
	Male	254	0	11	37	20	19	21	23	30	22	21	21	5	5	7	8	4
	Female	64	0	4	7	4	3	5	5	10	5	7	4	4	1	0	2	3
Total	Total	478	3	54	70	50	39	37	35	51	38	32	26	10	6	8	10	9
	Male	369	2	39	54	38	33	29	29	40	29	25	22	5	5	7	8	4
	Female	109	1	15	16	12	6	8	6	11	9	7	4	5	1	1	2	5

Source: New Zealand Mortality Collection

Suicide deaths									
By sex and broad ethnic group									
1996–2011									
Year	Māori				Non-Māori				
	Male		Female		Male		Female		
	Number	Rate ⁽¹⁾	Number	Rate ⁽¹⁾	Number	Rate ⁽¹⁾	Number	Rate ⁽¹⁾	
1996	71	28.3	24	9.1	357	22.5	88	5.5	
1997	77	28.0	26	9.4	363	22.4	95	5.8	
1998	87	32.5	25	8.3	358	21.8	107	6.2	
1999	58	19.9	20	6.3	327	19.9	111	6.6	
2000	69	25.5	11	3.8	306	18.8	72	4.2	
2001	57	20.3	22	6.7	331	20.0	97	5.4	
2002	59	21.2	21	6.8	294	17.0	92	5.2	
2003	67	22.7	20	6.4	309	17.0	121	6.4	
2004	82	29.0	27	8.4	297	16.5	82	4.5	
2005	78	26.9	26	8.3	302	16.8	105	5.4	
2006	75	25.9	33	10.7	313	17.0	105	5.3	
2007	74	25.9	23	7.3	297	15.7	93	4.4	
2008	56	19.8	31	8.9	325	17.0	108	5.4	
2009	58	19.3	25	7.4	335	17.4	92	4.4	
2010	74	23.9	32	9.4	312	15.7	117	5.9	
2011 ^(P)	80	25.7	28	8.4	289	14.6	81	3.8	
1. Age-standardised rates are per 100,000 population. They are age standardised to the WHO World Standard Population. See <i>Age standardization of rates: A new WHO standard</i> (PDF, 76kb), available at http://www.who.int/healthinfo/paper31.pdf .									
Symbol:									
P	provisional								
Source: Suicide Facts: Deaths and intentional self-harm hospitalisations 2011; Ministry of Health, Mortality Collection.									

Over the five years from 2007 to 2011:

- three DHB regions (Bay of Plenty, Tairāwhiti and MidCentral) had statistically significantly higher suicide rates than the total New Zealand rate
- Waitemata, Auckland and Capital & Coast DHB regions had statistically significantly lower suicide death rates than the country as a whole.

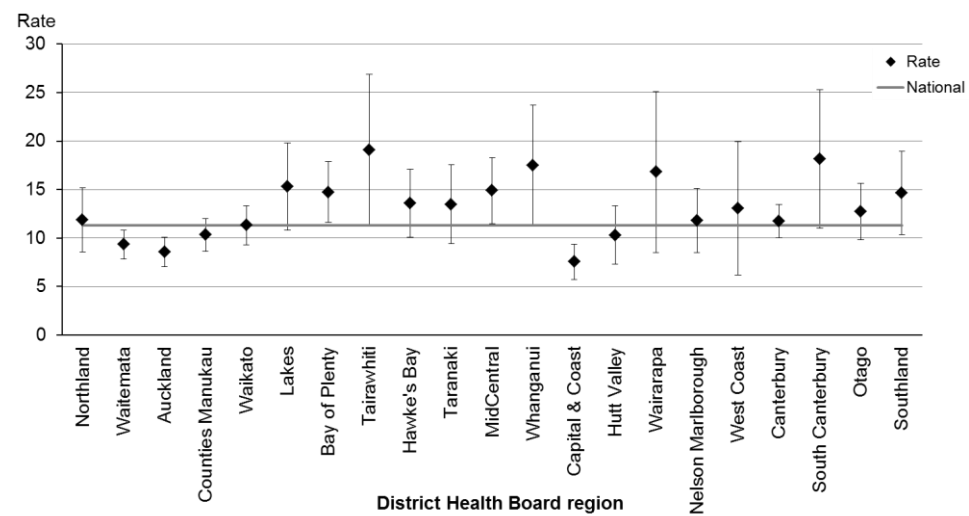
In this section, data for DHB regions has been aggregated over five years (2007–2011) because the small number of suicides annually in some areas makes analysis unreliable.

