The purpose of this population-based outcome framework is to strengthen intersectoral efforts to reduce the incidence and rate of suicide in Aotearoa/New Zealand.

Prepared by:
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This paper outlines the Suicide Prevention Outcome framework prepared for the Policy Business Unit of the Ministry of Health. This population-based outcome framework has been designed to support a nationwide response across the health, social and justice sectors to reduce the rate and incidence of suicide in Aotearoa/New Zealand.

This phase of work is intended to be followed by a second phase of work to deploy and populate this framework across communities, organisations and agencies working to prevent suicide in the health, social and justice sectors. This stage will involve completing the framework’s activity matrix and the associated performance measurement for the general and target populations. It will enable the suicide prevention outcome framework to be used to identify gaps and opportunities to improve the key result areas for the total population and targeted populations, and measure the performance of agreed programmes.

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2 EXECUTIVE SUMMARY

Approximately 500 New Zealanders die every year by suicide. By comparison, road traffic accidents account for around half as many deaths annually. Although overall suicide rates and numbers have declined since 1995, inequalities still exist. There is evidence in New Zealand and internationally that continuing a comprehensive approach with strong leadership could further reduce deaths by suicide and suicidal behaviour in Aotearoa/New Zealand.

This suicide prevention outcome framework was created with communities and experts in all aspects of suicide prevention using a population-based methodology specifically designed for complex health and social issues. The framework will strengthen the ability of the Ministry of Health and District Health Boards to lead and coordinate intersectoral and community approaches to reducing the incidence and rate of suicide and suicidal behaviour. It provides an organising tool designed to strengthen suicide prevention leadership and to improve outcomes for New Zealanders, ultimately to reduce the incidence and rate of suicide and suicidal behaviour.

The framework is built around a quality of life outcome – “New Zealanders are socially connected, healthy and experiencing wellbeing”. This is based on evidence that societies with high levels of social cohesion and wellbeing are less likely to experience suicide. The quality of life outcome is underpinned by three key result areas:

- New Zealanders are resilient and healthy
- Those at risk of suicide are protected
- The impact of suicide is relieved.

Attached to the quality of life outcome statement and result areas are three high level population indicators. These are designed to create a set of measures that are more sensitive to the impact of interventions than the currently used measure of suicide numbers. This, coupled with a results-based performance measurement set for suppliers can provide more timely information about the effectiveness of investments in improving wellbeing and reducing the risk of suicide and suicidal behaviour.

This suicide prevention outcome framework also identifies seven population categories and twelve groups at risk of suicide who are targeted to contribute to population wide change. These categories recognise the importance of understanding the role of shared social structures and other factors when seeking to design meaningful and effective service approaches for populations at risk.

Of the at risk populations, mental health service users are the biggest single target population by number, and have the highest rate of suicide. They account for 40% of suicides, while representing only 2.6% of the population. It is important to note that part of the risk profile for mental health service users reflects their increased vulnerability to the risk factors associated with suicide, including unemployment and social exclusion.

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1 The comparison with road traffic accidents has been chosen to provide a sense of the scale of suicide numbers in the New Zealand context. Road traffic accidents, like suicide, is an area of amenable mortality and has demonstrated success in reducing the overall rate and incidence of these deaths as a result of a multifactorial, whole of system response.

2 This number includes 8 undetermined deaths of Mental Health Services Users in the total of 285.
Previously ‘other males’, including males living in rural areas, have been identified as the largest risk population group by total number. Further analysis of this group shows that when adjusted for mental health service users, the rate of suicide in this population reduces by half, making them the second largest group by incidence.

The other major target populations identified are Māori and Pacific youth and males up to 44 years of age. The rate of suicide, rather than incidence is highest in small high risk populations including the prison population and the LGBTI community.

**Diagram one: Suicide Prevention Outcome Framework**

- **The goal**
  
  Reduce the incidence and rate of suicide and suicidal behaviours in Aotearoa/New Zealand.

- **The outcome**
  
  New Zealanders are socially connected, healthy and experience wellbeing

- **Result areas**
  
  - New Zealanders are resilient and healthy
  - Those at risk of suicide are protected
  - The impact of suicide is relieved

- **Population indicators**
  
  Distress in the community – 1x calls to NZ Police
  
  Suicidal behaviour – hospitalisations for self-harm
  
  Suicide mortality – rate and number

- **Target population categories**
  
  Mental Health Service Users  |  LGBTI  |  Other young people  |  Adult males  |  Māori & Pacific males & young people  |  Older people  |  People in custody & CYF care

- **Activity matrix**

<table>
<thead>
<tr>
<th>Resilient &amp; Healthy New Zealanders</th>
<th>Protecting those at risk from suicide</th>
<th>Relieving the impact of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Society/Iwi/Waka</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/hāpu</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social groups/Marae</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Whānau</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- **Service user accountability & Performance measures**
This report makes seven recommendations which includes using this suicide prevention outcome framework to complete the service user accountability for activities and interventions for each target group, including the identification of suppliers and the performance measurement set.

Other recommendations, outlined in section 13, focus on aligning data sets and reporting to the outcome framework including continuing work with NZ Police, on behalf of all agencies; developing a set of wider wellbeing population indicators; and considering the district and nationwide accountabilities for using the information and knowledge generated by this framework.
3 INTRODUCTION

This suicide prevention outcome framework has been prepared for the Policy Business Unit of the Ministry of Health. It has been developed by working with a range of experts in suicide and suicide prevention including clinicians, DHB suicide prevention coordinators, NGO providers and community providers using a population-based outcome framework methodology. It has been designed to support a coordinated nationwide response across the health, social and justice sectors to reduce the rate and incidence of suicide in Aotearoa/New Zealand.

This suicide prevention outcome framework draws from and supports the New Zealand Suicide Prevention Strategy 2006–2016 and the New Zealand Suicide Prevention Action Plan 2013–2016. This outcome framework was developed to fulfil Action 11.3 of the New Zealand Suicide Prevention Action Plan 2013–2016.

The framework has been developed with a limited budget and timeframe. These constraints mean the framework has been developed to the level of population accountability and the organising matrix for suicide prevention activity. The next stage is to deploy and populate this framework with the activities of communities, organisations and agencies working to prevent suicide in the health, social and justice sectors.
Every suicide in Aotearoa/New Zealand is a tragedy, for the families and communities of Aotearoa/New Zealand. Understanding the number of people affected by suicide in Aotearoa/New Zealand is useful to understanding the importance of ongoing suicide prevention work.

There are around 500 New Zealanders who die by suicide every year. A further 2,500 will be hospitalised after seriously harming themselves. Those making suicide attempts requiring hospital admission are at high risk of further hospitalization for suicide attempt and of death from suicide.

While, Aotearoa/New Zealand has experienced a decline in suicide rates and incidence since a peak for youth in 1995 and for adults in 1998, the decline is not consistent across all populations. Inequalities remain in the rate of suicide and although youth suicide rates have fallen, Aotearoa/New Zealand continues to have one of the highest youth suicide rates in the developed world, with particularly high rates for our Māori and Pacific youth relative to other youth as outlined in section 9 of this report.

Suicide now exceeds road deaths as a cause of death. For men, suicide mortality (17.0) is almost double that of motor vehicle accidents (9.8) per 100,000 of population.

Māori generally are over represented in our suicide numbers. In 2011, the total Māori suicide rate was 16.8 per 100,000 Māori population; 1.8 times higher than the non-Māori rate.

Consistent with international patterns, there is also a significant gender disparity in suicides. Overall men are 3.5 times more likely to die by suicide than women.

Mental health service users accounted for 40% of all suicide deaths in 2011, the largest population by number, though they only make up 2.6% of the total population. This reflects their increased

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5 Youth are defined as young people aged 15–24 years.
6 The suicide rate is measured as the incidence of deaths by suicide per 100,000 of the specific or total population. The incidence of suicide is the number of deaths by suicide of the target or whole population.
12 This number includes 8 undetermined deaths of Mental Health Services Users in the total of 285.
vulnerability to the risk factors associated with suicide, including unemployment and social exclusion, and highlights the need to ensure that suicide prevention activities include responses to wider risk factors. Furthermore the prison population, those in CYF care and the LGBTI communities have high rates of suicide.

Finally, to put all of this in context, for New Zealanders deaths by motor vehicle accidents are less than half of the number of deaths by suicide. The comparison with road traffic accidents has been chosen to provide a sense of the scale of suicide numbers in the New Zealand context. Road traffic accidents, like suicide, is an area of amenable mortality and has demonstrated success in reducing the overall rate and incidence of these deaths as a result of a multifactorial, whole of system response.

