A refreshed New Zealand Suicide Prevention Outcome Framework - applying the outcome framework and service landscape tool.

Prepared by:
Rachel Haggerty
www.haggerty.net.nz

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Introduction

Suicide is a devastating event and a major public health issue. Every year, in the region of 500 people die by suicide in New Zealand, and the rate of suicide has remained largely unchanged over the last decade and a half. The effect of suicide on whānau, friends and communities is devastating, long-lasting and far reaching. The cost to the country is significant, estimated to be around $2 billion per annum.

The magnitude of this impact and the desire to make a difference was evident in the generosity and willingness of communities, providers and agencies to engage in, and support the development of the Suicide Prevention Outcome Framework (SPOF) and demonstrating its use. Their hope that the SPOF will provide a tool to contribute to more comprehensive and effective suicide prevention was evident. Those who participated in this development and testing recognised that successful suicide prevention requires cross sectoral, and community engagement, and that this commitment needs to be a sustained if we wish to reduce suicide and suicidal behaviour in our communities.

1 Background to this report

This is the final in a series of three reports commissioned on a suicide prevention outcome framework. The original work to design a suicide prevention outcome framework was commissioned in early 2015. It introduced a new population-based approach to outcomes that placed people and populations consistently at the centre of actions to reduce suicide and the way we measure their impact. This outcome framework supports strategic planning by focusing activity on those most at risk, and creating a frame for creating consistent national and local information on population outcomes.

Further work was commissioned late in 2015, with two key deliverables:

- the application of the SPOF to understand the nature and focus of investment under the current Action Plan (complete)
- the application of the SPOF service landscape tool to demonstrate how it is used to inform strategic planning and engage partners. This work is the subject of this report.

During this work, the opportunity was also taken to revise the SPOF integrating it with ‘He Tāngata – the Mental Health and Wellbeing Outcome Framework’ (He Tāngata). Action three of the original SPOF presented in May 2015 recommended the development of a set of population indicators of wider wellbeing to create a set of balancing measures that consider the wider environmental issues. As intended, these metrics were developed as part of ‘He Tāngata’ in 2016 and reflect wider social determinants.

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2 This report

This report for the Ministry of Health provides the findings of the work completed to demonstrate the use of the SPOF and the service landscape tools. This includes:

- demonstrating the impact of applying the service landscape tool to create better understanding of the LGBTQI target population and associated priority issues that could be addressed as part of suicide reduction activity
- revision of the Suicide Prevention Outcome Framework (SPOF) to reflect a Te Ao Māori world view
- use of the SPOF and the landscape tool to provide a meaningful framework to think about target populations and identify partners and contributing activity to support a broader and more integrated approach to suicide prevention for the Hawkes Bay.

Early in the landscaping process with Te Rau Matatini (TRM) the focus quickly shifted to reviewing the framework to incorporate a stronger Te Ao Māori perspective reflecting Te Tiriti O Waitangi. Māori are over represented in those who suicide in NZ. There was discussion as to whether there be a discrete framework for Māori. The participants in the TRM workshop decided to focus on reviewing the framework to incorporate Te Ao Māori. In response, the landscaping process was put aside to instead focus on how the outcome framework might be changed to reflect this. This change in activity was discussed and agreed with the Ministry of Health.

Using the service landscape tool, with representatives of the LGBTQI community and the Hawkes Bay District, we bought together agencies providers and communities together to consider opportunities to improve their approach to suicide prevention. The workshop processes identified following areas of focus for these communities:

- developing more effective approaches to suicide prevention in the LGBTQI community including identifying the need for a focus on understanding the impact of policy and services on the LGBTQI community,
- the opportunity for a wider approach to suicide prevention in the Hawkes Bay district thinking about a focus on social determinants, a wider range of partners, and a target populations.

In completing this work with these three target populations there was substantial work using the outcome framework to explore the SPOF including the goal and outcome and consider equity amongst the population, and developing service landscapes created knowledge and engagement that could demonstrate use. It was also identified that it was not possible to review detailed contract information to measure service contribution and/or develop performance measures. The challenges included a lack of specificity in available contract information and a lack of relationship and trust amongst the parties.
Suicide in New Zealand

In this section, we provide an overview of suicide in New Zealand including that suicide and suicidal behaviour is not distributed amongst the population and most importantly that suicide is preventable.

3 The risk of suicide

Suicide is one of the top three causes of pre-mature death in New Zealand. Socio-economic factors, racism, colonisation and stigmatisation are recognised risk factors influencing suicide and suicidal behaviours. This is evidenced in the people and populations most often represented in our suicide statistics. Suicide and suicidal behaviours varies amongst the population. The SPOF segments the population as well as the total populations.

Suicide rates\(^4\) show a significant social gradient reflecting a greater than 2:1 ratio between suicides by people in quintile one compared to those in quintile four.\(^5\) Mental health service users, who in addition to the impacts of their mental health condition experience greater exposure to other risk factors, make up 40% of all people who suicide.

Māori are substantially over represented in our suicide statistics with young Māori making up half of our young people who die by suicide but only around 15% of the total population. The provisional suicide rate for Māori of all ages in 2015 is 21.74. This compares to 3.40 for our Asian population, 9.15 for Pacific peoples and 13.58 for the remaining, ‘other’ population\(^6\).

Age matters. Suicide is the leading cause of death for young people aged 15 to 24 years, and our youth suicide rate is consistently around the top of the OECD rankings\(^7\). We are beginning to see some very young people suiciding, together with some evidence suggesting the emergence of an increasing numbers of people aged 85 years and over suiciding. The latter may, at least in part, reflect the ageing of the population. Increased risk of suicide in older people is a phenomenon seen internationally, but not previously here in New Zealand. Gender is another notable factor. Men make up three out of four people who suicide, though our rates for women are among the highest in the OECD\(^8\), and women make up two thirds of people who self-harm seriously enough to be hospitalised.\(^9\)

While not collected as part of the standard suicide reporting data\(^10\), there is research and agency-level data showing high rates of suicide among other population groups such as the Rainbow Community, in particular our transgender youth; people in CYF care; and people in engaged in the justice sector (including pre-sentencing, community and custodial sentences and post release).\(^11\)\(^12\)\(^13\) There is also

\(^4\) Suicide rates are measured per 100,000 population.
\(^6\) Chief Coroner’s Provisional National Suicide Statistics, October 2015.
\(^8\) Rates of suicide for New Zealand women were 9th among 35 OECD countries in 2012.
\(^10\) Presented in the Ministry of Health publication, Suicide Facts: Deaths and intentional self-harm hospitalisations; and the Chief Coroner’s annual release of national provisional suicide statistics.
\(^11\) Phase One Suicide Prevention Outcome Analytics by Dr Gary Jackson.
clear evidence that people who’ve recently lost someone to suicide are themselves at increased risk of suicide.

4 We can make a difference

 Suicide and suicidal behaviour is the result of a range of complex underlying causes, including poverty, unemployment, relationship breakdown and financial stress. A family history of suicide, substance abuse disorders, social isolation, some mental health disorders and childhood abuse are associated with greater risk of suicide. Long-term medical conditions and disabling pain are also known to increase suicide risks.\(^{14}\) While these risk factors can impact on any individual these factors together with other known risk factors such as racism, colonisation and stigmatisation, cluster combinations and with greater frequency around some groups or populations.

Suicide is preventable.\(^{15}\)\(^{16}\) Understanding risk factors and a belief that we can make a difference is central to our ability to respond. At an individual level, suicide prevention is about the ability to recognise the signs and then intervening successfully. Effective services that meet the needs of individuals are important, but alone are insufficient to materially reduce suicides in New Zealand.

A population-based approach is also required to identify those populations at greatest risk of suicide, and to support equity of outcome across population groups. Identifying these ‘target’ populations allows activity and investment to be directed purposefully to those at greater risk, to undertake prevention activities and to create more effective responses tailored to the specific needs and characteristics of the target population. Alongside recognising suicide risk factors, and understanding our populations and their respective exposure to clusters of risk factors, successful suicide prevention also requires “sustained focus, investment and leadership”.\(^{17}\) It takes cooperation and collaboration across sectors, and partnering with communities. It is therefore essential that “governments assume their role of leadership, as they can bring together a multitude of stakeholders who may not otherwise collaborate.”\(^{18}\)

This ‘government’ rather than ‘health’-focused partnership approach is evident in the Scottish government’s successful approach to suicide prevention. The Scottish Suicide Prevention Strategy “marks another milestone in the progressive story of suicide prevention in Scotland. It continues the trend in previous strategies to focus on where the evidence leads. It echoes key messages – learned from practice and research – that suicide is preventable, that it is everyone’s business and that collaborative working is key to successful suicide prevention.”\(^{19}\)

An outcomes approach to suicide prevention

This section describes the purpose of the suicide prevention outcome framework and provides a short overview of the approach and methodology.

5 The purpose of the Suicide Prevention Outcome Framework

The SPOF is a commitment under the current New Zealand Suicide Prevention Action Plan 2013–2016 (the Action Plan). Action 11.3 of the Action Plan commits to the development of an outcome framework to support suicide prevention activity and measure its impact. The development of the SPOF drew on the skills and knowledge of people in communities, and experts in all aspects of suicide prevention.

The SPOF is a strategic framework to support the Ministry of Health and District Health Boards (DHBs) to lead and coordinate inter-sectoral and community activity and investment aimed at reducing the incidence and rate of suicide and suicidal behaviour.

The purpose of a population approach to the outcome framework is to hold people and populations at the centre of suicide prevention activity. A population approach recognises that the risk and impact of suicide is not spread evenly across the population. Not all at-risk populations are captured in standard reporting mechanisms such as Suicide Facts or the Annual Suicide Statistics published by the Chief Coroner. The outcome framework uses literature evidence and data to identify target populations, ensuring a clear focus on who activity and investment is for. The development of socially cohesive target populations enables services to be tailored to better respond to the specific characteristics and needs of a given population, with potential improvements in service efficacy. Target populations also create a platform to support equity, as they can be compared against each other and the general population.

Service landscaping provides a tool for use by the people planning, designing, and investing in suicide prevention services. The service landscaping tool is intended to be used together with the outcome framework to understand the services available for the target populations across each of the key result areas. It creates a mechanism to understand where investment is focused, who it is for, and the level of service coverage for the target populations. Service landscaping is a mechanism to bring together services commissioned by multiple funders and create a common platform for sharing information. This supports understanding of service gaps and overlaps, redesign services and consider and/or change investment choices.