The New Zealand national suicide rate for this five-year period¹³ was 11.3 suicides per 100,000 population; this is shown by the horizontal line in Figure 14. The figure also shows confidence intervals¹⁴ to aid interpretation. Where a DHB region's confidence interval crosses the national suicide rate, this means the DHB region's suicide rate was not statistically significantly different to the national suicide rate.

¹³ The national suicide rate has been calculated based on the New Zealand estimated resident population as at 30 June 2009 (the mid-point) and standardised to the WHO standard world population.

¹⁴ Confidence intervals are for 99 percent confidence.

Figure 14: Suicide age-standardised death rates, by DHB regions, 2007–2011



Source: New Zealand Mortality Collection

Table 15: Intentional self-harm hospitalisations, by ethnicity, age group and sex, 2011

Ethnicity	Sex	Total	Age group (years)																
			5–9	10–14	15–19	20–24	25–29	30–34	35–39	40–44	45–49	50–54	55–59	60–64	65–69	70–74	75–79	80–84	85+
Māori	Total	463	0	13	107	74	52	35	55	48	41	19	12	5	0	2	0	0	0
	Males	186	0	4	41	35	23	15	21	19	14	4	5	4	0	1	0	0	0
	Females	277	0	9	66	39	29	20	34	29	27	15	7	1	0	1	0	0	0
Pacific	Total	92	0	3	27	16	16	9	9	1	4	4	1	2	0	0	0	0	0
	Males	34	0	1	8	7	8	3	3	1	2	1	0	0	0	0	0	0	0
	Females	58	0	2	19	9	8	6	6	0	2	3	1	2	0	0	0	0	0
Asian	Total	79	0	1	21	15	7	5	9	8	7	1	1	1	0	2	0	0	1
	Males	23	0	0	5	5	1	3	2	4	2	0	0	1	0	0	0	0	0
	Females	56	0	1	16	10	6	2	7	4	5	1	1	0	0	2	0	0	1
Other	Total	2013	1	48	304	270	167	140	182	233	174	154	126	61	55	34	21	22	21
	Males	695	1	12	78	82	59	56	65	65	62	49	56	34	28	17	9	14	8
	Females	1318	0	36	226	188	108	84	117	168	112	105	70	27	27	17	12	8	13
Total	Total	2647	1	65	459	375	242	189	255	290	226	178	140	69	55	38	21	22	22
	Males	938	1	17	132	129	91	77	91	89	80	54	61	39	28	18	9	14	8
	Females	1709	0	48	327	246	151	112	164	201	146	124	79	30	27	20	12	8	14

Source: New Zealand National Minimum Dataset

Table 16: Intentional self-harm hospitalisation numbers and rates, by ethnicity and sex, 1996–2011