4.1 Suicide prevention in Aotearoa/New Zealand

It is agreed internationally and in Aotearoa/New Zealand that suicides are preventable with the right mix and range of interventions. This was reinforced by the World Health Organisation in 2014 when they published a major and definitive report on “Preventing Suicide”, emphasising that suicide is preventable and requires a comprehensive response across all of society. “Given the multiple factors and the many pathways that lead to suicidal behaviour, suicide prevention efforts require a broad multisectoral approach that addresses the various populations and risk groups and contexts throughout the life course”.

Since 1998 Aotearoa/New Zealand began taking a planned nationwide approach to reducing suicide. This began with the New Zealand Youth Suicide Prevention Strategy. This strategy was followed by the New Zealand Suicide Prevention Strategy 2006–2016 which took a broader view across all risk populations.

The current New Zealand Suicide Prevention Action Plan 2013–2016 was informed by health and social service agencies and providers, communities and academics ensuring a focus on a comprehensive range of activities. Actions include universal (for all), selective (for at risk populations) and indicative (individuals with risk) suicide prevention interventions. The Action Plan has a comprehensive, intersectoral focus with actions contributed by a range of agencies including the Department of Corrections, the Ministries of Education and Social Development (Youth Affairs) and the New Zealand Police. This cross agency input is explicit recognition of the range of factors influence suicide and suicidal behaviour.

In addition to activities directly undertaken by government, Aotearoa/New Zealand communities too have undertaken their own responses to suicide. In some cases this has been facilitated by government funded initiatives such as some of the work by Waka Hourua. In other cases this has been led by local mayors, Marae, and others in response to specific events such as suicide clusters. These responses have also had some localised success.

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16 Waka Hourua. National Suicide Prevention Programme for Māori and Pasifika Communities.
5 WHY A SUICIDE PREVENTION OUTCOME FRAMEWORK?

Although suicide prevention is agreed to be complex, there is good evidence that nationwide leadership and strong coordination across sectors will continue to strengthen suicide prevention and increase the likelihood of success in reducing the incidence and rate of suicide for Aotearoa/New Zealand and within target populations. The WHO Report on suicide prevention reinforces this view, identifying the importance of government’s leadership role in bringing together multiple stakeholders who might not otherwise collaborate.  

Evidence suggests that in addition to effective leadership, agreed and common goals that clearly align activities to support these goals is essential to achieving a successful reduction in suicides. The Australian Healthcare Evaluation of the Australian Suicide Prevention Programme noted the risk in not having a clear and shared understanding of suicide prevention and how the activities fit together. They found that a lack of clarity can result in participants who are uncertain about their contribution.

Aotearoa/New Zealand has a recent history of successful efforts in reducing mortality, for example initiatives to reduce tobacco use and deaths from road traffic accidents. These illustrate that Aotearoa/New Zealand can be further successful in reducing unnecessary deaths by continuing to apply a comprehensive, multisectoral strategy that remains sustained over time although it is recognised that suicide prevention is inherently more complex.

These programmes had common attributes of strong nationwide leadership, intersectoral approaches and organised and concentrated effort on behalf of multiple agencies, NGOs and local groups.

The development of this outcome framework signals a further strengthening of Aotearoa/New Zealand’s approach by creating an organising framework that supports agencies, District Health Boards, NGOs, providers, communities, marae and whānau to work together on a clearly articulated outcome and measure the performance of suppliers of activities and interventions. Importantly all activity and measurement focuses on target populations, as well as the whole, making transparent inequalities and opportunities to improve activities and interventions that work in these populations.

5.1 THE METHODOLOGY

This population-based outcome framework has been developed using a methodology designed to support broad intersectoral approaches to improving outcomes for populations with complex health and social issues, including addressing inequalities of outcome. It is a framework to engage stakeholders in developing and implementing agreed suicide prevention activities.

17 World Health Organisation (WHO). (May 2014) Preventing Suicide. pp 03.
21 In 1995 government began a programme of activity to achieve ambitious goals for reductions in road traffic deaths. This continues with the current road safety strategy, Safer Journeys 2010 – 2020.
The methodology draws on theories including complex adaptive system theory\textsuperscript{22}, collective impact\textsuperscript{23} and results based accountability\textsuperscript{24}. The outcome framework methodology was developed by Haggerty & Associates and CLS Ltd\textsuperscript{25}. As a structured process it creates a clear line of sight between individuals and communities and the whole of population outcome.

Workshop engagement processes are a critical element of the development process. Kaupapa Māori methodologies were drawn on throughout, taking an approach similar to whaikorero on the pae pae – intended to enable robust and critical discussion to occur throughout the development process.

This suicide prevention outcome framework is built around the following key components:

- an agreed population accountability that targets the reduction in suicide, suicidal behaviour and suicide risk factors in universal and target populations;
- a quality of life outcome that enables and encourages stakeholders, including communities, to contribute to suicide prevention;
- a social ethnographic approach that has identified 12 target populations, in seven categories, who have relevant unique social structures, in addition to the universal population;
- an evidence informed framework for organising interventions for the identified population groups, enabling a full range of stakeholders to respond to this complex social problem and create a service user accountability;
- a performance measurement system for service user accountability that can be used to determine the effectiveness of suicide prevention activities; this can then be used for streamlined (outcomes based) contracting with suppliers.

The outcome framework then creates an outcome statement, key result areas and population indicators for what is known as population accountability, and evidence informed organising matrix and performance measurement system for, what is known as, the service user accountability for the prevention of suicide in Aotearoa/New Zealand. Within the framework this is represented as five elements organised into two sections:

- **Population Accountability**
  - Quality of life outcome for suicide prevention including results areas and indicators;
  - Target populations to focus activity to achieve the result;
  - Organising matrix for the activities that are most likely to contribute to the result areas;

- **Service User Accountability**
  - Completed activity matrices for the universal and target populations;
  - Performance measurement of the impact of the identified activities.

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\textsuperscript{22} Complex adaptive system theory and complexity science have been applied to all aspects of healthcare including healthcare organisation theory.


\textsuperscript{24} Mark Friedman. (2011) Trying Hard is Not Good Enough – Results Based Accountability. Trafford Publishers.

\textsuperscript{25} Clear Line of Sight Limited.
In summary, the framework starts with the desired quality of life population outcome and key result areas, working through to planned activities intended to support the outcome - service user accountability. The relationship between the population accountability and the service user accountability is strengthened through the organising matrix which is designed to measure impact of activity on the total and target populations. Populating the matrix is intended to be completed together with relevant stakeholders.

**Diagram three: Population Outcome Framework Methodology**

The suicide prevention outcome framework can be used to:

- track population outcomes (what is working and what is not) for the universal and target population;
- identify each supplier's contribution to the desired outcomes including supplier performance;
- support a conversation with stakeholders about gaps, impact, changes needed and further opportunities to improve outcomes and performance;
- target and reduce inequalities between target populations;
- inform policy and funding decisions by Government and District Health Boards.
The language of population and service user accountability is part of the approach called “Results Based Accountability by Mark Friedman”\(^{26}\). This approach has been adopted by the Ministry of Business, Innovation and Employment\(^{27}\) to improve outcomes contracting in the health and social sector, and is referred to as streamlined contracting.

### 5.2 Suicide Prevention Outcome Framework Design Process

The process of development is as important as the methodology, and is designed to capture sufficient depth of expertise and knowledge to inform the framework and its future application. This involves the input of a wide variety of stakeholders and experts in suicide prevention that ensures a broad understanding of suicide and suicide prevention.

Risk and protective factors for suicide were explored through a parallel process of discussions with key leaders and a high level review of the evidence and literature. The process included whakawahangatanga or the development of high trust working relationships between participants. Establishing meaningful engagement and participation was critical to gaining an understanding of different cultural frames of reference for suicide and suicide prevention in the process.

The next step involved the development of a straw man framework. This provided participating stakeholders with a working model to dismantle and recreate through a workshop process. There were two workshops held with key stakeholders. The first workshop introduced the methodology and the straw man outcome framework and focused on an initial critical review of the draft framework. The second workshop reviewed a redeveloped draft suicide prevention outcome framework. The resulting framework was then tested with the Ministry of Health and other key stakeholders including Waka Hourua.

The stakeholders included in the development process included:

- Government agencies including:
  - Ministry of Health
  - New Zealand Police
  - Ministry of Youth Affairs
  - Department of Corrections
  - Ministry of Education
- District Health Board staff including Suicide Prevention Coordinators
- NGOs providing and suicide prevention and postvention activities including those who work with youth and rainbow communities
- Waka Hourua – the Māori and Pacific partnership for suicide prevention
- Expert clinicians in the field of suicide prevention
- Māori community providers.

This process completed the population accountability section of the suicide prevention framework and the organising matrix for the second section of the framework.