While the SPOF takes a strategic approach, it does not replace the need for a Suicide Prevention Strategy. Though the SPOF provides a tool to assist understanding of available services, coverage and investment for target populations it does not, and is not intended to, obviate the need for this analysis to occur. The outcome framework is a tool to focus activity, but recognises that target populations may change over time, as may partners, services and investment.

6 A population-based outcome framework to reduce suicide

The population-based outcome methodology used here is informed by complex adaptive systems theory, collective impact and Results-Based Accountability™ (RBA). As such, this population outcome approach aligns to the Ministry of Health accountability framework and builds on this to understand
investment and commissioning contributions to achieving population level outcomes. Each part is scalable so can be applied at a local, district, regional and nationwide levels, creating nationwide consistency whilst supporting local responsiveness. There are three parts to the SPOF; the outcome framework, the service landscape tool and population performance story.

6.1 The outcome framework
The outcome framework is arranged into three parts:

- A shared purpose: Quality of life outcome and goal
- Key result areas and population indicators
- The target populations

These five components come together to create a clear line of sight between the shared purpose (quality of life outcome and goal), the key result areas, and associated population indicators. Target populations focus attention on those groups at greatest risk and for whom activity should be targeted and services tailored to achieve the goal and to ensure equity of outcome across populations.

6.1.1 A shared purpose: Quality of life outcome and goal
What are we trying to achieve?
Activity under the framework is driven by the shared purpose. This is designed to focus commissioning, inter-sectoral and collective impact processes on contributing to the agreed goal and quality of life outcome.

The quality of life outcome describes the purpose or ultimate outcome being sought. The goal defines the scope and focus of the outcome framework. The quality of life outcome and goal are measured through the key result areas and their population indicators (described below).

The goal of the original SPOF was to *Reduce the incidence and rate of suicide and suicidal behaviours in Aotearoa/New Zealand*. The quality of life outcome to support this goal, and that the SPOF was built around, was -- “*New Zealanders are socially connected, healthy and experiencing wellbeing*”. The choice of this quality of life outcome reflects evidence that societies with high levels of social cohesion and wellbeing experience lower rates of suicide.

6.1.2 Key result areas and population indicators
What matters for people to live good lives?
The key result areas reflect those things that are recognised as necessary to achieve or experience the life outcome, and research into what matters most to the target populations.

Progress in achieving the key result areas is measured using a series of identified, quantifiable population indicators. These measures support equity by enabling comparison of variation between target populations. The population indicators encompass measures that reach across the health and social sectors. This supports the cross sectoral approaches necessary to effectively respond to complex health and social problems, and creates a shared reporting framework that integrates the range of factors that influence the desired quality of life outcome. Over time, headline measures across the life course can be developed where contributory relationships are identified.
The three key result areas in the original SPOF were: New Zealanders are resilient and healthy; those at risk of suicide are protected; the impact of suicide is relieved. These result areas created the organising structure for the main types of suicide prevention activity, otherwise known in the sector as ‘prevention, intervention and postvention’. The original population indicators identified to support the key result areas were: distress in the community (1X calls to Police); suicidal behaviour – people hospitalised as a result of self-harm; suicide mortality (rate and number). Reflecting the relationship of wellbeing and social cohesion and suicide, and following consumer feedback during the development of The Mental Health and Wellbeing Outcome Framework: He Tāngata, these were later expanded to include a set of wellbeing measures based on work by the OECD\(^{20}\). The wellbeing measures reflect socio-economic factors, or in health terms – the social determinants of health.

### 6.1.3 Target populations

Who are we doing it for?

Identifying and understanding the people we are serving is the central organising principle informing this population-based outcome framework. This is achieved through a process of population stratification to identify target populations. The underpinning analysis considers not only the people accessing services but also those who may be under-served or invisible in standard data sets by analysing a range of additional factors including the literature evidence. Importantly, target populations do not need to be discrete as factors often overlap.

The role of target populations

Creating target populations enables activity to be more clearly directed to populations most at risk and supports measurement across populations to better understand inequalities between populations. A population approach recognises the importance of shared social structures and other factors experienced by populations at risk of suicide. This in turn supports improvements to service design through better understanding of the attributes of target populations and the clusters of risk factors impacting on these populations, with the aim of improving outcomes at both an individual and population level.

The original SPOF target populations were Mental Health Service Users, Other Males 25 - 64yrs, Other 10 - 24 years, Māori 10 - 24 years, Other 75+ years, Māori Males 25-44 years, Pacific Males 25-44 years, Pacific 10-24 years, Prison Population, Child Youth & Family and LGBTQI.

### 6.2 The Service Landscape tool

What is available to support people?

There are a large range of health and social services available to support people in New Zealand, including community and natural supports. These services are commissioned and provided by many agencies, providers and communities. They are most often well planned, informed by evidence and structured to deliver results for individuals and communities. However, what they are, who they serve and what they are achieving is not always transparent to commissioners and funders across agencies or to communities, providers, or service users. The service landscape tool unlocks the complexity of service

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activity - to understand what service activities and supports are available, and the contribution that are making.

6.3 The population performance story

Do we know what is working?
The population performance story is created using the population-based outcome framework and the Service Landscape Tool. This presents the collective result for people and populations as a result of service, system and policy activity, and generates two performance stories:

- population outcomes
- contribution analysis.

6.3.1 Population outcome analysis
Population outcome analysis is critical to understanding what is working for target populations. It monitors the population outcome, using key result areas and population indicators. Outcome analysis dashboards can be created for each target population, providing baseline information from which to measure change over time and to identify inequities across target populations and the general population. The method to create population outcome dashboards for target populations is described in detail in the implementation section of this Report.

6.3.2 Contribution analysis
The contribution of services to outcomes is understood using the Service Landscape. This process links the service response to the population outcome, and enables a comparative analysis between populations, and across key result areas. Contribution analysis includes analysis of service coverage, investment and performance, and the results they generate for target populations.
Demonstrating the use of the SPOF and service landscape tool

This section outlines the process and findings from working with a district to develop approaches in the Hawkes Bay and the LGBTQI target population, as a representative of a small nationwide population,

7 Working with a District Health Board - Hawkes Bay DHB

This SPOF is specifically designed to strengthen and support the role of district health boards (DHBs) by creating a strategic framework and a tool to support the development of collaborative approaches to suicide prevention and to organise investment at the local level. Working with Hawkes Bay District Health Board (HBDHB), the service landscape tool was used to identify partners and the range of services available to support suicide prevention. Overall the workshop processes gave the Hawkes Bay participants an organising system for understanding where the opportunities exist to improve approaches to suicide prevention.

Sustained ownership of the outcome framework, the availability of population outcome dashboards, routinely available analysis of suicides and suicidal behaviour, and the use of the inter-sectoral data would strengthen the work of DHBs in suicide prevention.

7.1 Introduction

The Hawkes Bay DHB offered the following advantages for investigation of the activities and measures of mental health users because it: is optimally sized to secure good representation of service providers and users; has a mixed rural and urban population; has a significant Māori population; and less financial distress that could distract from the workshop. The Hawkes Bay District Health Board has a well-established Suicide Prevention programme of work. There is good intersectoral participation and the partners are well known to each other.

There were two workshops held in the Hawkes Bay; the first being to introduce the SPOF and look at the opportunities it presented. The second being to develop service landscapes. This was followed up with telephone and email contact to create the service landscape schedule.

7.2 Suicide in the Hawkes Bay

Suicide and suicidal behaviour is not spread evenly across the country. Analysis of local data against national level information is important to inform local decisions about where to focus activity and investment. The table below shows this for the Hawkes Bay. Please note the total numbers are for 2.5 years, which was the available data set. The nationwide analysis was analysed over five years. The numbers in the second brackets are those who are mental health service users. The rate of suicide has been annualised. The suicide rate in the Hawkes Bay is slightly higher that the nationwide result with some notable differences:

- a lower proportion of those who died by suicide are known to the Mental Health services being 26% locally and 40% nationwide
- the rate of Pacific suicide is higher reflecting very low numbers of Pacific people alongside small suicide rates
- Māori youth, males and females had a higher suicide rate than nationwide.

Table 1: Suicide incidence and rate
Mental health service users are the population with the highest rate of suicide in New Zealand. They account for 40%\(^\text{21}\) of suicides, whilst representing only 2.6% of the total population. During the workshop process it rapidly became clear that working with HBDHB presented a specific opportunity to understand the services available for Mental Health Service Users. During the workshops the analysis extended beyond Mental Health Service Users to Māori Rangatahi and Older People.

### 7.3 Applying the SPOF

In the Hawkes Bay District a group of providers and community providers who work in suicide prevention were invited to participate in a process that introduced the SPOF and used the service landscaping tool to develop understand current activity and identify opportunities. The participants received a copy of the SPOF. The workshop explored the suicide rate and incidence to understand possible target populations in the Hawkes Bay. Initially, the intention was to focus on mental health service users as the target population.

Using the service landscape tool follows a four-step process. In this demonstration, we completed step one and two. Step three and four require access to very detailed contract performance and financial information. In completed step one and two, the limited structured and focused investment in suicide prevention and associated social determinants was apparent.

Figure 1 Four step process for service landscaping

### 7.3.1 Choosing the target population
The workshop participants reviewed the information outlined above in section 8.2 on suicide in the Hawkes Bay. The participants identified that it would be worthwhile to consider three target populations. They were:

- Mental Health Service Users
- Rangatahi Māori
- Older People

### 7.3.2 Identifying partners
A number of participants were invited to the workshop including health service providers, NGOs, communities, Māori communities. These participants represented services and organisations seeking to support the community and prevent suicide.

### 7.4 Mental Health Service Users
Mental health service users have the greatest risk of suicide of the target populations with an age standardised rate of 137.1, compared to 12.9 for the remainder of the population. In this population, like that of the general population, more men (76%) than women (24%) die by suicide. Importantly, unlike the rest of the population of people who suicide they are less likely to be Māori and Pacific, suggesting that these communities are less likely to be accessing mental health services.

In the Hawkes Bay the picture is slightly different as mental health service users represent only 26% of all suicides. Furthermore, Māori and Pacific mental health service users who suicide is proportionate to their representation in the population. In Table 2 below we have identified the partners who may contribute to the prevention of suicide for mental health service users.

#### 7.4.1 Workshop discussion
Workshop participants from the DHB indicated that they have an established practice of working closely with their mental health services users to understand suicide risk. They also had a comprehensive follow-up programme for those who presented at the Emergency Department with suicidal behaviour. Overall, there was a passion and commitment to work collaboratively to prevent suicide.

