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What works? Individuals' Experiences and Knowledge of Suicide
Prevention Interventions in Aotearoa/New Zealand

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A thesis submitted in fulfilment of the requirements for the Doctor of Philosophy in Social
Work, the University of Auckland, 2019.

Abstract

In Aotearoa/New Zealand, suicide rates first peaked in 1998 when 577 people died by suicide and the country had the highest number of youth suicides among all OECD¹ countries (WHO, 1999). The number of deaths by suicide has since fluctuated each year; however, latest figures show a concerning increase that exceeds those of 1998; with 668 people dying between June 2017 and May 2018 (Chief Coroner's Office, 2018). This figure is the highest number of deaths by suicide to date in Aotearoa/New Zealand.

In response to suicide rates in 1998, the Ministry of Health constructed and published several frameworks, reviews, strategies and action plans. Historically, these documents have been written with input from academics, health professionals and bereaved family/whānau members. Input from current users of these services has not featured in any Ministry of Health documents to date. People who use suicide prevention interventions and who could arguably be seen as experts in this area have not been asked for their knowledge and feedback regarding the efficacy of these interventions.

This thesis by research aims to gain further insight into the effectiveness of suicide prevention intervention in Aotearoa/New Zealand by asking service users 'what works?' Throughout the North Island, twenty semi-structured interviews were conducted with individuals with lived experience of suicidal ideation and/or attempt. Using thematic analysis, the resulting data revealed a variety of interventions that participants found effective including art therapy, the diagnoses of auto-immune diseases, practising mindfulness, certain medications and spirituality. These interventions, among other effective services and treatments, are presented as themes of the data that were developed through the lens of the four dimensions of Durie's (1994) Te Whare Tapa Whā model of health, with an addition of tukutuku representing the overlapping psychosocial interventions. Participants' discussions of best practice are also explored in an attempt to inform practice to make it 'best' or at least better, practice.

With a constructionist epistemology, this research uses a qualitative descriptive methodology and aims to give service users 'a voice' by contributing to the existing field of suicide prevention research. The findings and subsequent discussion of the data promote the use of a strengths-based approach within social work. It is hoped that this study can influence future legislation and policy formation and ultimately, reduce the rates of suicide in Aotearoa/New Zealand.

¹ OECD: Organisation for Economic Co-operation and Development Countries.

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Glossary

Term	Meaning
Aotearoa	The Māori name for New Zealand, thought to translate as <i>land of the long white cloud</i> . Therefore, throughout this thesis, the term Aotearoa/New Zealand is used.
DHBs	District Health Boards are responsible for ensuring the provision of health and disability services to populations within a defined geographical area in Aotearoa/New Zealand.
Hapū	Kinship group, clan, subtribe - section of a large kinship group and the primary political unit in traditional Māori society.
Hauora	A Māori philosophy of overall health and wellbeing.
HDEC	Health and Disability Ethics Committee - a Ministerial Committee whose function is to secure the benefits of health and disability research by checking that it meets or exceeds established ethical standards.
Hui	A meeting, gathering or congregation.
Iwi	Extended kinship group, tribe, nation, people, nationality, race - often refers to a large group of people descended from a common ancestor and associated with a distinct territory.
Kaumātua	Chosen elders of either gender in a Māori community who have been involved with their whānau for a number of years. They are respected elders who have the capacity to teach and guide others.
Mihimihi	A greeting and introduction in Māori culture through which people describe their lineage and their background.
NGO	Non-Governmental Organisations that often operate not-for-profit, working independently of government, typically with a purpose to address a social or political issue.
Pōwhiri	A process whereby hosts welcome visitors. Often this is conducted within a marae (the courtyard of a Māori meeting house) but the pōwhiri process can also be used in other situations that involve welcoming visitors.