\(^{26}\) Mark Friedman. (2011) *Trying Hard is Not Good Enough – Results Based Accountability.*

\(^{27}\) MBIE
The next stage is the completion of the activity organising matrices and development of detailed performance measures for the whole and target populations to create service user accountability. This measurement set will be as consistent as possible across activities to enable the comparison of effectiveness for target populations. This section of the framework is completed by working with stakeholders and suppliers involved in suicide prevention to create a comprehensive understanding of the contribution of a wide range of activities to suicide prevention. This is referred to as the deployment stage.

### 5.3 Working with Communities

One of the attributes of this methodology is that it intentionally engages and values the work of communities and whānau when working with complex health and social issues. This includes enabling the development and incorporation of community knowledge as to what may be, and is effective in target populations, as well as the whole.

For example, the knowledge created in the work of Waka Hourua, fostering and developing Māori and Pacific approaches to suicide prevention, can be integrated transparently into the framework and its effectiveness for the populations they serve be considered.

Furthermore, the strength and support offered by the natural support systems that exist within whānau, hapu, marae and other social networks including charities, special interest groups and membership of organisations can be included. The organising matrix actively encourages these activities for target populations by making transparent the areas in which such supports can add value. This means they can also be measured in a meaningful way.

The population and service user accountabilities created using this framework can be used to support a collective impact approach. Collective impact is the commitment of stakeholders to a common agenda for solving complex social problems and is otherwise known as a social transformation methodology. 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 as it exists in many proverbs such as: “Ma Whero, Ma Pango, ka otia te mahi” - “With the red thread, and the black, the work will be completed”.

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28 Natural support networks are the people present in a person’s life who may be able to support them in particular situations.
6 UNDERSTANDING SUICIDE IN AOTEAROA/NEW ZEALAND

Evidence from research, literature and experts is used to shape the outcome framework to ensure it is able to organise and strengthen existing activity and contribute to understanding what is effective whilst ensuring it does not unintentionally exclude opportunities to improve suicide prevention activity and therefore outcomes.

Broad sources of information were used including literature reviews prepared by the Ministry of Health, reviews of international approaches to suicide prevention including the Australian suicide prevention strategy and the WHO 2014 report on preventing suicide. The specific reports are:


This information was supplemented by engagement with experts in suicide and suicide prevention, agencies involved in the New Zealand Suicide Prevention Action Plan 2013–2016, providers of suicide prevention activity and District Health Boards.

There is a wide range of knowledge evidence, theories and experience regarding the causes of suicide. It is clear that no single suicide theory accounts for all suicides and the causes of suicide can only be described as complex. No single stressor is sufficient to explain a suicidal act, but rather “it is the impact of several factors that act cumulatively to increase an individual vulnerability to suicidal behaviour”.

Consideration was given to both risk factors and protective factors. Risk factors are sometimes called vulnerability factors because they increase the likelihood of suicidal behaviour. Protective factors are those factors which reduce the likelihood of suicidal behaviour and work to improve a person’s ability to cope with difficult circumstances.

The available evidence, together with input from workshop participants created three categories of factors that impact on the likelihood of suicidal behaviour. These are:

- **Individual resilience, strengths and wellbeing** – the combination of personality and individual resilience that influence the response of an individual to risk factors.

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30 World Health Organisation (WHO). (May 2014) Preventing Suicide. pp 03.
• **Individual risk factors** – known risk factors for suicide and suicidal behaviour for an individual, such as social isolation or exposure to other suicides. These are sometimes called proximal factors.

• **Environmental risk and protective factors** – those wider issues known to influence the incidence and rate of suicide but their impact cannot be primarily attributed to the individual. These are sometimes called distal factors and include factors such as economic conditions.

### 6.1 Individual Resilience, Strengths and Wellbeing

There is an important discourse in the literature regarding individual resilience and personality and their relationship to suicide and suicidal behaviour. Resilience at an individual level can be assessed and is demonstrated to have an impact on the ability of some individuals to be more protected from the suicide risk than others in the context of similar patterns of individual and environmental risk factors. The recognition of this is the development and delivery of activities and interventions is likely to have a meaningful impact on suicide prevention.

### 6.2 Suicide and Individual Risk Factors

The research and evidence referenced in the documents outlined above describe a number of factors that may contribute to potential suicide, suicidal behaviour and suicidal ideation in individuals. These factors may be experienced by an individual over the course of a lifetime and will usually intersect with one another. The table below groups these factors into five summarised categories.

This table is not exhaustive but gives an indication of the areas that should be considered in the planning of activities and interventions. The impact of these individual factors will vary for target populations as they likely to be influenced by individual ethnicity, gender, sexual orientation, age and life experiences.

**Table One: Suicide and Individual Risk Factors**

<table>
<thead>
<tr>
<th>Adverse experiences</th>
<th>Health challenges and disabilities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Adverse childhood experiences</td>
<td>Mental health disorders</td>
</tr>
<tr>
<td>Family violence</td>
<td>Substance abuse disorders (alcohol &amp; drugs)</td>
</tr>
<tr>
<td>Abuse – physical, emotional and psychological</td>
<td>Medical long term conditions</td>
</tr>
<tr>
<td>Bullying</td>
<td>Disabilities</td>
</tr>
<tr>
<td>Traumatic events</td>
<td>Other genetic &amp; biologic conditions</td>
</tr>
<tr>
<td>Bereavement by suicide</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Psychosocial stress</th>
<th>Close to suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Financial/Job Loss</td>
<td>Prior suicide attempts</td>
</tr>
<tr>
<td>Relationship and interpersonal loss</td>
<td>Suicide contagion</td>
</tr>
<tr>
<td>Deprivation</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Social isolation</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Discrimination (e.g. sexual orientation) &amp; Stigmatisation (e.g. mental health)</td>
<td></td>
</tr>
<tr>
<td>Racism</td>
<td></td>
</tr>
<tr>
<td>Geographic or physical isolation (e.g. rurality)</td>
<td></td>
</tr>
</tbody>
</table>

31 World Health Organisation (WHO). (May 2014) Preventing Suicide. pp43
6.3 Suicide and Environmental Risk and Protective Factors

The research and evidence reviewed also identifies a number of wider environmental and policy factors that have an impact on the incidence and rate of suicide at a population level. In the table below these have been grouped into four categories.

Again, the table is not exhaustive but gives a clear indication of the areas that should be fully explored and considered in planning interventions. The impact of these individual factors will vary for target populations as they likely to be influenced by ethnicity, gender, sexual orientation, age and locality.

Table Two: Suicide and Wider Environmental Risk Factors

<table>
<thead>
<tr>
<th>Economic conditions</th>
<th>Social inclusion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Employment</td>
<td>Colonisation and cultural alienation</td>
</tr>
<tr>
<td>Education</td>
<td>Discrimination &amp; stigmatisation</td>
</tr>
<tr>
<td>Income equality</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>Policy settings for risk factors</td>
<td>Social and health support</td>
</tr>
<tr>
<td>Policy settings for access to means of suicide</td>
<td>Entitlement for social and housing support</td>
</tr>
<tr>
<td>Media and agency reporting controls</td>
<td>Entitlement and access to health and mental health services</td>
</tr>
<tr>
<td>Policy settings for access to alcohol and drugs</td>
<td></td>
</tr>
</tbody>
</table>

6.4 Complex Interplay of Factors

The diagram below, and the tables above, provide a structure for understanding suicide and therefore create a structure for planning interventions and activities that are likely to improve suicide prevention outcomes. The diagram illustrates the layers of stressors that contribute to suicide and how the interplay of these risk and protective factors will then interact with individual resilience.

The prevalence of these risk and protective factors can be evaluated for the target, as well as the whole population to assist in the planning of activities and interventions that are more likely to be effective for that populations.

The WHO recognises that “the foundation of any effective response in suicide prevention is the identification of suicide risk factors that are relevant to the context and their alleviation by implementing appropriate interventions”32.

Comprehensive evaluation of research, literature and the opinion of experts both in those target populations and suicide prevention should contribute to the planning of the activities and interventions.

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Diagram Four: Risk and Protective Factors for Suicide

Environmental Factors

- Economic conditions
- Health challenges and disabilities
- Social cohesion
- Close to suicide
- Social isolation

Individual Factors

- Social and health support
- Adverse events
- Psychosocial stress
- Policy settings for risk factors

Individual resilience, strengths and wellbeing
7 THE SUICIDE PREVENTION OUTCOME FRAMEWORK

The following sections outline the three population accountability components of the Suicide Prevention Outcome Framework. These are:

- **Quality of life outcome** (what are we trying to achieve?) for suicide prevention including results areas and indicators;
- **Target populations** (who are we doing this for?) to focus activity to achieve the result;
- **Organising matrix** (what are the best things to do?) for the activities that are most likely to contribute to the result areas;

8 QUALITY OF LIFE OUTCOME: WHAT ARE WE TRYING TO ACHIEVE?

Agreeing on what is trying to be achieved is the critical first element of the outcome framework. It has four components to ensure comprehensive and shared understanding of the intended outcome. The four components are:

- a goal for suicide prevention,
- a quality of life outcome statement,
- key result areas and,
- population indicators.