In the workshop discussion attendees identified several opportunities to use the outcome framework approach to improve results:

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Firstly, it was evident that suicide is not recognised as preventable by all mental health professionals. The importance of establishing a clear shared purpose for mental health service users, and those who have exhibited suicidal behaviour was critically important.

Secondly, that communication across providers working with individuals at risk was significantly important. It highlighted that there was an opportunity to better share information and risk assessments across the providers. The workshop identified five providers who could immediately do more work to share information on suicide risk, namely: Emergency Department; Mental Health Service Providers; Te Taiwhenua O Heretaunga; Springhill (the private AOD Hospital); and Te Wharenui – a community provider.

Finally, that a collaborative approach to suicide prevention for mental health service users across provider would be valuable in building integrated and joined up approaches.

7.4.2 Identifying partners

The table below identifies the partners who could also be supporting mental health service users. The partners are separated out into:

- those providing universal health services available to all people with a healthcare need
- the social service NGOs for those services have eligibility criteria for access
- community services that may be supporting mental health service users.

Appendix one provides the detailed draft service landscape map. This map highlights the significant opportunities to extend the engagement of social service providers and to address the wider wellbeing challenges for mental health service users.

Table 2: Identifying partners working with mental health service users

<table>
<thead>
<tr>
<th>Government Agencies</th>
<th>Universal services</th>
<th>Social Service NGOs</th>
<th>Community Supports</th>
</tr>
</thead>
<tbody>
<tr>
<td>Work &amp; Income NZ</td>
<td>Emergency Department Mental Health inpatient and community services CAFS – Child, Adolescent &amp; Family Services Older Person Mental Health Primary Mental Health Care Primary Care Community Pharmacy Optometrist Hearing Aid/Audiologist Dentists</td>
<td>EAP/GAINS Psychology Family Works Awhina Whānau (Counselling) Te Taiwhenua O Heretaunga Mental Health Whatever it Takes (Workbridge) Emerge Services Wairoa Tāngata Emerge Aotearoa (Richmond Fellowships) Springhill – private AOD Hospital* Hawkes Bay Housing Coalition Te Wharenui Home support services Red Cross Salvation Army Innov8 (Waka Hourua)</td>
<td>Wairoa Kahungungu Papa Kainga Swimming Pools Recreation Centres Citizens Advice Bureau Libraries Men in Sheds Churches Federated Farmers</td>
</tr>
</tbody>
</table>
7.5 Young Māori people: Rangatahi

Suicide is the leading cause of death for rangatahi. For rangatahi Māori the rate of death by suicide is 3.1 times greater than for non-Māori youth. The rate for young Māori women, the rate is almost 4.8 times greater than for young non-Māori women. For young Māori males that rate is 2.6 times greater than non-Māori males. In the Hawkes Bay, there has been significant concern regarding the rate and incidence of suicide by young Māori.

7.5.1 The workshop discussion

Workshop participants raised a shared concern regarding the suicides amongst young Māori, and that this problem was becoming insurmountable. The service landscape process identified the centrality of wellbeing and early intervention as critical to effective suicide prevention for rangatahi Māori, and the importance of healthy home environments and schools. During the workshop process opportunities were identified using coherent and cross sector approach to suicide prevention:

- Firstly, the importance of school environments in creating positive environments and providing opportunities for early intervention such as using the Year 9 HEADSS Assessment, and the Positive behaviour for Learning programmes. There were also local initiatives, for example the Positive Living programme at Wairoa College. The need for more intensive services in schools for at-risk rangatahi was identified.

- Secondly, there is value in further stratifying Māori youth at the local level to differentiate activity and investment for those with complex needs and exhibiting suicidal or self-harming behaviour, from those who are thriving. The range and calibre of support services available was identified as an issue, as many of those at-risk found it hard to identify and access support. The Youth Directions Service was seen as fulfilling a critical role for young people in enabling access to services. The role of Child, Youth and Family, and the family violence services (LIVE Hawkes Bay and POLS400\(^23\)) were identified as critical for responding to those with complex needs. Workshop participants noted that those rangatahi with complex needs were at even greater risk where they were also engaged with the justice system. This insight is supported by the findings of the recent Suicide Mortality Review undertaken by the Health Quality and Safety Commission.

- Thirdly, the importance of comprehensive support for those who exhibit suicidal or self-harming behaviours. Although self-harm may not lead to suicide, it is a significant indicator of distress and potentially risk. Responses for these young people are currently poorly coordinated or simply not available.

- Finally, workshop participants raised the need for greater support for whānau members to ensure they have the skills and support to keep their whānau safe following self-harm, suicidal behaviour, where there is diagnosed mental illness. This sits alongside the need for good postvention support after suicide.

Table 3: Identifying partners working with Māori Youth

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<th>Social Service NGOs</th>
<th>Community Supports</th>
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Māori Rangatahi in School

\(^23\) Responses for children who witness violence.
7.6 Older people in the Hawkes Bay

In the previous 18 months, eight people over the age of 65 years died by suicide in the Hawkes Bay. Although the rate of suicide is reducing as the population ages and the size of the older population is growing, and as such the total number of people dying by suicide is increasing. This was a population that the participants had not previously identified, although the numbers in the Hawkes Bay were significant.

Mental health service users are not broken down by age, however, there is clear evidence that older people experience rates of depression between 15-20% and that social isolation is a significant issue for this population. Brown, Woolf, and Smith (2010)\textsuperscript{24} used the NZGSS\textsuperscript{25} to show that social isolation and loneliness were negatively associated with well-being among New Zealand adults\textsuperscript{26}. NZGSS 2010 data showed that adult New Zealanders who felt lonely all of the time in the last four weeks were less likely to be satisfied with their life overall (59 percent) than those who never felt lonely (91 percent).

Workshop participants noted that the partners who work with older people have not traditionally been engaged in a suicide prevention process. This was potentially a population where low cost interventions such as engaging community supports and engaging service providers in suicide prevention training could have a positive impact on suicide rates for this population. Appendix Three: The Draft Service Landscape for Older People identifies the significant community connections already available to older people.


\textsuperscript{25} New Zealand General Social Survey. The Survey is undertaken every two years by Statistics New Zealand.

7 LGBTQI/Rainbow Community

This workshop processes with LGBTQI representative and service providers identified the following:

- challenges in developing the service landscape for the LGBTQI community
- key issues that affect the entire LGBTQI community
- sub-populations of the LGBTQI community across the life course.

The LGBTQI or Rainbow Community includes people who identify as lesbian, gay, bisexual, queer, or are intersex or transgender. This is a relatively small population most appropriately considered at a nationwide level. Literature evidence\(^{27}\)\(^{28}\)\(^{29}\)\(^{30}\) and population analysis undertaken for the original SPOF shows the Rainbow community has a significantly higher rate of suicide than the general New Zealand population. LGBTQI people also have a higher risk of poor mental health throughout their lives, including depression, anxiety, suicide and self-harm, substance misuse and eating disorders.\(^{31}\) This population, however, is diverse and not all groups within the population have an elevated risk of suicide.


In mid-2016, two workshops were held with LGBTQI community representatives and organisations working with the Rainbow community. Workshop discussions were supported using New Zealand and international research, and policy documents from the United States, Denmark, the United Kingdom and Australia. Summaries of the literature, workshop discussions and issues identified for the at-risk sub-populations were circulated for comment and further contributions among workshop participants and some associated networks. The findings of these workshops are summarised below.

A service landscape was initiated as part of the workshop process. It very rapidly became clear that there were significant issues in relation to policy and legislative settings, and service availability specific to this community. With the agreement of the Ministry of Health, the focus of the workshops then shifted to using the service landscape tool as the structure to further examine and record these issues, and the opportunities for improved responses for those most at risk in this target population.

### 7.1 Suicide risk in the LGBTQI community

A combination of insights from workshop attendees, research, and endeavours to create a service landscape for this population was used to better understand the risk of suicide for the New Zealand LGBTQI community. Included among the workshop participants were representatives from Ara Taiohi. Ara Taiohi is a peak body for Youth Development and is responsible for administering the Queer/Trans Grants Programme established in 2014. The Grants Programme was the first of its kind for Aotearoa/New Zealand and sees Ara Taiohi engaged with 57 groups working to support Rainbow youth around the country, and 48 organisations received funding under the programme. They commented that of these organisations, 76% are working with young people who are suicidal, and 65% working with young people who have lost someone close to suicide.

Work undertaken in the development of the original SPOF shows a higher risk of suicide for both the young adult (14-25 years) and adult LGBTQI populations, compared to the general population. Workshop participants considered that available data significantly under-represents the rate of suicide in the on the LGBTQI population, and this is supported in the literature. Gender and sexual orientation may not be known by Coroners, and therefore not recorded as a factor in a suicide. This situation can be further complicated where a Coroner is aware that making a person’s sexuality an explicit factor in a suicide would be distressing for the person’s family.

### 7.2 Specific risk factors for people and sub populations of the LGBTQI community

Recognition and acceptance of identity are important for wellbeing. In policy terms this is expressed through a legal framework that recognises identity and gender, and enshrines rights equal to those of other citizens. Recent legislative reforms that enshrine lesbian and gay rights to civil union (in 2004) and

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32 One was held in Wellington, and a second was held in Auckland.
to marriage and the adoption of children (in 2013), have supported greater recognition and acceptance, thereby reducing experience of stigmatisation and social isolation. While these are important symbols of acceptance, wider public attitudes are slower to change. Public support for these changes was still only polled at 63% in 2012\(^{40}\) meaning social isolation and stigmatisation based on sexual orientation remain very real issues for this population.

The ability to easily and formally nominate a preferred gender identity is limited by highly restrictive criteria in New Zealand. This is particularly challenging for transgender and intersex people who wish to record a gender change or an intersex identity. These legal barriers to asserting identity affects people’s daily experience of life.\(^{41}\) Differences between a person’s appearance and their documented gender can generate repeated questions from people in authority, whether in government services or private organisations. The impact for the transgender or intersex person can be traumatic. In contrast to New Zealand, a 2014 law change in Denmark permits people to change their gender following a person signalling intent and a six-month waiting period to confirm the change.\(^{42}\)

The issue of minority stress was a significant discussion point in the Wellington workshop. Minority discrimination and stress has an important impact on people’s sense of wellbeing and belonging. Stigma has wide-reaching effects including access to housing, employment and social support. People can be the targets of verbal abuse and physical violence. Lack of acceptance can be internalised by affected individuals further undermining their self-esteem and capacity to function in their daily lives.\(^{43}\)

People from Māori and Pasifika families can find their communities less accepting of LGBTQI identities, again impacting of people’s sense of belonging within their families and their communities.\(^{44}\) These communities often respond to culturally understood terms that more generally indicate differences in gender identity and sexual orientation, for instance takatāpuhi and whakawahine in Māori, fa’afafine in Samoan, fakaleiti in Tongan fakaleiti, and fiafifine in Niuean. Workshop participants commented that attention to these language preferences is important for crafting interventions for suicide prevention.