Year	Number									Rate								
	Māori			Pacific			Non-Māori/non-Pacific			Māori			Pacific			Non-Māori/non-Pacific		
	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total	Male	Female	Total
1996	147	249	396	32	32	64	994	1576	2570	56.3	89.7	73.5	32.8	31.3	31.8	69.9	113.5	91.5
1997	178	262	440	23	51	74	955	1605	2560	64.0	87.9	76.1	26.1	50.0	38.2	64.7	112.0	88.0
1998	217	268	485	29	34	63	983	1572	2555	76.7	91.9	84.5	29.4	35.0	32.2	66.6	107.2	86.7
1999	194	260	454	28	48	76	867	1441	2308	67.4	85.0	76.3	29.6	47.0	38.4	58.9	98.5	78.5
2000	191	293	484	38	41	79	919	1535	2454	66.7	96.2	81.6	35.7	38.1	37.0	62.0	105.8	83.6
2001	211	302	513	30	42	72	873	1678	2551	71.7	96.6	84.1	26.6	35.3	30.8	59.2	113.9	86.5
2002	152	268	420	46	59	105	796	1581	2377	53.0	87.9	70.8	40.7	50.3	45.5	51.4	103.6	77.5
2003	193	305	498	29	52	81	827	1736	2563	66.1	97.1	82.0	25.1	46.1	36.2	53.3	112.0	82.6
2004	178	259	437	27	41	68	777	1718	2495	60.8	81.9	71.4	22.2	35.8	29.3	49.5	110.2	79.7
2005	187	275	462	40	42	82	726	1473	2199	63.9	85.2	74.6	33.3	33.3	33.2	45.8	93.8	69.7
2006	174	299	473	36	34	70	781	1545	2326	60.2	93.5	77.2	28.5	25.9	27.2	47.5	95.5	71.5
2007	194	269	463	36	40	76	710	1437	2147	68.0	82.9	75.3	29.6	30.4	29.9	42.4	86.7	64.5
2008	152	262	414	47	36	83	678	1293	1971	52.3	79.8	66.3	35.2	26.3	30.6	39.5	77.5	58.4
2009	176	281	457	35	42	77	736	1269	2005	59.7	83.7	71.6	27.0	29.7	28.3	43.0	75.9	59.4
2010	223	312	535	46	50	96	721	1473	2194	75.2	92.5	83.6	32.2	34.8	33.5	41.4	88.3	64.8
2011	186	277	463	34	58	92	718	1374	2092	59.8	82.6	71.5	23.9	40.1	32.1	40.8	82.0	61.2

Source: New Zealand National Minimum Dataset

Note: The rates in this table are age-standardised rates per 100,000 population, standardised to the WHO standard world population (see Appendix 1, Table A11).

Appendix 4: Suicide data by district health board regions

Summary

Over the three years from 2009 to 2011:

- 12 DHB regions had statistically significantly higher rates for intentional self-harm hospitalisations than the national rate, with Wairarapa being notably higher than all other DHB regions
- Auckland, Counties Manukau, Hawke's Bay and MidCentral DHB regions had statistically significantly lower rates than the national rate.

Hospitalisation data has been filtered to allow as much consistency as possible over time and between DHBs. However, filtering cannot completely eliminate differences caused by different methods of managing patients and keeping records.

In this section, data for DHB regions has been aggregated over three years (2009–2011) since intentional self-harm hospitalisation rates vary considerably from year to year. Table 19 and Figure 33 show accumulated numbers and rates for each DHB region by sex.

Table 19: Intentional self-harm hospitalisation numbers and age-standardised rates, by DHB region of domicile, 2009, 2010 and 2011 (accumulated data)

DHB	Males		Females		Total		Female:Male rate ratio
	Number	Rate	Number	Rate	Number	Rate	
Northland	132	66.8	243	114.2	375	90.3	1.7
Waitemata	378	47.2	569	71.2	947	59.2	1.5
Auckland	207	27.8	234	33.3	441	30.5	1.2
Counties Manukau	197	27.3	261	35.2	458	31.3	1.3
Waikato	269	52.4	443	85.5	712	69.0	1.6
Lakes	92	64.8	125	88.0	217	76.2	1.4
Bay of Plenty	183	63.7	287	99.7	470	81.6	1.6
Tairāwhiti	34	53.5	63	101.0	97	77.2	1.9
Hawke's Bay	81	38.4	97	42.4	178	40.5	1.1
Taranaki	90	60.6	138	94.2	228	77.2	1.6
MidCentral	79	34.4	144	60.3	223	47.5	1.8
Whanganui	53	58.7	68	79.4	121	68.8	1.4
Capital & Coast	186	42.2	548	120.2	734	82.1	2.8
Hutt Valley	102	49.9	271	125.9	373	88.1	2.5
Wairarapa	45	87.9	102	199.4	147	144.2	2.3
Nelson Marlborough	108	55.6	283	161.2	391	107.2	2.9
West Coast	34	77.7	64	137.2	98	106.9	1.8
Canterbury	288	37.1	618	87.8	906	62.2	2.4
South Canterbury	46	63.5	69	102.0	115	82.6	1.6
Otago	199	70.2	386	137.8	585	104.3	2.0
Southland	67	41.9	111	75.4	178	58.0	1.8
Overseas and undefined	5	...	13	...	18