8.1 GOAL OF THE SUICIDE PREVENTION OUTCOME FRAMEWORK

The goal statement ensures clarity of purpose for the outcome framework. The goal of this outcome framework is to:

*Reduce the incidence and rate of suicide and suicidal behaviour in Aotearoa/New Zealand.*

It recognises that “suicide and suicidal behaviour are a major health and social issue in Aotearoa/New Zealand”.33

8.2 QUALITY OF LIFE OUTCOME

The quality of life outcome is an inclusive statement that has resonance for agencies, professionals and communities. It provides the focus for building long term and sustainable solutions for communities.

*New Zealanders are socially connected, healthy and experiencing wellbeing.*

33 Ministry of Health (2014) Suicide Facts 2011. ppili

19 | Page
The WHO report identified that a society that is less likely to experience suicide is considered to be one where there are high levels of social cohesion and wellbeing. This informs the quality of life outcome for this suicide outcome framework.

8.3 Key Result Areas

This outcome statement is strengthened by three key result areas. During the early phases of this work, the key result areas of prevention, intervention and postvention were proposed as a framework for considering what activities contribute to preventing suicide in a community. This is language used by people working in the suicide prevention field, however, it is not meaningful to lay people. To ensure the framework was accessible to a wide range of potential users, the result areas where changed to:

- New Zealanders are resilient and healthy: reflecting the role that protective factors play in preventing suicide and the importance of building resilience and protective factors that will strengthen individuals and communities.

- Those at risk of suicide are protected: recognises that there are people within our society who are exposed to individual risk factors and are more vulnerable to suicide than others.

- The impact of suicide is relieved: responds to the impact of a suicide on those individuals, families, whānau and communities close to a person who suicides. These groups are at increased risk of suicide themselves.

These key result areas also provide a focus for population indicators and the organising matrix.

8.4 Population Indicators

Population indicators measure the impact of interventions in the key result areas and their contribution to the outcome and ultimately the overarching goal of reducing the incidence and rate of suicide and suicidal behaviours in Aotearoa/New Zealand. They are designed to be more sensitive than the historically used overarching goal. It is therefore expected that they can inform future investment choices in a timelier manner.

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

- Population indicators for suicide prevention (direct)
- Population indicators of wider wellbeing (indirect).

When considered with performance measures for activities and interventions, the indicators develop a set of 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.

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35 This work draws on the WHO Mental health definition which defines a state of well-being as that in which every individual realises his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his community. The positive dimension of mental health is stressed in WHO’s definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
36 WHO definition of health as contained in its constitution: “Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.”
8.4.1 Population indicators for suicide prevention (Direct)

This framework includes measures of suicidal behaviour and distress in the community to build this 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

8.4.1.1 Suicide mortality - rate and number

The first metric is the number and rate of suicide for Aotearoa/New Zealand. The advantage of a rate is that you can compare rates in different (target) populations to one another. This indicator is critical to retain the focus on suicide prevention.

This information is currently reported in Suicide Facts published by the Ministry of Health. These results are delayed because classification of a death as suicide is subject to a coroner’s inquiry and it can take several years before this is completed. The 2011 figures were published in 2014. Provisional annual suicide statistics are published from Coronal Services within two months of the end of the July to June year. In 2011, the Ministry of Health reported that 478 people died by suicide. This equates to 10.6 deaths per 100,000 population.

8.4.1.2 Suicidal behaviour - hospitalisations for serious self-harm

The second population indicator is hospitalisation to address the physical impact of serious self-harm. Studies show that of those who die by suicide a significant proportion will have made previous suicide attempts, ranging in studies from 17 to 68%, median of 25%, with estimates of the risk of suicide after an attempt ranging from 3.6 to 31.7 (median 5.8). This is not a causal metric but it is a meaningful indicator of distress in the wider community.

The Ministry of Health currently measures and reports on intentional self-harm hospitalisations in Suicide Facts. It 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.

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38 The odds ratio of suicide occurring after a suicide attempt.
Furthermore, it was premised in this development process that 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 well\textsuperscript{41}.

At an estimated number of 2,500 incidents per annum, intentional self-harm hospitalisations currently have a rate of 55 per 100,000 people. 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.

8.4.1.3 DISTRESS IN THE COMMUNITY – 1X CALLS TO NZ POLICE FOR SUICIDE OR SUICIDE RISK IN THE COMMUNITY

NZ Police receive calls from individuals regarding suicide and suicidal behaviour. These calls are known as 1X calls and come to the 111 number. In 2013/14 there were 12,465\textsuperscript{42} 1X calls. These calls regarding suicide and suicidal behaviour, along with others, are made to express concerns about friends or family, to seek help accessing mental health services or to report crimes that are subsequently unsubstantiated. If, upon attending the scene a crime is noted, such as family violence, the activity is removed from 1X call numbers.

Although these are not uniquely identifiable events of specific people they remain an indicator of a level of distress related to suicidal behaviour in the wider community that may be mitigated by suicide prevention activity. The estimated rate of 1X calls is 278 per 100,000 people\textsuperscript{43}. 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.

8.4.2 POPULATION INDICATORS OF WIDER WELLBEING (INDIRECT)

Measuring wider wellbeing in the community is recommended to create a set of balancing measures that consider wider environmental issues that may impact on suicide, suicidal behaviour and distress in the community. It is beyond the scope of this draft outcome framework to determine these measures as an in-depth piece of work is required to review the evidence and fully explore the data to understand the relationships between the wider environmental risk and protective factors and suicide, suicidal behaviour and distress.

Exploration of balancing measures could include the following:

- Measures in each of the key risk and protective factors that influence suicide and suicidal behaviour:

\textsuperscript{42} Sourced from New Zealand Police Statistics Group
\textsuperscript{43} NZ Police Mental Health Team
- Environmental factors
- Economic conditions
- Social inclusion and connection
- Access to health and social support

- The consideration of survey data that includes metrics of wellbeing as reported by individuals and the communities they represent:
  - Youth 2000 Survey Series
  - New Zealand General Social Survey
  - New Zealand Health Survey
  - New Zealand Mental Health Survey

- Specific social and economic factors that can also be measured at a population level and monitored alongside suicide and suicidal behaviour over the medium term include:
  - Employment
  - Education
  - Family Violence
  - Reported child abuse
  - Economic performance.

These indicators can then be considered alongside the population indicators for suicide prevention, building an understanding of the relationship between whole wider wellbeing population indicators and the suicide prevention specific population indicators. This information could be informative in predicting future rates and identifying appropriate interventions.
9 WHO ARE WE DOING IT FOR?

The New Zealand Suicide Prevention Action Plan 2013–2016 actions include universal (for all), selective (for at risk populations) and indicative (individuals with risk) suicide prevention strategies. The stratification of populations is recognised as improving the understanding of population need and targeting effort to reduce inequalities and improve outcomes. The suicide rate and incidence of suicide and hospitalisations for self-harm do vary by population groups. Suicide Facts\(^44\) reports these variations using demographic analysis including age and ethnicity.

To develop this population-based outcome framework a social ethnography approach was adopted that is informed by disciplines such as social epidemiology, social ethnography and population health. These approaches identify that understanding the social structures of target populations can improve service design and therefore outcomes.

It can be argued that social characteristics of target populations become even more important when interventions are for complex problems, such as suicide prevention, in which different communities, social groups and individuals experience and respond to different risk factors in different ways.

To create these target populations the process focused on analysing those populations that have a greater incidence or rate of suicide, or suicidal behaviour. This included demographics, locality, deprivation, place of residence, social groups, service users and other identifiable characteristics.

This process was informed by published evidence, research and survey data. Suicide Facts\(^45\) analyses suicide and self-harm hospitalisations and Dr Gary Jacks on, Health Partners Consulting Group conducted further population-based analysis to identify cohorts of the population and create a finer granularity in the analysis.

Dr Jackson made some important findings in his analysis. Please note the term ‘other’ is used to describe the non-Māori and non-Pacific members of the Aotearoa/New Zealand population. These findings are consistent with Suicide Facts\(^46\) but use a five year dataset from 2007 to 2011 for suicide mortality provided to us by the Ministry of Health.