Several other issues were also identified by workshop participants, including:

- demand exceeds the availability of the paid workforce
- there are gaps in the workforce from Māori and diverse cultural backgrounds meaning a lack of support for appropriate resource development
- homelessness is a major issue for young Rainbow people who often find themselves without economic or family support
- there are no Ministry of Health-level best practice guidelines for Rainbow healthcare and no accountability for healthcare responses for Rainbow young people
- there are no Ministry of Education level best practice guidelines for Rainbow education and no accountability for education environments to Rainbow young people.


\(^{44}\) https://www.mentalhealth.org.nz/assets/ResourceFinder/takatapui.pdf
Participants in both Wellington and Auckland workshops commented on what they saw as a lack of specialist services for this community. They noted the importance of recognising and funding a representative or peak body to support communication about LGBTQI issues with government. They saw this as contributing to improving the quality of policy advice and to more effective commissioning of services for suicide prevention among LGBTQI.

7.3 LGBTQI/Rainbow through the life course and sub-populations
This section provides an overview of challenges for the Rainbow community across the life course and for sub-populations.

Tamariki 0-14 years
The socioeconomic factors (social determinants) that can lead to poor outcomes including self-harm, suicidal ideation and suicide can begin to impact in early life. There are risks for tamariki who experience disapproval from parents and peers for behaviour that diverges from their conventionally accepted gender role. Disapproval does not need to be overt to have damaging effects.

A second source of risk for tamariki is their school environment. In New Zealand, same and both sex attracted young people are more likely to be bullied, physically harmed or be afraid that someone will hurt them at school. Surveys have shown children and young people have significant mental health issues, including 59% self-harming and 18% attempting suicide in the preceding 12 months. Forty-one percent experienced depressive symptoms compared to 11% of opposite-sex attracted students.\(^\text{45}\) Programmes to address bullying in schools are not likely to be sufficient to address the distress experienced by LGBTQI students. United States research has shown that LGBTQI-identified students were over three times as likely to think about and attempt suicide and 1.4 times more likely to be absent from school, as heterosexual-identified students within the same school and who reported equivalent levels of bullying.\(^\text{46}\) Workshop participants reported that in New Zealand just a few schools operate diversity programmes, and these programmes are vulnerable to closure through changes to school leadership and funding. Both anti-bullying and pro-diversity programmes are important to address suicide among LGBTQI tamariki.\(^\text{47}\)

Family acceptance of gender identity and sexual orientation appears to be a lifetime protective factor leading to better health and social outcomes for LGBTQI people.\(^\text{48}\)

Rangatahi 15-24 years
Adolescence is time of rapid physical, sexual, social and emotional change. It’s a time of identity formation, with young people transitioning from childhood and school to adulthood and entry into higher education and employment. Young people are moving in adulthood, taking on greater responsibility for themselves and moving toward independence. The changes over this period increase


young people's susceptibility to all kinds of risks. These include the impacts as a result of inequalities, increased risk taking behaviour such as risky sexual behaviour and substance use. This is also the period when serious mental illnesses may emerge, such as depression or schizophrenia.

For LGBTQI young adults' ‘coming out’ adds an additional complexity. Risks may be particularly intense for young men, those from conservative cultural backgrounds, and intersex people. Meta-analysis of research shows that gay and bisexual men have more suicide attempts. On this basis, workshop participants suggested that this life-stage could be extended to 30 years for this population group.

New Zealand school surveys have found that nearly four percent of student’s report being attracted to others of their own sex or both sexes. While more young people are ‘coming out’ (around 50% of those attracted to the same or both sexes, in 2012), only 14% said that they could talk about this easily with their family. In New Zealand, there are few resources for people negotiating LGBTQI related issues. There appears to be even less support available for parents.

Cultural differences also affect the degree of acceptance for LGBTQI people. Workshop discussions highlighted the importance of sensitivity to culturally acceptable language as a means to reach certain communities, for instance among Māori and Pasifika. While some whānau may find traditional terms more acceptable, the workshop participants noted that some Pasifika families can be influenced to reject their LGBTQI members by churches. It was noted that churches are an important vehicle for community support and social programmes. There were also reports of difficulties for people coming out where they belonged to recent immigrant and refugee communities. Workshop participants noted they were more likely to reach out for support through telephone helplines.

For young men, early openness about their gender orientation combined with parental efforts to discourage their atypical gender behaviour has been linked to attempted suicides. There seems to be less social tolerance for boys who are ‘feminine’ compared to girls who are ‘tomboys’. Gay and bi-sexual males are also less likely to report being bullied than heterosexual males. Among LGBTQI youth, suicide attempts have been linked to parents discouraging a young person from atypical gender behaviour, for instance ‘being a sissy’ for boys or a ‘tomboy’ for girls.

50 https://www.ncbi.nlm.nih.gov/books/NBK53412/
Transgender and intersex people face additional risks. These include a greater risk of verbal, physical and sexual assault than the general population, or other LGBTQI population sub-groups, related to their appearance. Assaults may not be reported due to fears of engaging with police and health professionals who may be ignorant or prejudiced.\textsuperscript{58} Seeking general healthcare can be traumatic, due to health professionals' lack of expertise in conversing with transgender and intersex people. There is a lack of pathways for people who need specialist services related to gender reassignment, such as hormone treatment and hair removal. Workshop contributions indicated that this is an ongoing problem despite being previously identified as a significant issue.\textsuperscript{59} For suicide reduction, research supports the importance of psycho-social support as an integral part of gender reassignment services.\textsuperscript{60}

\textbf{Pākeke and older people}

The suicide risk associated with ‘coming out’ can be experienced at any stage through the life course. Population analysis during phase one of the development of the SPOF identified a higher rate of suicide among LGBTQI people over 25 years, compared to the general population. Among young people, there has been a growing acceptance of gender identity and sexual orientation as being ‘fluid’.\textsuperscript{61} However, people coming out as older adults risk a more conservative response from their whānau and friends.\textsuperscript{62} There can be variations in experience among this age group. Some who may have explored their sexuality earlier in life could still have access to support from old friends made during this period, while others face the complexity of negotiating their new identity for the first time.\textsuperscript{63} Older adults who lose life partners as a result of coming out may become particularly isolated.

The workshops confirmed that there are older people in New Zealand contacting LGBTQI helplines for support with ‘coming out’ later in life. This includes coming out with transgender and intersex identities. It was also noted that this includes immigrants to New Zealand who come from culturally diverse backgrounds, which in many cases include more conservative attitudes to LGBTQI identities.

\textbf{Institutional populations}

Workshop participants identified problems with discrimination in retirement accommodation and residential care for people who are LGBTQI. This included being unwelcome in retirement villages, being unable to express identity, or being unable to live as a couple in residential care.

\begin{footnotesize}
\end{footnotesize}
Research out of the United States suggests there are difficulties for LGBTQI people employed in, or after leaving the defence forces.\(^6\) LGBTQI people can serve in New Zealand, but there was no information about their experiences available through the literature or workshops.

The Human Rights Commission has identified difficulties for transgender and intersex people in the New Zealand court system, and the risk of assaults in prison.\(^{65}\)

### 7.4 Key opportunities to improve outcomes

To improve suicide prevention for LGBTQI, the workshops identified two main strategies:

- Creating improved capability in government data collection, such as a wider range of gender categories in census data collection, to support a greater ability to understand the size of the population, recognising there will always be some limitations to the accuracy of this.
- Improved engagement with health and social agencies, including tailoring services to better meet the needs of LGBTQI people, their families and communities.

In relation to point one above, it is important that people can claim their identity and have this recognised as legitimate, for their wellbeing. This is likely to need to include a status of ‘indeterminate gender’ and the disclosure of sexual orientation in government data collections. The priority areas for consideration would include:

- Provisions for people to change their gender on government documentation with the six month stand down period, like Denmark. Such as change would be immediately affirming for affected individuals and could ameliorate the minority and internalised distress for many.
- Inclusion of gender identity and sexual orientation in the New Zealand Census Survey, which would support production of information on housing, economic status, and social information for this population group, and sub-populations. Other surveys important for monitoring suicide risk include the General Social, and the Household Economic and Labour Force Surveys.

In relation to point two, improving engagement by social agencies would include improving communication skills and normalising the disclosure of indeterminate gender and sexual orientation:

- Some New Zealand schools currently record gender and sexual orientation, and support diversity programmes. This could be encouraged nationwide, and would enable data collection specific to sexual identity and preference in relation to school absences and qualifications. Education currently funds programmes to support parents with children experiencing behavioural and learning related difficulties. These programmes could be extended to include children experiencing distress related to gender identification and sexual orientation issues.
- Young people rejected by their families face an uncertain future of ‘couch surfing’ or living on the streets. Workshop participants reported that it is difficult to access ‘independent youth’ benefits as families often misrepresent the issues as behavioural and a matter of choice for the young person. The extent to which ‘coming out’ and being rejected contributes to youth ‘not in


employment, education or training’ is not known. The Ministry of Social Development could assist through policies to ensure that these issues are not missed when dealing with youth who are homeless or living outside of their families.

- Health services could improve their engagement with LGBTQI people. The workshops identified engagement with health services as particularly traumatic for transgender and intersex people. There are barriers to accessing services due to health professionals being unaccustomed with communicating with or addressing issues related to transgender and intersex. This ranges from simple treatments like hair removal to more complicated procedures and psychosocial support. Other considerations for the Ministry of Health include: reporting sexual identity and orientation in data on self-harm, abuse and assaults; and protections of rights around sexual identity and orientation in contracts for residential care.

### 7.5 Working with the LGBTQI/Rainbow community

The likelihood of understating of the incidence of suicide and suicidal behaviour was a significant concern for the representatives at the workshops. There is evidence that improving approaches to supporting wellbeing, recognition and acceptance, and access to appropriate services for this population is likely to deliver major benefits for this target population.

A central theme from the workshops was that there is no funding for a LGBTQI representative or ‘peak’ organisation to work with government funders to identify need and prioritise services. The workshops also highlighted some very specific opportunities to improve protective factors, and mitigate risk factors for this community. Understanding that being part of this community is not in itself a risk factor, but rather that it is specific experiences related to gender identity or sexuality such as minority stress and exclusion that creates suicide risk, especially for those who experience transphobia and homophobia in their daily lives. Importantly, the need for specific support to improve the quality of services available that include and meet the needs of this community requires consideration.