Source: New Zealand National Minimum Dataset

Notes:

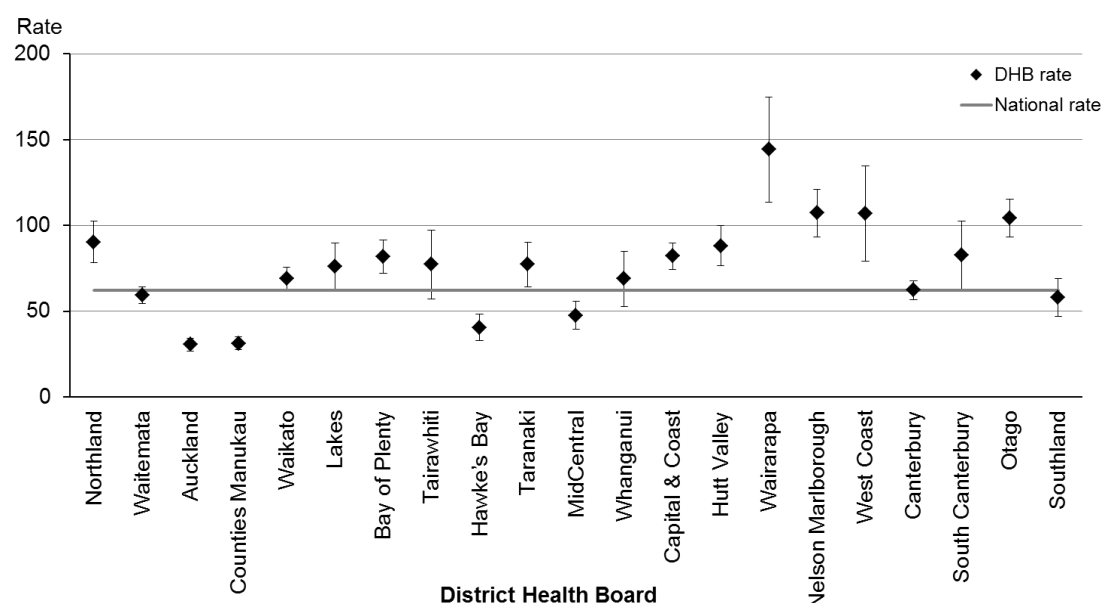
The rates shown are age-standardised rates per 100,000 population, standardised to the WHO standard world population.

... = not available.

The national rate was 62.2 intentional self-harm hospitalisations per 100,000 population over the three years from 2009 to 2011. This is represented by the horizontal line in Figure 33 below.¹⁵ The figure also provides confidence intervals¹⁶ to aid interpretation. Where a DHB region's confidence interval crosses the national rate, this means the DHB region's intentional self-harm hospitalisation rate was not statistically significantly different from the national rate.

Figure 33 shows that Wairarapa DHB region had the highest rate for intentional self-harm hospitalisations across all DHB regions over the three-year period 2009–2011. Twelve DHB regions had rates statistically significantly higher than the national rate. Auckland, Counties Manukau, Hawke's Bay and MidCentral DHB regions had statistically significantly lower rates than the national rate.