The following findings were made:

- Suicide as a cause of death is most significant in the male population under 40 years of age;
- Māori have a consistently higher suicide rate than non-Māori for both males and females most especially amongst youth;
- Pacific rates are similar to Māori at younger ages;
- Māori youth rates are more than double non-Māori youth;
- Māori male suicide rate drops below ‘other’ males after age 50;
- Pacific male suicide rates dropped below ‘other’ males after age 40 years;
- ‘Other’ males 75 years and over experience an increase in rate;

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• Māori and Pacific suicide rates in 15-34 year olds vary by deprivation where ‘other’ do not;
• Rural areas have slightly higher rates, more pronounced in males and older persons;
• Self-harm hospitalisations per suicide is much higher for females at a rate that is 13x more than suicide, for males the intentional self-harm hospitalisation rate is 2.3x that of suicide;
• ‘Other’ are more prominent in intentional self-harm hospitalisation data than in suicide mortality data – six hospitalisations for every death, compared with Māori five and Pacific three to four.

Further evidence was also reviewed that identified some population groups not specifically identified in the health data sets as having high rates of suicide. For these populations the rate of suicide can only be estimated. The following populations experiencing high rates of suicide were noted:

• In 2011, approximately 40% of those who have died by suicide\(^{47}\) (aged 10 to 64 years) were mental health service users; this is by far the biggest single group of people who suicide\(^{48}\).
• Surveys of LGBTI\(^{49}\) youth and adults experience high rates of suicide and self-harm;
• Those people in the custody of Corrections, specifically the prison population, experience higher rates of suicide\(^{50}\);
• There is evidence that youth in Child, Youth & Family (CYF) care are also more at risk of suicide.\(^{51}\)

For mental health service users and prison population the numbers who suicide is known but the populations are estimated. For the LGBTI populations the suicide numbers and populations are estimated. These estimated numbers indicate a high rate of suicide.

Analysis was also undertaken to consider the relationship between these demographic populations. The most significant impact is the separation of the mental health services users and prison population which results in a significant reduction in the ‘other’ male 24 to 64 years suicide rate, which halves in the process of becoming the ‘other’ male non-mental health non-prison, non-LGBTI 24 to 64 years suicide rate.

### 9.1 Understanding Target Populations

Determining the target populations is a process of balancing the rate of suicide, and the incidence of suicide in these identifiable populations. The largest identifiable population who suicide are recent mental health service users aged between 24 and 64 years of age. These are people who suicide who have had contact with a specialist mental health service, including alcohol and drugs, in the past year\(^{52}\). The other major groupings are youth between 10 and 24 years of age, males between 25 and 64 years and Māori.

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\(^{47}\) This number includes 8 undetermined deaths of Mental Health Services Users in the total of 285.


\(^{49}\) Lesbian, Gay, Bisexual, Transgender and Intersex (LGBTI)

\(^{50}\) New Zealand Department of Corrections – Ara Poutama Aotearoa. Website.

\(^{51}\) Beautrais A, Ellis P and Smith D. The risk of suicide among youth in contact with Child, Youth and Family. Social Work Now: August 2001

Young people in CYF care, LGBTI community, ‘others’ who are 75 years plus, and the prison populations have high rates of suicide, although their absolute numbers are relatively low.

9.1.1 Mental Health Service Users

In 2011 mental health service users accounted for 40% of all suicides and are 24% female and 76% male with this ratio being consistent with the wider suicide population. The age standardised rate by ethnicity was greatest for ‘other’ at 133 per 100,000 population, Māori at 116 and Pacific at 74. 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 profile of this group is outlined in the Office of the Director of Mental Health Annual Report 2013 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. It is known that those who are mental health services users are likely to be more vulnerable to the risk factors associated with suicide, including 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 live. 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”.

Whether to identify this group separately was carefully considered. It was determined that identifying them separately ensures that future consideration of service interventions and responses recognises this increased vulnerability and could target activities to prevent suicide and suicidal behaviour in this very high risk target group.

9.1.2 Adult Males 25 to 64 Years

Using five years of suicide data adult males account for 44% of all suicide deaths. Within this 44%, 6% are Māori and 1.4% are Pacific, with the remaining 36% being ‘other’. When these numbers were analysed in detail it became apparent that the Māori male suicide rate drops below ‘other’ males after

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53 This number includes 8 undetermined deaths of Mental Health Services Users in the total of 285.
57 Stories of Success 2014 pp7.
age 50; and Pacific male suicide rates dropped below ‘other’ males after age 40 years. Even more strikingly as identified previously this number is almost halved when mental health service users are removed. Then adult males account for 22% of all suicides with the greatest reduction being in ‘other’ males from 35% of all suicide deaths to 17%.

The Suicide Mortality Review Committee (SUMRC) is an independent committee that reviews and advises the Health Quality & Safety Commission on how to reduce the number of suicide deaths in Aotearoa/New Zealand. The Committee has been established as a trial, for a limited time, to consider the benefits that may be able to be gained from mortality review in the area of suicide. Among other groups, the SUMRC is focusing on males in this age group. This will potentially provide meaningful data to understand this large cohort further\textsuperscript{58}.

9.1.3 MĀORI POPULATION

Suicide is an issue that disproportionately affects the lives of Māori families/whānau. In 2011, the total Māori suicide rate was 16.8 per 100,000 Māori population; 1.8 times higher than the non-Māori rate (9.1 per 100,000 non-Māori population)\textsuperscript{59}. In addition the trends for suicide by Māori are not improving in line with the trends for the non-Māori population. Suicide Facts\textsuperscript{60} identified the following key trends:

- Between 1996 and 2011, non-Māori male suicide rates trended downwards, while the trend for Māori male suicide rates was less pronounced. No obvious trend was evident for either Māori or non-Māori females;
- In 2011, the Māori youth suicide rate (36.4 per 100,000 Māori youth population) was 2.4 times higher than the equivalent rate for non-Māori youth (15.1 per 100,000 non-Māori youth population);
- Youth rates for non-Māori are trending downwards over time, but Māori rates show no such trend.

In interpreting the information it became apparent that Māori and Pacific males had a different rate of suicide than ‘other’ males. As identified in 9.1.2 Māori and Pacific males’ rate of suicide are significantly higher between but dropped significantly after 40 years of age whereas ‘other’ rates continue at a higher level until 60 years. For this reason we have used different age bands for these populations. It is suggestive that Māori and Pacific males have different experiences as they age to ‘other’ males. Waka Hourua confirmed this is consistent with their experience and the emerging knowledge from the work they are undertaking in suicide prevention.

9.1.4 LGBTI COMMUNITIES

A report commissioned and published as part of the Ministry of Health’s suicide prevention research fund managed by Te Pou on behalf of the Ministry of Health found that gay, lesbian, bisexual,
transgender and intersex people have higher lifetime risk for mental health problems including depression, anxiety, suicide and self-harm, substance misuse and eating disorders.\textsuperscript{61}

This is further reinforced by the Youth 2000 survey series which continues to identify elevated risk of suicide and suicide ideation in young LGBTI people. In the Youth’07 study, researchers saw an increase in opposite-sex attracted students who felt happy or satisfied with life and a decrease in suicide attempts between 2001 and 2007. The same improvements were not seen for same or both-sex attracted students\textsuperscript{62}.

The rainbow or LGBTI community has a reported higher rate of suicide and self-harm than the general population. Although overall numbers are low this is a community where a focus on LGBTI young people and adults would have a positive impact in this relatively small community.

9.1.5 Young People

Young people aged 10 to 24 years account for 26\% of all suicides, an estimated annual number of 140. Suicide as a proportion of all deaths reaches its peak between 20 and 24 years. There is a significant debate regarding the definition of young people. In the development process for the suicide prevention outcomes framework it became clear that for at risk youth an age range up to 25 was consistent with social patterns of behaviours.

9.1.6 Those in the care of Child Youth and Family

A study of children in contact with Child Youth and Family (CYF) in 2001 highlighted particularly risk for this population. The study is dated 2001 but the indications are that this remains a high risk group. Importantly the study identified that in contrast to the general population where males have a higher risk of suicide than females. Māori females aged 16 years in contact with CYF have the highest risk of suicide of any CYF client group under 17 years of age. This study has not been updated.

This research also noted that, while improved detection by CYF social workers may lower the chances of a young person attempting suicide, it is unlikely to prevent all deaths as in some cases the factors that lead to, and increase the risk of, suicide may be outside the ability of CYF to intervene\textsuperscript{63}. This is no different to the experience of other sectors as there are often factors that are outside the direct responsibility of a single agency.

9.1.7 Older People

Older people dying by suicide peaks at around 80 years of age for ‘other’ but is not an identifiable issue for Māori and Pacific people as they rarely suicide over 65 years of age. It is worthwhile to note that overall suicide rates for male and female older people have declined consistently over the previous 60 years. The incidence is of concern and is the fifth largest incidence in this analysis. It is hypothesised that older people may have different risk factors for suicide. This would benefit from further investigation in considering activities in this area.