### 8 Using the Outcome Framework and Service Landscape Tool

In the Hawkes Bay district and with the LGBTQI community applying the outcome framework and the service landscape tool identified opportunities to:

- improve the understanding of populations at risk of suicide and suicidal behaviour
- integrate community supports, alongside NGO activity to contribute to improved outcomes for the populations with whom they work
- understand the contribution of different levels of activity from policy to individual services
- create cross-sectoral understanding of the challenges.

One of the key findings of the workshops was the importance of identifying partners and working collectively toward the goal of reducing the rate, incidence and impact of suicide. This included:

- the importance of building trust among partners and being collectively focused through a shared purpose
• recognition that coherent responses to communities is worthwhile and that potentially important partners may not have previously identified and may contribute previously un-thought-of and lower cost solutions
• simply providing a structure to get people talking about the opportunities and partners that could work together in suicide prevention created new opportunities to improve outcomes and get greater value from existing investment
• better use of data through population outcome dashboards and analysis of suicides and suicidal behaviour, together with the use of IDI to monitor shared populations would strengthen and support DHBs to fulfil district functions, and coordinate and lead suicide prevention activity
• service landscaping is a strong analytical tool for exploring service responses and investment
• that collection of information takes time, and very few services collect activity lines that align to outcome approaches consistent with phase two report.
The Revised Suicide Prevention Outcome Framework

The section presents the revised Suicide Prevention Outcome Framework. While this was outside of the scope of the contract, the writers considered it important to honour the information shared by workshop participants and to ensure the SPOF aligns with the soon to be released, He Tāngata, and the incorporation of the Te Ao Māori view.

9 Linking with He Tāngata

The population indicators from the original SPOF were: suicide mortality – rate and number, suicidal behaviour – self-harm hospitalisations; and distress in the community – 1X calls. Following consultation with the Ministry of Health and other government agencies, the initial report also recommended that a set of balancing metrics be developed to measure wider wellbeing in the community. This is consistent with the wider evidence on wellbeing, social determinants, mental health and suicide prevention. Measuring wellbeing provides a mechanism to include wider personal and environmental risk and protective factors that may impact on suicide, suicidal behaviour and distress in the community.

As was agreed, this work was completed in the context of the development of He Tāngata: The Mental Health and Wellbeing Outcome Framework (He Tāngata), and a series of detailed population wellbeing indicators have now been developed. These indicators are intentionally common to both the SPOF and He Tāngata. For obvious reasons, He Tāngata also contains the original population indicators from SPOF. This embeds the link between the two frameworks.

10 A Māori community working with Te Rau Matatini

The rate of suicide for Māori exceeds that of non-Māori, with Māori men and youth having some of the highest rates in 2013. Waka Hourua, through the work of the partners Te Rau Matatini and LeVa, has made substantial progress in building responses that support the prevention of suicide in Māori communities.

The original proposal was to conduct a service mapping within a local district working with Te Rau Matatini. What became apparent in discussions with the team at Te Rau Matatini was the substantive opportunity to improve the Suicide Prevention Outcome Framework to better reflect a Te Ao Māori perspective. Over the course of a one-day workshop we worked with representatives from Te Rau Matatini, the Māori research community, and Kia Piki to redevelop the outcome framework. These changes are incorporated throughout the outcome framework and include:

- changes to language to reflect Māori concepts of wellbeing including the concepts in Te Whare Tapa Whā and the Te Pou Matakanaka whānau ora outcome framework
- the modification of the protective, risk and environmental factors to reflect important concepts for Māori

identifying Māori as a unique target population and their separation from the Pacific community.

These changes are incorporated throughout the outcome framework and have had a material impact on the language, structure and utility of the outcome framework.

11 Working with communities

This population-based outcome methodology incorporates a broad range of knowledge and contribution including intentionally engaging with, and valuing the work of communities and whānau working to prevent suicide and suicidal behaviour throughout New Zealand. For example, the work of Te Rau Matatini has generated new knowledge on how to foster and develop approaches to suicide prevention for Māori and Māori communities. This knowledge can be integrated transparently into the framework, and can be seen in the changes to the SPOF as a result of input from Te Rau Matatini during the engagement process for the Māori population work stream.

The Service Landscape can also incorporate the strength and support offered by the natural support systems that exist within whānau, hāpu, marae, communities and other social networks including charities, and membership of interest groups and organisations. The Service Landscape encourages development and investment in activities for target populations by showing where such activities are most needed. Their inclusion also means they can be recognised and their contribution measured in a meaningful way.

The population and service user outcome analysis created by using this framework can support intersectoral, collaborative and collective impact approaches. Collective impact, also known as a social transformation methodology, is the commitment of stakeholders to a common agenda for solving complex social problems. It is a structured mechanism for engaging a wide range of stakeholders within a community to achieve meaningful change.

Indigenous peoples have understood the nature of collective impact for centuries:

“Ma Whero, Ma Pango, ka otia te mahi”

“With the red thread, and the black, the work will be completed”.

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68 Natural support networks are the people present in a person’s life and may be able to support them in particular situations.
12 The Suicide Prevention Outcome Framework

Shared Purpose
Why are we doing this work?

The Quality of Life Outcome
‘All people in New Zealand experience whānau ora, wellbeing and social connection.’

The Goal
Strengthen those at risk and reduce the incidence, rate and impact of suicide and suicidal behaviour in Aotearoa/New Zealand.

Key Result Areas and Population Indicators
What matters for people?

- People in New Zealand have maori ora and wellbeing.
- Strengthening and protecting those at risk of suicide
- The impact of suicide on family, friends, whanau and communities is relieved.

- Rangatiratanga
  - Material Wellbeing
  - Financial security and living standards
  - Healthy, safe and secure homes
  - Employment, education and participation

- Taha Tautua
  - Taha Hinengaro
  - Physical and mental health
  - Physical health
  - Mental health and freedom from addiction

- Taha Whakapapa
  - Taha Whānau
  - Social wellbeing
  - Wellbeing and respect
  - Social and cultural connection

Suicide mortality, Suicide behaviour, Distress in the community

Target Populations
Who are we serving to ensure equity of outcome?

Exposure to risk factors and the presence of protective factors influences the risk for individuals and groups of people. The impact of the social gradient is also strongly correlated to suicide, suicidal behaviour and mental distress.

- Mental Health Service Users/Tāngata Whai Ora/Previous Suicidal Behaviour
- Māori – Youth: Males 25 – 44, Women (Māori women have a greater rate than non-Māori women)
- Youth including Māori, Pacific and Other
- Pacific Males aged 25 to 44yr / Other Males 25 to 65yrs
- Those engaged in the justice sector, including pre-sentencing, prison and post-release
- Those who have been or are in the care of Child, Youth & Family (Oranga Tamariki)
- LGBTQI/Rainbow community
- Older people (not Māori or Pacific) who experience loneliness and isolation
- Some professions also experience greater risk including those in the entertainment sector, health professionals, serving and non-serving veterans and those working in the farming industry.
12.1 The shared purpose: Why are we doing this work?

The quality of life outcome provides a focus for building long-term solutions with communities to prevent suicide occurring:

\[ \textit{All people in New Zealand experience whānau ora, wellbeing and social connection.} \]

Our goal states purpose for the outcome framework. It is to:

\[ \textit{Strengthen whānau at risk and reduce the incidence, rate and impact of suicide and suicidal behaviour in Aotearoa/New Zealand.} \]

12.2 Key result areas and population indicators: What matters for people?

Key result areas help to group the activity that evidence tells us is necessary to reduce suicide and improve mauri ora and wellbeing. The areas are:

- People in New Zealand have mauri ora and wellbeing. (Prevention)
- Protecting and strengthening those at risk of suicide. (Intervention)
- The impact of suicide on family, friends, whānau and communities is relieved. (Postvention)

When coupled with service performance measures for activities and interventions, the population indicators create knowledge about the impact of activities in reducing the incidence and rate of suicide and suicidal behaviour for target populations, as well as the whole population.

Two sets of population indicators are proposed, direct and indirect:

- Population indicators for suicide prevention. (Direct)
- Population indicators of wider wellbeing and mauri ora. (Indirect).

12.2.1 Population indicators for suicide prevention (Direct)

This framework incorporates measures of suicidal behaviour and distress in the community to add to the usual incidence and rate measures of suicide in order to build a wider base of measurement that is more sensitive to the impact of interventions.

The incidence and rate of suicide in Aotearoa/New Zealand is a low base rate measure, and the low numbers mean that changes can only be measured reliably over longer periods of time. This contributes to the challenge in measuring the impact of suicide prevention investment made by government, and the activities and intervention undertaken by service providers and communities.

The three proposed population indicators are:
• suicide mortality - rate and number
• suicidal behaviour - hospitalisations for self-harm
• distress in the community – 1X calls to NZ Police for attempted or threatened suicide in the community.

Suicide Mortality - Rate and Number
The population indicator set is the number and rate of suicide for Aotearoa/New Zealand. The advantage of a rate is that it supports comparison across target populations. The continued inclusion of this indicator is critical to maintaining the focus on suicide prevention.

This information is currently reported in Suicide Facts published by the Ministry of Health. There is always a delay in the publication of this information as the classification of a death as a suicide is subject to a coroner’s inquiry and it can often take several years before this is completed, for example the 2011 data was published in 2014. Alongside Suicide Facts, provisional annual suicide statistics are published from Coronal Services within two months of the end of the July to June year, every year.

Suicide data on the Ministry of Health website shows that 508 people died by suicide in 2013. This equates to 11 deaths per 100,000 population69.

Suicidal behaviour - hospitalisations for serious self-harm
The second population indicator is self-harm hospitalisations. This may be considered both a measure of suicidal intent, as self-harm serious enough to require hospitalisation can reasonably be assumed as a proxy for suicidal intent, and as a meaningful indicator of distress in the wider community.

The Ministry of Health currently measures and reports on intentional self-harm hospitalisations in Suicide Facts70. The measure includes all hospitalisations, bringing together medically and surgically serious admissions with those hospitalised in mental health facilities. We propose that this measure is amended by removing admissions to mental health facilities from this indicator. Those admitted to a mental health facility following self-harm are likely to be a more heterogeneous group and to include a greater proportion that did not have suicidal intent.

The proposal to amend this measure is based on the premise that those who harm themselves sufficiently to be hospitalised as a medical or surgical inpatient are, at a group level, more likely to have been exhibiting suicidal behaviour than those not medically or surgically hospitalised. Research examining self-injury in just over 2000 university students indicates that as the severity of self-injury accelerates, the degree of suicidal intent increases as well71.