Figure 33: Intentional self-harm hospitalisation age-standardised rates, by DHB region of domicile, 2009, 2010 and 2011 (accumulated data)



Source: New Zealand National Minimum Dataset

Note: The rates shown are age-standardised rates per 100,000 population, standardised to the WHO standard world population.

Table 20 indicates considerable variation between DHB regions for Māori and non-Māori rates of intentional self-harm hospitalisation over the period 2009–2011. Among Māori, the highest rates were in the Waitemata DHB region for males and the Otago DHB region for females. The highest non-Māori rates for both males and females were seen in the Wairarapa DHB region. However, when the DHB region data is broken down into population subgroups, the numbers in some subgroups (for example, Māori males) are small and should be treated with caution.

¹⁵ The national rate has been calculated based on the New Zealand estimated resident population as at 30 June 2010 (the mid-point) and standardised to the WHO standard world population.

¹⁶ Confidence intervals are for 99 percent confidence.

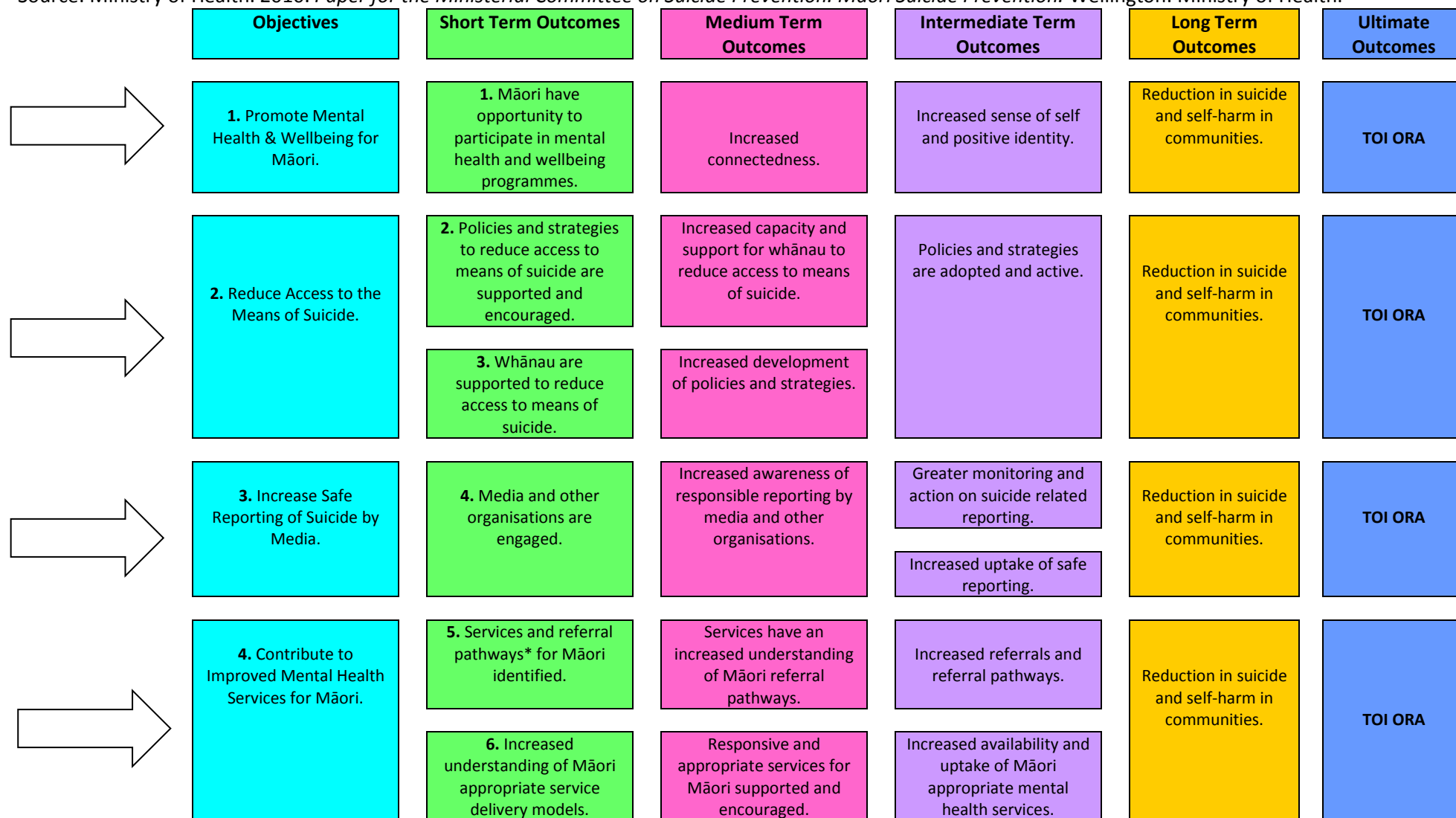
Table 20: Intentional self-harm hospitalisation numbers and age-standardised rates for Māori and non-Māori, by DHB region of domicile and sex, 2009, 2010 and 2011 (accumulated data)