\textsuperscript{62} Rossen, F.V., Lucassen, M.F.G., Denny, S. & Robinson, E. (2009). Youth’07 the health and wellbeing of secondary school students in New Zealand: Results for young people attracted to the same sex or both sexes. Auckland: The University of Auckland.

9.2 Target Populations

Identification of rates and numbers of suicide for these populations was conducted by Dr Gary Jackson of Health Partners Consulting group using five years of Ministry of Health data. Each possible target population has been calculated exclusively where possible. So, for example the Māori 25-44 male figures exclude Māori LGBTI, Māori prisoners and Māori mental health service users. The main exception to this is youth where the prison and mental health service users have not been separated. This is because the youth population is considered to have strong social characteristics and the numbers of youth in prison and mental health service user numbers are relatively small. Also not attempted is the cross-over between mental health, prisons and LGBTI. The figures for those in CYF care were not estimated.

The challenge is structuring the target populations that create sufficient focus on the target groups, enable the impact of services to be monitored and recognise the meaningful social structures of these populations.

The table below outlines seven categories with 12 target populations. These are target but not discreet populations. For example, the population of mental health service users includes people who are Māori and Pacific. It is recognised that there is overlap in the populations and in the analysis of the population indicators this should be considered. The table below accounts for over 80% of suicides in Aotearoa/New Zealand, whilst covering 44% of the population. The universal interventions and strategies will capture those other populations.

**Table Three: Target Populations - Rate and Incidence of Suicide**

<table>
<thead>
<tr>
<th>Population category</th>
<th>Estimated suicides*</th>
<th>Target Populations</th>
<th>Percentage of Population</th>
<th>Percentage of Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Service Users</td>
<td>est 200 deaths pa</td>
<td>Mental Health Service Users</td>
<td>2.6%**</td>
<td>40%</td>
</tr>
<tr>
<td>Māori and Pacific Young People and Males</td>
<td>est 85 deaths pa</td>
<td>Māori 10 - 24yrs</td>
<td>4.0%</td>
<td>8.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific 10-24yrs</td>
<td>1.6%</td>
<td>2.5%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Māori Males 25-44yrs</td>
<td>1.7%</td>
<td>4.0%</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Pacific Males 25-44yrs</td>
<td>0.8%</td>
<td>1.0%</td>
</tr>
<tr>
<td>Other Young People</td>
<td>est 65 deaths pa</td>
<td>Other 10 - 24 yrs</td>
<td>14.0%</td>
<td>12.0%</td>
</tr>
<tr>
<td>Adult Males</td>
<td>est 95 deaths pa</td>
<td>Other Males 25 - 64yrs</td>
<td>17.0%</td>
<td>17.0%</td>
</tr>
<tr>
<td>LGBTI</td>
<td>est 24 deaths pa</td>
<td>LGBTI 10 - 24 yrs</td>
<td>0.4%**</td>
<td>1.4%**</td>
</tr>
<tr>
<td></td>
<td></td>
<td>LGBTI 25+ yrs</td>
<td>0.5%**</td>
<td>3%**</td>
</tr>
<tr>
<td>Older People</td>
<td>est 22 deaths pa</td>
<td>Other 75+ yrs</td>
<td>2.2%</td>
<td>4.1%</td>
</tr>
<tr>
<td>People in Custody and CYF Care</td>
<td>Not estimated</td>
<td>Child Youth &amp; Family</td>
<td>Not estimated</td>
<td></td>
</tr>
<tr>
<td></td>
<td>est 4 deaths</td>
<td>Prison Population</td>
<td>0.2%</td>
<td>0.8%</td>
</tr>
</tbody>
</table>

* on five year data 2007 to 2011

** estimated populations.
The diagram below illustrates the comparison between the number and rates of suicide for these target populations. The rate is calculated on the estimated or actual population size. This shows that mental health service users have both the highest rate and the highest number of suicides. The LGBTI community, although low in number have high rates of suicide.

**Table Four: Rate and Incidence of Suicide Ranking**

<table>
<thead>
<tr>
<th>Number of Suicides</th>
<th>Rate of Suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Service Users</td>
<td>Mental Health Service Users</td>
</tr>
<tr>
<td>Other Males 25 - 64yrs</td>
<td>Prison Population</td>
</tr>
<tr>
<td>Other 10 - 24 yrs</td>
<td>Child Youth &amp; Family</td>
</tr>
<tr>
<td>Māori 10 - 24yrs</td>
<td>LGBTI 25+ yrs</td>
</tr>
<tr>
<td>Other 75+ yrs</td>
<td>LGBTI 10 - 24 yrs</td>
</tr>
<tr>
<td>Māori Males 25-44yrs</td>
<td>Māori Males 25-44yrs</td>
</tr>
<tr>
<td>Pacific Males 25-44yrs</td>
<td>Māori 10 - 24yrs</td>
</tr>
<tr>
<td>Pacific 10-24yrs</td>
<td>Other 75+ yrs</td>
</tr>
<tr>
<td>Prison Population</td>
<td>Pacific 10-24yrs</td>
</tr>
<tr>
<td>Child Youth &amp; Family</td>
<td>Pacific Males 25-44yrs</td>
</tr>
<tr>
<td>LGBTI 10 - 24 yrs</td>
<td>Other Males 25 - 64yrs</td>
</tr>
<tr>
<td>LGBTI 25+ yrs</td>
<td>Other 10 - 24 yrs</td>
</tr>
</tbody>
</table>

In this outcome framework these 12 target populations and the whole population (the universal population) become the focus of organising activity and interventions to change outcomes. This focus is most likely to result in an improvement in the population indicators through a focused approach to achieving the key result areas:

- New Zealanders are resilient and healthy
- Those at risk of suicide are protected
- The impact of suicide is relieved

The development of these target populations also enables a very explicit consideration as to whether the services and interventions being promoted for this community are the most likely to be successful for this target group. This includes careful consideration of access to services and appropriateness of suppliers enabling explicit focus on the needs and social structures of these populations.
10 What are the best things to do?

Organising a comprehensive response to the complex challenge of suicide prevention requires consideration of a substantial body of evidence, research and new approaches that need to be filtered to identify the contribution intervention and activities will make to the result areas and the outcomes for target and whole populations.

For this reason this framework promotes an organising matrix to assist experts, key stakeholders and communities to consider the interventions that are most likely to have an impact in the key result areas for the population target populations. This matrix aims to achieve the following:

- Ensure all activity contributes to a suicide prevention result area;
- Create clarity as to the level at which the activity is working, whether for individuals, social groups, communities or across all of NZ society;
- Identify gaps and opportunities for improvement and innovation where there are too many or too few interventions and ensure coverage;
- Enable suppliers at all levels identify where they can make a contribution to the desired outcome including aligning activity that is not funded by Suicide Prevention programmes.

10.1 The suicide prevention matrix

Comprehensive strategies need to work at all levels of the social system to increase the likelihood of impact and a reduction in suicide, suicidal behaviour and community distress.

The need for activity at all levels is identified by both the World Health Organisation report and the Ministry of Health in its suicide prevention strategy.

Four levels are identified and they are matrixed against the three key result areas; New Zealanders are resilient and healthy, those at risk from suicide are protected and the impact of suicide is relieved. This ensures activity is aligned and contributing to the reducing the incidence and rate of suicide and suicidal behaviour in Aotearoa/New Zealand.

The four levels are:

**Society/Iwi/Waka** – those activities that need a nationwide and whole of society focus;

**Community/Hāpu** – those activities that are effective at a community level and are best coordinated and delivered within the community. This is particularly the level at which District Health Board coordination could be most important;

**Social groups/Marae** – those activities where activities are working to build social connection and solutions within unique social groups;

**Individual/Whānau** – those activities that are designed to support individuals to prevent suicide and suicidal behaviour.
### Diagram Five: The Suicide Prevention Activity Framework

<table>
<thead>
<tr>
<th>Suicide Prevention Activity Matrix</th>
<th>Resilient &amp; Healthy New Zealanders</th>
<th>Protecting those at risk from suicide</th>
<th>Relieving the impact of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Society/Iwi/Waka –</td>
<td>those activities that need a nationwide and whole of society focus;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community/Hāpu –</td>
<td>those activities that are effective at a community level and are best coordinated and delivered within the community. This is particularly the level at which District Health Board co-ordination could be most important;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Social groups/Marae –</td>
<td>those activities where activities are working to build social connection and solutions within unique social groups;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Individual/Whānau –</td>
<td>those activities that are designed to support individuals to prevent suicide and suicidal behaviour.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

The suicide prevention activity matrix is an organising framework. It is designed to be completed for each target population, and for the universal approaches used for the whole population. The completion of the matrix creates an understanding of the relationship between suicide prevention activities, the target populations and the achievement of results areas.