At an estimated number of 3,000 incidents per annum, intentional self-harm hospitalisations currently have a rate of 71 per 100,000 people72. The impact of removing admissions to a mental health facility is unknown at this time.

It is recommended that the Ministry of Health modify the method of measurement of hospitalisations for self-harm to reflect the above proposal. Consideration will need to be given as to the impact on the measurement of historical trends.

Distress in the community – 1X calls to NZ Police for suicide or suicide risk in the community

New Zealand Police classify 111 calls from individuals regarding suicide and suicidal behaviour as 1X calls. In 2013/14 there were 12,465\textsuperscript{73} 1X calls. These emergency calls about threatened suicide or suicidal behaviour may be made by the individual themselves or by concerned family, friends or members of the public. If, upon attending the scene a crime is noted such as family violence, the activity is removed from 1X call data.

Although these are not uniquely identifiable events in respect of individual people they remain an indicator of a level of distress expressed through suicidal behaviour in the wider community and as such potentially mitigated by suicide prevention activity. These calls offer a potentially more sensitive measure of the impact of effective suicide prevention activity.

The estimated rate of 1X calls is 278 per 100,000 people\textsuperscript{74}. It is recommended that the Ministry of Health and NZ Police continue to work together to ensure this data is recorded and reported in a way that enables all agencies to identify and consider responses to the determinants of the distress.

12.2.2 Population indicators for maori ora and wellbeing (Indirect)

The following make up the set of indirect population indicators. The indicators themselves replicate the wellbeing metrics contained in ‘He Tāngata’: The Mental Health and Wellbeing Outcome Framework.

- Mauri Ora – Material Wellbeing
  - Healthy, safe and secure homes
  - Financial security
  - Employment, education and participation
- Taha Tinana, Taha Hinengaro - Physical and Mental Health
  - Mental health and freedom from addiction
  - Physical health
- Taha Wairua, Taha Whānau - Social and cultural connection
  - Wellbeing and respect
  - Environmental health

The population indicators are measured for these target populations, as well as the total population. This provides a critical equity lens to the outcome framework.

The specific measures underpinning: Mauri Ora – Material Wellbeing; Taha Tinana, Taha Hinengaro - Physical and Mental Health; and Taha Wairua, Taha Whānau - Social and cultural connection are detailed respectively in the table below.

Table 5: Mauri Ora - material wellbeing

\textsuperscript{73} Sourced from New Zealand Police Statistics Group
\textsuperscript{74} NZ Police Mental Health Team
### Mental health & freedom from addictions

<table>
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<tr>
<th>Whānau experience less mental distress, illness and addiction</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
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<td>Proportion of people in treatment &gt; 6 mths</td>
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<td>Mental health distress calls to NZ Police (1M)</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Self-reported diagnosis (survey)</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Strengths &amp; Difficulty Questionnaire (4yrs)</td>
<td>✓</td>
<td>na</td>
<td>na</td>
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<tr>
<td>ADD/ADHD - 2-14 yrs</td>
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<td>na</td>
<td>na</td>
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### Whānau do not suicide or experience the impact of suicide

<table>
<thead>
<tr>
<th>Whānau do not suicide or experience the impact of suicide</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Suicide rates</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Suicide behaviour rates</td>
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<tr>
<td>Suicide ideation in young people</td>
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<tr>
<td>Suicide related distress calls to NZ Police (1X)</td>
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### Whānau do not misuse alcohol and drugs

<table>
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<th>Whānau do not misuse alcohol and drugs</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td>Drink driving/Disorderly conduct rates</td>
<td>na</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Drinking frequency</td>
<td>na</td>
<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Misuse of substance</td>
<td>✓</td>
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<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Substance misuse/conviction</td>
<td>na</td>
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### Physical health

<table>
<thead>
<tr>
<th>Whānau have good health</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
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<th>Older Adults</th>
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<tr>
<td>Life expectancy</td>
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<td>✓</td>
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<tr>
<td>Incidence of long term health conditions</td>
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<td>✓</td>
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<tr>
<td>Long term disability by type</td>
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<td>✓</td>
<td>✓</td>
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<tr>
<td>Older people living independently</td>
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<td>Supported living benefit</td>
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### Whānau have healthy behaviours

<table>
<thead>
<tr>
<th>Whānau have healthy behaviours</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
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<tbody>
<tr>
<td>Healthy behaviour index</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
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<tr>
<td>Dental health</td>
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<td>✓</td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>Obesity rates</td>
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<td>✓</td>
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<tr>
<td>Self-reported personal health</td>
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<tr>
<td>Enrolment in a PHO</td>
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<td>Smoking rates</td>
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### Table 6: Taha Tinana, Taha Hinengaro - Physical and mental health

<table>
<thead>
<tr>
<th>Healthy, safe and secure homes</th>
<th>Tamariki 6-14yrs</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Whānau have security of accommodation</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Home ownership rate</td>
<td>na</td>
<td>na</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Tenancy &gt; 12 mths rate</td>
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<td>na</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Accommodation supplement</td>
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<td>na</td>
<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Homelessness rate</td>
<td>√</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<tr>
<td><strong>Whānau live in healthy homes</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Crowding of households</td>
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<td>√</td>
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<tr>
<td>WOF Rating of homes</td>
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<td>√</td>
<td>√</td>
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<tr>
<td><strong>Whānau live in safe homes</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>In dwelling assault rate</td>
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<td>Reported abuse</td>
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<td>Child report to CYF with follow-up</td>
<td>√</td>
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<tr>
<td>Witness reported violence at home</td>
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<tr>
<td><strong>Financial security &amp; living standards</strong></td>
<td></td>
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<td></td>
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<tr>
<td><strong>Whānau have financial security</strong></td>
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<tr>
<td>Individual income</td>
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<td>More than 3 sources of debt</td>
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<td>Sickness or invalid beneficiary</td>
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<tr>
<td><strong>Whānau do not experience deprivation</strong></td>
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<td>Households experiencing deprivation (MW1)</td>
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<tr>
<td><strong>Participation, education and employment</strong></td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td><strong>Whānau are participating in their communities</strong></td>
<td></td>
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<td></td>
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<tr>
<td>School exclusion rates</td>
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<td>Literacy rates</td>
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<tr>
<td>Voluntary hours worked</td>
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<tr>
<td>Not in education, training or employment (NEET)</td>
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<td>na</td>
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<tr>
<td><strong>Whānau are achieving in education</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Participation in alternative education</td>
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<tr>
<td>Levels of tertiary qualifications</td>
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<td>NCEA level 2 achievement</td>
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<tr>
<td><strong>Whānau are in quality employment</strong></td>
<td></td>
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<tr>
<td>Long term unemployment &gt;12mths</td>
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<tr>
<td>Employment rate</td>
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Table 7: Taha Wairua, Taha Whānau - Social and cultural connection

<table>
<thead>
<tr>
<th>Wellbeing and respect</th>
<th>Tamariki 6-14ys</th>
<th>Rangatahi (Youth)</th>
<th>Pākeke</th>
<th>Older Adults</th>
</tr>
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<tbody>
<tr>
<td>Whānau have social equality</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Income inequality</td>
<td>na</td>
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<tr>
<td>Wealth inequality -derived</td>
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</tr>
<tr>
<td>Whānau report wellbeing</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult life satisfaction/purpose</td>
<td>na</td>
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<td>√</td>
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<tr>
<td>Feeling lonely most the time</td>
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</tr>
<tr>
<td>Whānau do not experience stigma and discrimination</td>
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<tr>
<td>Accepting of diversity &amp; social inclusion</td>
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<td>√</td>
<td>√</td>
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<tr>
<td>Experience of discrimination</td>
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<td>√</td>
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<tr>
<td>Experience of bullying</td>
<td>√</td>
<td>√</td>
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<td>√</td>
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<tr>
<td>Social and cultural connection</td>
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<td></td>
<td></td>
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<tr>
<td>Whānau have friend and social networks</td>
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</tr>
<tr>
<td>Strength of social network for support</td>
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<td>√</td>
<td>√</td>
</tr>
<tr>
<td>Yr 9 feel connected to parents</td>
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<td>√</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Yr 9 feel connected to school</td>
<td>na</td>
<td>√</td>
<td>na</td>
<td>na</td>
</tr>
<tr>
<td>Whānau do not participate in criminal activity</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Criminal conviction</td>
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<td>√</td>
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<tr>
<td>On charge and in criminal proceedings</td>
<td>na</td>
<td>√</td>
<td>√</td>
<td>√</td>
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<tr>
<td>Whānau enjoy cultural participation</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Adult able to express identity</td>
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<td>√</td>
<td>√</td>
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<tr>
<td>Voter participation</td>
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<td>√</td>
<td>√</td>
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</tbody>
</table>

12.3 Create and report population indicators for target populations

Population indicators require significant investment and effort to develop. He Tāngata and SPOF takes advantage of the investment the health sector and other government agencies have already made to develop indicators and will develop the reporting system for population indicators.

12.3.1 Compile population outcome monitoring dashboards

Dashboards are developed collaboratively between the Ministry of Health and district health boards. It is likely that several dashboards will need to be constructed to capture the dynamic system changes for people experiencing mental health and addictions. These dashboards will provide baseline information from which to measure change over time and to maintain the relevance of He Tāngata and the strategy and investment choices it supports.

12.4 Target populations

All people are at risk of suicide or suicidal behaviours, depending on their personal circumstances and the complex interplay of individual characteristics, protective, risk and environmental factors. Below the suicide protective, risk and environmental factors are outlined.
12.4.1 Factors that impact on a person’s risk of suicide behaviour:

Protective factors
An individual’s personality and strengths are the strongest indicators of their vulnerability and risk of suicide or suicidal behaviour. If a person experiences high levels of mauri ora or wellbeing, they are less likely to be affected by the impact of other risk factors in their lives. Protective factors include:

- Cultural identity and participation including Te Ao Māori
- Achievement in education, employment and financial stability
- Safe homes and environments
- Quality parenting and sustained healthy family connection
- Social inclusion and respect
- Health and wellbeing.