DHB region	Māori				Non-Māori				Māori:non-Māori rate ratio	
	Males		Females		Males		Females		Males	Females
	Number	Rate	Number	Rate	Number	Rate	Number	Rate		
Northland	52	84.8	86	113.2	80	56.1	157	110.9	1.5	1.0
Waitemata	76	107.3	69	86.0	302	41.3	500	67.9	2.6	1.3
Auckland	29	53.8	31	54.8	178	26.2	203	30.9	2.1	1.8
Counties Manukau	55	53.4	54	43.1	142	23.3	207	32.8	2.3	1.3
Waikato	81	74.0	112	91.4	188	45.4	331	80.5	1.6	1.1
Lakes	27	58.6	55	103.1	65	65.4	70	78.2	0.9	1.3
Bay of Plenty	40	57.2	80	102.5	143	66.2	207	95.6	0.9	1.1
Tairāwhiti	18	58.4	31	90.6	16	42.3	32	110.3	1.4	0.8
Hawke's Bay	34	68.8	35	60.3	47	26.6	62	35.4	2.6	1.7
Taranaki	21	83.3	23	86.0	69	53.7	115	93.4	1.6	0.9
MidCentral	14	35.9	19	38.7	65	33.9	125	64.6	1.1	0.6
Whanganui	13	59.5	18	71.8	40	55.7	50	80.6	1.1	0.9
Capital & Coast	37	78.2	68	135.8	149	37.3	480	115.7	2.1	1.2
Hutt Valley	27	76.9	30	79.7	75	42.0	241	134.2	1.8	0.6
Wairarapa	6	69.1	20	201.4	39	87.5	82	190.9	0.8	1.1
Nelson Marlborough	5	25.3	21	108.1	103	58.3	262	167.9	0.4	0.6
West Coast	2	38.7	7	118.5	32	80.1	57	130.8	0.5	0.9
Canterbury	20	34.2	37	63.3	268	37.0	581	89.9	0.9	0.7
South Canterbury	5	86.3	6	100.4	41	60.0	63	100.8	1.4	1.0
Otago	12	64.6	43	218.5	187	70.6	343	128.4	0.9	1.7
Southland	11	57.2	22	118.9	56	39.0	89	68.3	1.5	1.7
Overseas and undefined	0	...	3	...	5	...	10

Source: New Zealand National Minimum Dataset. Note: The rates shown are age-standardised rates per 100,000 population, standardised to the WHO standard world population.

Appendix 5: Kia Piki Te Ora: All Age Suicide Programme Logic

Source: Ministry of Health. 2010. *Paper for the Ministerial Committee on Suicide Prevention: Māori Suicide Prevention*. Wellington: Ministry of Health.



* Referral pathways are across primary and secondary mental health service