This creates the necessary layering of services and ensures the interventions meet the unique characteristics and needs of the target group, as well as the whole population, increasing the focus, and the impact, of the interventions on these groups.

The first step is to complete the matrix with current activity, not only that funded for suicide prevention but the related activity that is identified in section 6 in the diagram outlying risk factors. The second stage is to consider what should or could be in the matrix for the whole and target populations. Completing this matrix should engage with a wide range of stakeholders as outlined in section 12, implementation.

The activities and interventions agreed will reflect the best knowledge of the experts, providers and communities. Careful consideration of access to services and appropriateness of providers (suppliers) is important to create an explicit focus on the needs and social structures of the whole and target populations.

The word suppliers is used intentionally to identify not only those who are commissioned in the suicide prevention space but the wider suppliers who may contribute to the three key result areas for the whole and target populations. These programmes may or may not be funded by suicide prevention funding but may be part of other programmes supporting target populations, or may be community based support that can assist in achieving the desired outcome. Suppliers can include government agencies, District Health Boards, NGO providers, community organisations and communities themselves who may supply activities at different levels within and across the target and whole populations. There will be many suppliers for key result areas for target and whole populations.
A completed suicide prevention matrix is completed for illustration using the current suicide prevention action plan. As described before, a suicide prevention matrix would be completed for the whole population and for the twelve target populations.

**TABLE FIVE: ORGANISING MATRIX — EXAMPLE ONLY USING THE CURRENT SUICIDE PREVENTION ACTION PLAN**

<table>
<thead>
<tr>
<th>Resilient &amp; Healthy New Zealanders</th>
<th>Protecting those at risk from suicide</th>
<th>Relieving the impact of suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Society /Iwi /Waka</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Māori and Pacific national leadership group for suicide prevention [MoH]</td>
<td>• Māori and Pacific national leadership group for suicide prevention [MoH]</td>
<td>• Māori and Pacific national leadership group for suicide prevention [MoH]</td>
</tr>
<tr>
<td>• Building the evidence base/ research of what works for Māori and Pasifika to prevent suicide [MoH]</td>
<td>• Building the evidence base/ research of what works for Māori and Pasifika to prevent suicide [MoH]</td>
<td>• Building the evidence base/ research of what works for Māori and Pasifika to prevent suicide [MoH]</td>
</tr>
<tr>
<td>• Suicide prevention information service [MoH]</td>
<td>• Suicide prevention information service [MoH]</td>
<td>• Suicide prevention information service [MoH]</td>
</tr>
<tr>
<td>• Suicide prevention outcomes framework [MoH]</td>
<td>• Suicide prevention outcomes framework [MoH]</td>
<td>• Suicide prevention outcomes framework [MoH]</td>
</tr>
<tr>
<td><strong>Community /Hāpu</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• National coordination centres for Pacific and Māori community suicide prevention [MoH]</td>
<td>• National coordination centres for Pacific and Māori community suicide prevention [MoH]</td>
<td>• National coordination centres for Pacific and Māori community suicide prevention [MoH]</td>
</tr>
<tr>
<td>• Māori and Pasifika community based suicide prevention initiatives [MoH]</td>
<td>• Māori and Pasifika community based suicide prevention initiatives [MoH]</td>
<td>• Māori and Pasifika community based suicide prevention initiatives [MoH]</td>
</tr>
<tr>
<td>• Youth in emergency services programme [MSD (MYD)]</td>
<td>• Support for small communities to overcome the loss of a major employer [MSD]</td>
<td>• Suicide prevention toolkit for DHBs [MoH]</td>
</tr>
<tr>
<td></td>
<td>• Suicide prevention toolkit for DHBs [MoH]</td>
<td>• Preventing and responding to suicide resource kit for schools [MoE]</td>
</tr>
<tr>
<td>Social groups/Marae</td>
<td>Individual/Whānau</td>
<td></td>
</tr>
<tr>
<td>---------------------</td>
<td>-------------------</td>
<td></td>
</tr>
</tbody>
</table>
| • Preventing and responding to suicide resource kit for schools [MoE]  
  • Training of community health and social support services staff and community members to identify and support individuals at risk of suicide [MoH]  
  • Cyber-bullying prevention programme aimed at schools, parents and young people [MoE]  
  • Reducing access to means in correctional facilities [DoC]  
  • Support services for prisoners at risk of suicide or with mental health issues [DoC]  
  • Providing information and training to Corrections staff on mental health, suicide awareness and suicide prevention [DoC]  
  • Training of social work practitioners in suicide identification assessment and management [MSD (CYF)]  
  • Specialist training of all CYF carers, care and protection staff and youth justice residential staff [MSD (CYF)] | • Suicide prevention information service [MoH]  
  • Specialist-facilitated group support programmes for people bereaved by suicide [MoH]  
  • Provide support and guidance for people bereaved by suicide, including peer support groups [MoH]  
  • Community Postvention Response Service to provide support to communities experiencing suicide clusters or contagion [MoH]  
  • Training of frontline police officers to respond to people who are at risk of suicide and/or | • Provide information and support to prisoners, Corrections staff and prisoners’ support people after a suicide death or attempt [DoC]  
  • Trial of the monitoring of social media during a suicide cluster [MOH/Police]  
  • Initial response service to provide support to |
| **Training of Work and Income staff to respond to people who are at risk of suicide and/or are experiencing poor mental health [MSD]** |
| **Training of District Court security staff, victims’ advisors and Family Court Coordinators in suicide awareness and prevention [MoJ]** |
| **Training of primary health practitioners on recognizing and managing common mental disorders [MoH]** |
| **Mental health and suicide screening of prisoners [DoC]** |
| **Strengthened suicide identification and assessment in assessment tool used by social work practitioners [MSD (CYF)]** |
| **Improved care of people presenting to emergency departments with self-harm injuries [MoH]** |

| **people bereaved by suicide [MoH/Police]** |

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**Note:** lead agency/agencies in square brackets.

**Legend**

- **CYF** = Child, Youth and Family
- **DoC** = Department of Corrections
- **MoE** = Ministry of Education
- **MoH** = Ministry of Health
- **MoJ** = Ministry of Justice
- **MSD** = Ministry of Social Development
- **Police** = New Zealand Police
11 PERFORMANCE MEASUREMENT — KNOWING WHAT WORKS

This suicide prevention outcome framework is explicitly designed to improve outcomes in complex health and social problems by creating new knowledge regarding what works for both universal approaches and target populations.

The system of performance measurement is a key element in the creation of knowledge on the impact of interventions for the whole and target populations.

Performance measurement is part of the service user accountability framework. Service user accountability is focused on the customers, clients and patients of the health and social service programmes that deliver suicide prevention activities and interventions. It is applied to all contributing suppliers who are identified in the suicide prevention activity matrix. It creates an understanding of whether activities are contributing to improved outcomes for the whole or target populations.

Measuring impact and performance in this framework is aligned to the results based accountability framework adopted by MBIE\(^4\) for the streamlined contracting process. This suicide prevention outcome framework has created the population accountability including an understanding of risk factors, identified priority target populations, and a suicide prevention activity matrix that can be agreed with suppliers at each level of the system.

11.1 KEY PERFORMANCE MEASUREMENT CONSIDERATIONS

Effective performance measurement can make a critical contribution. There will be gaps in measures that are meaningful and useful to measuring performance that can be used to determine whether the activity or intervention is having the desired and intended effect. We recommend the development of performance measures that are explicit about the intended effect of all activities and interventions.

11.1.1 MEASURES OF IMPACT

There are three important elements to ensure that performance measurement structure can be used to evaluate impact and effect for the service user. This can then inform the relationship to achievements in the three key results areas and on the population indicators of suicide and suicidal behaviour.

These elements are:

- Activity coverage for target populations;
- Change of circumstance for service user;
- The recognition of the impact and experience for the consumer/individual or whānau.

11.1.2 COVERAGE

Coverage is an important concept when seeking a change in population outcomes. This very simply identifies what proportion of the target population has access to suicide prevention activities to

\(^4\) Ministry of Business Innovation and Employment
achieve the desired impact, or change of circumstance. Low coverage or lack of intensity can compromise performance.

11.1.3 Change of Circumstance
A change of circumstance is a critical element of the purpose for activities. In results based accountability language this can include changes in skills and knowledge, attitude and opinion, behaviour and specific circumstance. Examples include moving into a job, increased financial literacy and improved relationship management skills. To increase the likelihood of an impact and change in outcome a very explicit approach to change in circumstance is needed.

11.1.4 People/Whānau Experience
Underlying all aspects of service delivery is whether the service is appropriate and accessible to the target population. This measure must be beyond satisfaction survey data and must consider whether members of the target population are engaged with the service and experience a change of circumstance as a consequence of engagement with the supplier.