Individual risk factors
Risk factors can occur any time in a person’s life and often in combination with each other. The impact of these factors on a person will vary, depending on individual ethnicity, gender, sexual orientation, age and life experience. Known individual risk factors include:

- Adverse experiences
  - Damaging childhood experiences
  - Family violence
  - Abuse – physical, sexual, emotional and psychological
  - Bullying especially cyberbullying
  - Traumatic events
  - Bereavement by suicide
- Health challenges and disabilities
  - Mental health disorders
  - Substance abuse disorders
  - Medical long term conditions & disabilities
  - Other genetic & biologic conditions
- Psychosocial stress
  - Financial/Job Loss
  - Relationship and interpersonal loss
  - Deprivation, conditions of poverty
- Close to suicide
  - Prior suicide attempts
  - Suicide contagion
- Social isolation
  - Discrimination
  - Minority stress (LGBTQI/Rainbow)
  - Stigmatisation
  - Racism

Environmental factors
Environmental factors can affect people at both an individual level or at a population level. They may represent risk or protective factors, and include:

- Economic conditions
  - Employment
  - Education
  - Income equality
- Social inclusion
  - Colonisation and cultural alienation
  - Discrimination & stigmatisation
- Policy settings for risk factors
  - Access to means of suicide
  - Digital harm and bullying
  - Media and agency reporting controls
  - Access to alcohol and drugs
  - Social and health support
  - Entitlement for social and housing support
  - Entitlement and access to health and mental health services


12.5 The revised target population structure

The original Suicide Prevention Outcome Framework analysed deaths by suicide over a five-year period. The framework drew on the literature, Suicide Facts, the Suicide Mortality Review, and expert knowledge and experience to identify groups of people who have greater risk of suicide, and have shared characteristics that influence the risks of these populations. Following that the revised target populations are identified. The key factors considered in identifying target populations include:

- exposure to risk factors and the presence of protective factors influences the risk for individual
- the impact of the social gradient knowing that those who experience the greatest deprivation have a greater risk of suicide.

It is important to review the target populations from time to time. The risk may over time reduce for some identified populations, while new populations may emerge. It has become apparent due the course of this work that there may be other populations to consider for inclusion in the group of target populations, in particular the risk associated with some professional groups. These are signalled in the revised SPOF.

The revised populations are:

- mental health service users/Tāngata whai ora
- Māori - youth, males 25-44 years, women (Māori women have a greater rate than non-Māori women)
- youth including Māori, pacific and other
- Pacific males aged 25 to 44years and other males 25 to 64 years
- those engaged in the criminal justice sector, including pre-sentencing, prisons and post-release
- those who have been, or are in the care of child, youth and family (Oranga Tamariki)
- lesbian, gay, bisexual, transgender, queer and intersex people / Rainbow community
- older people (not Māori or Pacific) who experience loneliness and isolation.

There are potential sub-populations including those in the entertainment sector, health professionals, non-serving and serving veterans and those working in the farming industry. We believe it would be valuable to further explore these sub populations as work on suicide prevention progresses. These sub populations are likely to provide insight into the group of non-Māori and non-Pacific males who die by suicide, who are the largest single population.

12.5.1 Mental Health Service Users, and those who have attempted suicide

In 2014, mental health service users accounted for 40 percent of all suicides. The age standardised rate for mental health service users is 137.1 per 100,000 population. Considering the mental health service user population is estimated at 2.6% of the population, this rate of suicide is significant and the highest identified. The next highest rate for a target population is 59.2 for Māori youth (males).

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75 This number includes eight undetermined deaths of Mental Health Services Users in the total of 285.
The profile of this group is outlined in the Office of the Director of Mental Health Annual Report 2014 which analyses age standardised rates by ethnicity and gender. This shows interesting variations from the wider population:

- Mental health service users who suicide have a greater proportion of ‘other’ population than Māori or Pacific. This is in contrast to the non-service users who are more like to be Māori and Pacific.
- The age standardised suicide rate is substantially higher for males than females but both genders experience higher rates in age bands 25-29 years and 45 to 49 years.
- The age standardised suicide rates vary from those demonstrated by non-service users across the age bands.

The characteristics of this population are identified by their engagement with mental health and alcohol and drug service users, however, it is also known that those people using mental health services are more likely to experience other risk factors associated with suicide, including insecure housing, unemployment and social exclusion. A small research study published by the Mental Health Foundation identifies that meaningful employment increases people’s sense of value, participation in, and contribution to, the society within which they live77. Furthermore, they identified that a consistent barrier to social inclusion “is the negative labelling and stereotyping of people diagnosed with mental illness, and their subsequent experience of overt stigma and discrimination”78.

A sub-population identified within the mental health service user population is those people who have previously attempted suicide as “prior attempts predict future behaviour.”79 Studies show that of those who die by suicide, a significant proportion will have made previous suicide attempts. Studies show that somewhere between 17 and 68% of people (with a median of 25%) go on to suicide at a future time. Estimates of the risk of suicide80 following a suicide attempt range from 3.6 to 31.7 (median 5.8) 81.

While not all the people in this sub-population will necessarily be identified as mental health service users, they are likely to have been assessed by mental health services following an attempt. Included in this sub-population would be those who are hospitalised as a result of serious self-harm as those who harm themselves sufficiently to be hospitalised as a medical or surgical inpatient as a group are more likely to have been exhibiting suicidal behaviour than those not medically or surgically hospitalised. Research examining self-injury in just over 2000 university students indicates that as the severity of self-injury accelerates, the severity of suicidality increases as well82.

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80 The odds ratio of suicide occurring after a suicide attempt.
12.5.2 Māori – youth and males and females 25 – 44yrs
Māori are disproportionately affected by suicide. In 2011, the total Māori suicide rate was 15.8 per 100,000 Māori population, this is 1.6 times the non-Māori rate (9.7 per 100,000 non-Māori). The Māori youth suicide rate is 39.1 per 100,000. This is 3.1 times higher than the rate for non-Māori youth (12.6 per 100,000 non-Māori youth). For Māori females, the discrepancy is even greater with the rate being 4.8 times greater than the rate for non-Māori women.

There are many reasons explored in research studies as to the drivers of this difference. Put simply, Māori are over-represented in the presence of risk factors including social deprivation. They also experience the impact of colonisation and discrimination which contributes to this already greater risk profile. Although suicide rates have decreased in general, they have not decreased for Māori.

12.5.3 Youth including Māori, Pacific and Other
Youth suicide accounts for nearly 35% of all youth deaths. Young people aged 15 to 24 years accounted for 22% of all suicides in 2013, a total of 113 young people for that year. The suicide rate for this population group reaches a peak between 15 and 19 years. For Māori and Pacific, the rate is higher than that for ‘Other’, but the numbers of Other youth are almost as high as Māori deaths in 2013. This group is considered collectively as many of the responses are embedded in youth environments. There was debate regarding the definition of young people. During the development process for the SPOF it became clear that for at-risk youth an age range up to 25 was consistent with social patterns of behaviour.

12.5.4 Non-Māori males 24 to 64 years
Adult males aged 25 to 64 make up 47 percent of all suicide deaths, being 241 of all deaths. When adjusted for mental health services users who are non-Māori males the number reduces to 151 deaths, a total of 30 percent of all deaths. This is a large group that are not well understood. There is emerging evidence that understanding the impact of risk factors in professional groups may assist in changing outcomes for this population.

12.5.5 Those engaged in the justice sector
There is evidence of greater risk of suicide in the prison population. This includes not only people in custody but also during the remand processes and upon release. This can be a point of significant risk where people are known to the system and interventions can be planned to reduce risk. There is limited information on incidence and rates but there are suggestions that the rate of suicide in the Prison population could be as high as 38 per 100,000, as high as Māori youth.

12.5.6 LGBTQI/Rainbow communities
Lesbian, gay, bisexual, transgender, queer and intersex people have a higher risk of mental ill-health throughout their lives. This includes depression, anxiety, suicidal ideation and self-harm, substance misuse and eating disorders. LGBTQI includes people who have a lesbian, gay, or bisexual sexual orientation, and those who identify as transgender, intersex or questioning around their gender or

83 Ministry of Health (2014) Suicide Facts 2011, pp12
84 New Zealand Department of Corrections - Ara Poutama Aotearoa. Website.
sexual identity. These people have a higher risk of poor mental health throughout their lives, including depression, anxiety, suicide and self-harm, substance misuse and eating disorders. Yet this population is diverse and not all people will have a high risk of suicide. The issue of minority discrimination and stress lies at the heart of the higher suicide rate among people who identify as LGBTQI. Stigma has wide-reaching effects because it can undermine access to housing, employment and social support, expose the people targeted to verbal and physical violence, and be internalised by affected individuals further undermining their capacity to function in their daily lives.

12.5.7 Those who have been or are in Child Youth and Family (Oranga Tamariki) care
A 2001 study showed a high suicide risk for children who are in contact with Child Youth and Family (CYF). While obtaining presents some challenges, literature evidence and exposure to risk factors that this group continue to be at high risk. In contrast to the general population, females in this group have the higher rate of suicide. The study also noted that some risk factors are outside the ability of CYF to intervene. It is important to note that CYF do not collate statistics on self-harm or suicide by people who are in their care.

This group, like those engaged with Corrections, represent a group of people who are more likely to have accumulated adversity and significant risk factors than other parts of the population. Many of them will also be Māori. This was identified in the Suicide Mortality Review undertaken by the Health Quality and Safety Commission. It is not possible to separate out the sub populations at this time, but future use of Integrated Data Infrastructure (IDI) could provide clarity over time.

12.5.8 Older People
Older people dying by suicide peaks at around 80 years of age for non-Māori and non-Pacific people. It is worthwhile noting that overall suicide rates for male and female older people have declined consistently over the previous 60 years. The current rising incidence is of concern and is the fifth largest incidence in this analysis. There is emerging evidence that loneliness and social isolation are significant risk factors.

Implementing the Suicide Prevention Outcome Framework

The SPOF creates a consistent nationwide framework to measure progress against the goal of reducing the incidence, rate and impact of suicide and suicidal behaviour, and to measure equity of outcome across groups through the target populations. The SPOF identifies the populations at the greatest risk and sets out the key result areas that contribute to their mauri ora and wellbeing.

The baseline information created through the outcome framework and the service landscape tool then becomes a powerful source of information to support commissioning for mental health services and for further developing inter-sectoral and social investment approaches to suicide prevention. The service landscape tool also creates the organising system for understanding the services available and analysing the contribution of investment and service performance to outcomes.

13 Nationwide application

It is anticipated that the application of the SPOF at a nationwide level would be led by the Ministry of Health given their current responsibility for leadership of the Suicide Prevention Strategy. This would need to occur in conjunction with social and justice sector partners, and with DHB and wider social sector collaboration at the local level.

Implementing the SPOF will require:

- the development of a process of regular reporting against the population indicators
- the compilation of population outcome monitoring dashboards.

The implementation of this reporting and measurement structure with enable government, as an investor and funder, all participants contributing to suicide prevention activity to understand more about the needs of their populations at risk of suicide or self-harm.

The alignment of this revised SPOF with He Tāngata means that the process to develop the reporting process and dashboards actions will occur in the context of the implementation of He Tāngata – the Mental Health and Wellbeing Outcome Framework. Detailed information on this process can be found in He Tāngata.

14 A strategic framework

The SPOF identifies the populations we are most seeking to support, and the key result areas that are known to contribute to mauri ora and wellbeing, and as such suicide prevention. The impact of resulting service responses can be analysed using accountability, system and population data. The population outcome and the response analysis enables the linking of this information through target populations and key results areas. This population outcome and contribution analysis can support the understanding of:

- how social circumstances and health status change for population groups over time among the target populations
- the inter-relationship between key result areas for different populations
• how the current service landscape, community and natural supports may have influenced the population indicators
• the contribution of other policy settings to the population indicators
• the relationship between service performance and the result.

The outcome framework and the service landscape tool create an analytical frame to examine the relationships between coverage, investment and results for target populations to inform commissioning decisions on prioritisation and investment. The analysis can look at changes to population results, the impact of responses and investment choices and non-commissioned services such as community support, for target populations and key results areas.

This analysis is intended to improve transparency and understanding across agencies, providers and communities, and better identify opportunities to change and improve responses, including within communities, to improve results. Working with partner agencies, the health sector and other providers, the Ministry of Health can use the ‘gap analysis’ to inform conversations about how to best align investments to population need with the goal of reducing suicide in New Zealand.

The tools to undertake analysis are:

• The service landscape
• Service contribution analysis.

15 Service landscape
What is available to support people?
The purpose of a service landscape is to know what services are available to support people and how effective they are in order to know what must be improved or re-designed, or where there are gaps and opportunities, enabling re-designed services and responses. The service landscape then brings together the service map and the service performance measures to analyse the contribution and alignment of services (existing or future) to outcomes for target populations, and key result areas.

The service landscape maps the service activities, not the providers. Service activities include policies, programmes, services and individual interventions regardless of provider, including DHBs, government agencies and local government. It includes natural supports (everyday relationships) that exist within whānau, hāpu, marae and other social networks including charities and special interest groups to encourage the inclusion of these activities clarifying the areas in which such supports can add value.

Service landscapes then inform mental health commissioning processes, intersectoral projects including place based and social investment projects, and collective impact processes working with communities as part of commissioning and service improvement processes.

15.1 Creating the service landscapes
The creation of service landscapes is a process completed with partners who are providing services to the identified target population. Some of the information will be imperfect and it should be expected that there will be areas in which information regarding services is not available.
There are three stages to creating a service landscape:

15.1.1 Identify one of the target populations and the associated partners

The identified target population should be specific and identified as either nationwide or within a region, district or locality. Appropriate partners that support the target population, including providers, other agencies, local councils and communities, can then be identified. Below we describe the range of partners that could be considered for each target population highlighting that there are a wide variety of partners who can contribute to suicide prevention.

- **Nationwide services** are the services that are provided against a national policy framework on a national basis, such as Prisons, Oranga Tamariki (Vulnerable Children), the Courts and entitlement to income support.
- **Universal social services** are services that are provided against a national framework but are provided locally within communities and include early childhood education, primary and secondary schools, tertiary education, specialist health services, primary healthcare, police and local government.
- **Social support services** are those services provided by NGOs and Agencies in communities, available to target groups of people and reflecting the needs of that community.
- **Community supports** are those supports that exist in a community and include community groups, churches, support groups, volunteer agencies and libraries.
- **Business services** include privately purchased support services such as counselling or private healthcare services, or those services that may be provided by private businesses for example for the welfare of their employees.
- **Natural supports** are the people and groups in individuals’ and families lives that support them including wider whānau and whānau, and friends. Explicitly including natural supports recognises that much of people’s every day support, capability and resilience comes from those closest to them.

The figure places the people at the centre, with the range of supports layered around them. Proximity to the centre illustrates the closeness of the support to people in their communities.

*Figure 2: The classification of services that contribute to outcomes*
15.1.2 Complete the service mapping with partners

The services activities for the target population are mapped against key result areas at four levels: policy; community and social support; family, friends and whānau; and the individuals themselves.

- **Policy**: Supporting all New Zealanders, including policy settings and universal and marketing strategies. Examples are de-stigmatisation programmes or policy settings on access to alcohol outlets.
- **Community and social support**: Supporting communities, for example local employment programmes or social housing programmes.
- **Family, friends and whānau**: Supporting social groups and communities of interest, for example networks to prevent family violence or marae based programmes.
- **Individual**: Support for the individual is generally the largest category and contains all service activities for individuals.

Below are illustrative service landscape templates, and the linked service information sheet. All service activities are recorded against the appropriate service level and the key result areas for a target population.

**Figure 3: Service map template**
Collate service investment contribution

Service investment against the target populations is analysed to shift the focus of investment from services to populations. This analysis informs funders of the level of investment made in target populations, including for individuals. The resulting information enables the service contribution to the outcomes for target populations to be completed. This service investment information contributes to analysis of service coverage and service investment. For each service activity, the following information is required:

- the service activity
- the eligible population (which may be a sub-population of the target population)
- the key result area the activity is designed to support
- how many unique individuals are served – not the count of activity, but the numbers of people who will receive the service
- the contract investment for that activity and the service funding source.

Service performance measurement

For each of the service activities in the service landscape performance, information on service performance is needed to analyse the performance story. Ideally service performance measures are consistent across all services to enable comparison and evaluation of both the delivery of the service against contract, and the quality and effectiveness of the service for target populations. The same performance measurement requirements should apply to all providers including district health boards, services provided by government agencies as well as NGOs and community providers.

This service performance measurement approach is designed to create the performance story. There are three types of performance measures: structural; process; and impact measures. These are described in the table below. This approach is consistent with the MBIE streamlined contracting for NGOs.


<table>
<thead>
<tr>
<th>Measure</th>
<th>Example</th>
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| **Impact measure: is anyone better off?** | Change of circumstance measures:  
  - Living at home with stable condition  
  - Able to pay bills independently  
  - Enrolled in an education facility  
  - Improved HoNOS score  
  - Having stable accommodation  
  **User experience measures:**  
  - User experience is captured as an important element of service performance. |
| Understanding impact is an important part an outcome framework. All services should be able to demonstrate two things:  
  - change of circumstance, which should focus on the intention of a service. This can be a behaviour change contributing to a life outcome.  
  - that the user experience of a service is important and has relevance to the cultural appropriateness of services. | |

| **Process measures: how well are we doing it?** | |
| Ensuring the service has been delivered to the right standard, in the right time and to the right frequency. | Evidence markers:  
  - FTE appointed to roles within agreed time frames  
  - Number of people who accessed the website tools  
  - Number of partner organisations engaged in workshops  
  **Quality & completion:**  
  - Proportion of people who completed the whānau planning programme  
  - Programme tools developed and validated for use in programmes  
  - Proportion of inmates entering the judicial system who have had a suicide risk assessment |
| This includes considering evidence markers, and quality and completion measures.  
  Evidence markers indicate the achievements that are identified as important to the success of the service.  
  The quality and completion measures identify the agree markers that support the quality of the services. | |

| **Structural measures: how much are we doing?** | |
| The activity measure ensures critical information on service coverage and access.  
  The competency and compliance measures are designed to identify service standards and expectations that maintain service quality. | Activity counts measures:  
  - Number of unique clients receiving services  
  - Number of facilitated peer support groups  
  - Number of community treatment days per service user  
  **Competency and compliance measures:**  
  - Evaluation programmes established as agreed.  
  - Number of GPs providing primary mental health services who have completed training on suicide risk  
  - Proportion of prisons using the agreed suicide-risk screening tool for all entering inmates |

Consistent performance measurement will be applied over time as guidelines and eligibility criteria are developed. This will support streamlined contracting in future contracts to include the following information to support national performance measurement:

- the service activity  
- the eligible population  
- the key result area the activity is designed to support  
- the activity count for the service by how many unique people are served and the level of service they will receive  
- the contract investment for that activity and the service funding source.
The Ministry of Health would be expected to lead the development of service activity descriptions to support consistency across performance measures. This information generates a framework for contracting that focuses on results for people.

15.2 Contribution analysis – the performance story
The SPOF builds a performance story, engaging with population data, group and individual-level data to build a shared understanding of the population outcomes, and the contribution of services and other responses to these outcomes. Again, analysing the contribution through target populations and the key result areas creates a people centred frame for analysis, linking the response to the population outcome. This allows comparative analysis amongst populations, and across key result areas forming the basis for analysing service coverage, investment and performance on results for populations.

- Service contribution
  - Service coverage
  - Service investment analysis
  - Service performance

15.3 Service coverage
Service coverage is the number of people served divided by the target population. It is a measure of access considering the volume of activity available to the target populations. The stratification of the population into target populations, combined with knowledge of eligibility criteria increases the accuracy and utility of service coverage.

15.3.1 Service investment
In understanding service coverage, we also understand service investment (funding) creating the opportunity to analyse value for money as service investment can be linked to service coverage, and results for each target population.

15.3.2 Service performance
The service performance measures, structural, process and impact, create a depth of information on the performance of services that can be used to compare across performance between services and across target populations.

15.4 Analysing outcomes
The information generated by the population outcome framework and the service landscape is designed to inform commissioning choices, intersectoral projects and collective impact processes. This enables both population outcome and service contribution analysis that can support understanding of:

- how social circumstances and health status change for population groups over time among the target populations
- the inter-relationship between key result areas for different populations
- how the current service landscape, community and natural supports may have influenced the population indicators
- the contribution of other policy settings to the population indicators
- the relationship between service performance and the result.
This analysis examines the relationships between coverage, investment and results for target populations to inform commissioning decisions on prioritisation and investment. It measures changes to population results, the impact of responses and investment choices and non-commissioned services such as community support, for target populations and key results.

The analysis is intended to improve transparency and understanding across agencies, providers and communities to identify opportunities to change and improve responses, including within communities, to improve results.

8 Conclusion

SPOF is major shift in the approach to measuring outcomes, focusing on people and their experiences both of health and mental health services. It recognises that responses that improve outcomes are not only about suicide prevention activity but the whole range of activity including mental health and wellbeing and social determinants. This is emphasised by the key result areas, and their associated population indicators. The outcomes for populations should be a shared accountability across government. SPOF should be supporting District Health Boards to improve suicide prevention activity across New Zealand and in its communities.