11.2 Performance Measures
The performance measures have two parts and four components:

- Service measures:
  - Activity – how many?
  - System performance – how well?
  - Impact – is anyone better off?
- Infrastructure:
  - Setting of standards.

11.2.1 Service Measures
Below we have outlined examples of the performance measures that could be applied to suicide prevention services and what should be considered when they are developed. Developing these measures is a collaborative process of working with suppliers using the outcome framework.

<table>
<thead>
<tr>
<th>Measure</th>
<th>Discussion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Activity – how many?</td>
<td>Consideration of measures that enable evaluation of activity coverage for populations increases the utility of this measures.</td>
</tr>
<tr>
<td>Measure</td>
<td>Discussion</td>
</tr>
<tr>
<td>---------</td>
<td>------------</td>
</tr>
<tr>
<td><strong>System performance – how well?</strong></td>
<td>The effectiveness of the agreed activity or intervention being delivered at an appropriate timeframe, to a specific standard or with sufficient frequency. These measures should be informed by existing evidence to create the target that is set for system performance, or create new knowledge as to the required standard.</td>
</tr>
<tr>
<td>% of families contacted by response service, which provides specialist support to those bereaved by suicide, who participate in three support sessions of support;</td>
<td></td>
</tr>
<tr>
<td>% of people who self-harm and are admitted to hospital receive a follow-up contact within 24 hours of discharge;</td>
<td></td>
</tr>
<tr>
<td>% of participants who report increased confidence in responding to a person at risk of suicide.</td>
<td></td>
</tr>
<tr>
<td><strong>Impact – is anyone better off?</strong></td>
<td>Understanding the effect for those who receive services and ensuring measurement considers a specific change of circumstance including skills and knowledge acquisition, attitude and opinion, experience and behaviour.</td>
</tr>
<tr>
<td>% of young people enrolled in the programme XYZ who obtain employment;</td>
<td></td>
</tr>
<tr>
<td>% of young people who completed programme XYZ report and report an improved understanding of safe use of alcohol;</td>
<td></td>
</tr>
</tbody>
</table>

**11.2.2 INFRASTRUCTURE – STANDARDS**

It is common practise in contract measurement to include standards or infrastructure measures as part of contract performance. In this approach, as in the Results Based Accountability approach, standards are separately identified as base requirements of the contract rather than as measures of activity or performance.

This can include use of specific assessment tools by the workforce, skills and qualifications which are identified as making a difference to the quality or impact of the intervention or service provided. Specific examples are:

- All GPs providing primary mental health service users have completed a required training programme on suicide risk;
- An agreed and validated screening tool to identify suicide risk is used with 100% of all inmates when entering the judicial system.

These can be set as performance standards in the contract process. These standards are those specific to the suicide prevention activity and intervention and do not replicate contracted quality requirements for providers.
**12 IMPLEMENTATION SERVICE USER ACCOUNTABILITY**

The suicide prevention outcome framework has been completed as an organising framework as illustrated in the diagram below, to the level of ‘domains of activity’ creating a population accountability and activity matrices.

Completion of the service user accountability for activities and interventions for each target population enables the identification of suppliers and the performance measurement set for the activities provided. As illustrated below this is completed with key partners and suppliers who have a contribution to make to suicide prevention for these populations.

**DIAGRAM SEVEN: SERVICE USER ACCOUNTABILITY**

Collaboration between the Ministry of Health and District Health Boards will be important in this process as District Health Boards are accountable for developing local suicide prevention action plans and may have relationships with the local and district suppliers.
12.1 Creating Service User Accountability

The methodology used to develop the suicide prevention outcome framework creates a population accountability and activity matrix that can be used to work with communities and current and potential suppliers to create service user accountability.

The key steps in creating an activity matrix and service user accountability for a target population are outline in the diagram below.

**Diagram Eight: Implementing Service User Accountabilities**

- **Select the target population**
  - Determine the scope of the target population;
  - Consider who suppliers and experts might be for this target population;
  - A focus within a locality or district may be required, for this target population.

- **Identify the partners who may contribute to the outcome**
  - Think at community/hapu, social groups/marae and individual hanau level for that target population;
  - Ensure a spread of partners including communities and interest groups as well as experts and providers to create suppliers.
  - Identify natural supports and contributions from communities.

- **Use workshops to identify the contributions the partners may make to the key result areas**
  - Deploy collective impact workshop processes using the population accountability and activity matrix to populate activity matrices.
  - From the activity matrices for the selected target population develop service based performance measures.

It is important to remember some key things when populating the framework for target populations:

- This analysis is a process. Some of the answers will be imperfect and it should be expected that some of the existing funded activities will not align to the framework, and that there will be gaps in commissioned activity;
- The process should remain open to funded activities that may not be specific to suicide prevention, non-funded activities such as natural supports and supports from community and charitable agencies;
- The process should remain focused on coverage, change of circumstance and impact in the activities and performance measures.

12.1.1 Analysis of Existing Investment

It is useful to complete an analysis of existing investment and programmes to inform collective impact processes. The analysis of the existing funded work including aligned activities and interventions (services) that are commissioned from the formal health and social services funders including
government agencies and District Health Boards. This will create the first activity matrix and draft performance measures for the target populations. The analysis process should include identifying:

- The target group they serve with a specific focus on coverage of the target populations;
- The interventions and which key result area they are contributing to at what level;
- Determining the measures that could be applied to the intervention framework with a key focus on:
  - Coverage of the target group and whole population
  - Change of circumstance
  - The people/whānau experience

### 12.2 Service User Accountability

Service user accountability creates the population of suppliers and the performance measurement that determines whether interventions and activities are working to improve outcomes for target and the whole population. Ensuring the data generated is used by suppliers and partners in communities to ensure outcomes are achieved is important to taking an outcomes approach.
13 RECOMMENDED ACTIONS

There are recommended actions made throughout this report to ensure the suicide prevention outcome framework makes a useful contribution to reducing incidence of suicide and suicidal behaviour in Aotearoa/New Zealand. The recommended actions are:

**Action one:** That the outcome framework is deployed to create service user accountabilities for all populations by implementing the processes outlined in section 12.

**Action two:** Consideration is given to the district and nationwide responsibilities for collation and use of the information and knowledge generated from the population indicators and performance measurement sets for target populations. This includes identifying what works, and what does not work for these populations.

**Action three:** That a set of population indicators of wider wellbeing are developed to create a set of balancing measures that consider the wider environmental issues that impact on suicide and suicidal behaviour as discussed on pp22. It is recognised that this will be a challenging task.

**Action four:** That the measurement of suicidal behaviour (i.e., intentional self-harm hospitalisations) is amended to remove admissions to mental health facilities. This is likely to be a more heterogenous group and to include a greater proportion that did not have suicidal intent as outlined in pp21.

**Action five:** That the Ministry of Health and NZ Police continue to work together to ensure 1X data is recorded and reported in a way that enables all agencies to identify and consider responses to the determinants of the distress as outlined on pp22.

**Action six:** As some of the risk factors identified in section six also contribute to other related areas including family violence, mental wellbeing and substance abuse, it is recommended that the overlap of future outcome frameworks is carefully considered to ensure an integrated approach.

**Action seven:** That consideration is given as to how future Ministry of Health - Suicide Facts reports are configured to report against the suicide prevention outcome framework including the population indicators for the whole population and the 12 target populations.
14 CONCLUSIONS

Approximately 500 New Zealanders die every year by suicide, almost twice that who die in road traffic accidents. There is evidence that continuing a comprehensive approach to suicide prevention, including the use of this outcome framework, could further reduce deaths by suicide and suicidal behaviour in Aotearoa/New Zealand.

This suicide prevention outcome framework was created with communities and experts in suicide prevention. Its purpose is to strengthen the leadership of the Ministry of Health, and other government agencies, to focus and organise suicide prevention activity to achieve the shared goal of reducing the incidence of suicide in Aotearoa/New Zealand. It does this by creating a shared population accountability that engages agencies, District Health Boards, NGOs, providers, communities, marae and whānau.

The value of the suicide prevention outcome framework is not only in its completion but in the implementation of the recommendations and the use of the suicide prevention outcome framework to develop service user accountabilities. This creates the information and knowledge to inform future investment choices and ensure that achievement of the outcome and the goal are always the priority.
15 ACKNOWLEDGEMENTS

This suicide prevention outcome framework was developed with the input of a wide range of experienced professionals and community members dedicated to suicide prevention and postvention in Aotearoa/New Zealand. Without the input of these representatives this framework could not have been developed. It is informed by their experiences, skill and expertise as professionals and knowledge of the communities they serve across Aotearoa/New Zealand.