Term	Meaning
Service user	A person who uses health and/or social care services from service providers – may also be referred to as consumers.
Tagata	A (Samoan) word meaning people with the same ethnicity as oneself.
Tāngata Whenua	A Māori term that literally means ‘people of the land’; it is often used when referring to the original inhabitants of Aotearoa/New Zealand.
Te Ao Māori	The Māori World.
Te Whare Tapa Whā	Translates from Te Reo Māori as the house [with] four sides. However, Durie’s (1994) framework uses the whare (house) as a metaphor that represents the four dimensions of one’s overall health and wellbeing (hauora).
Tukutuku	These can be found inside traditional Māori whare (meeting houses) in the form of ornamental and interwoven panels or carvings that tell a story of the history of the iwi (tribe) or hapū (subtribe) who belong to a particular whare.
Whakapapa	Refers to a persons’ identity; reciting one’s whakapapa places them in a wider context and links them to lands, ancestors and tribes.
Whānau	Refers not only to the immediate family unit but the term also includes extended family, friends and community members.
Whare	A house, hut or habitation.

Chapter 1

Introduction

1.1 Setting the scene

Suicide is among the three leading causes of death in the world and the second leading cause of death among 15-29 year olds (World Health Organisation (WHO hereafter), 2018). In Aotearoa/New Zealand, suicide rates first peaked in 1998 when 577 people died by suicide and the country had the highest number of youth suicides among all OECD² countries (WHO, 1999). The number of deaths by suicide has since fluctuated each year; however, recent figures show a concerning increase that exceeds those of 1998; with 606 people dying from suicide in the year from June 2016 - May 2017 (WHO, 2017). Latest figures reveal another increase; the number of deaths by suicide is now at its highest since records began with 668 people dying in the twelve months between June 2017 and May 2018 (Chief Coroner's Office, 2018). Although the rate of deaths per 100,000 people has remained fairly consistent over the past ten years, this latest figure of 668 is the highest number to date in Aotearoa/New Zealand and is the highest number of deaths by suicide since the coroner's annual provisional suicide statistics were first recorded in 2007-08. These most recent figures indicate that suicide rates remain at a very concerning level, with an imperative for services and policy to respond accordingly.

In response to concern about the suicide rates that first peaked in 1998, the Ministry of Health has since researched, constructed and published several frameworks, reviews, strategies and action plans, including the New Zealand Suicide Prevention Strategy 2006-2016³ (Ministry of Health, 2006b) and the related Suicide Prevention Action Plan 2013-2016 (Ministry of Health, 2013). These documents aimed to refocus the attempts of the New Zealand Government to “mobilise renewed efforts to work together to prevent suicide and suicidal behaviour” (Ministry of Health, 2006b, p.6).

To succeed the 2006-2016 New Zealand Suicide Prevention Strategy, the (then National Party) Government commissioned a draft for public consultation in 2017 titled ‘A Strategy to Prevent Suicide in New Zealand: Draft for public consultation’ (Ministry of Health, 2017). However, possibly due to the change in Government, an updated strategy did not result from this consultation and the document remains in its draft form. The now Labour Party-led coalition

² OECD: Organisation for Economic Co-operation and Development Countries.

³ This document remains to be the Government's guiding policy for suicide prevention.

government still refers to the document as a draft and states that it has been absorbed into data being collated as part of a new inquiry into mental health and addiction (Ministry of Health, 2018a). In January 2018, the Government announced the Inquiry into Mental Health and Addiction as having the aim of improving mental health services with a particular focus on equity of access to quality services and better outcomes. The aim is for the inquiry to gather feedback from the mental health sector, service users and the wider community about their experiences, expectations and the current strengths and weaknesses of the mental health system. The inquiry will report back to the Government by the beginning of November 2018.

Before 2017, however, the Ministry of Health's Suicide Prevention Strategy (Ministry of Health, 2006b), which remains to be the current Government's suicide prevention policy, and the related Action Plan, were produced by and with health professionals, academic researchers, advisory groups (formed from charity employees with professional experience) and steering groups (consisting of family/whānau members affected by suicide). The (surviving) service users themselves do not feature in the qualitative efficacy reviews of the interventions. When service users *are* represented in the reviewing data they are shown as quantitative figures: for example, how many people have used the services and how many people have gone on to re-attempt suicide.

However, in an attempt to strengthen shared understandings between service users, family/whānau and all staff working directly or indirectly within mental healthcare provision, the Ministry of Health and Te Pou o te Whakaaro Nui⁴ (henceforth referred to as Te Pou) launched the *Let's get real* framework in 2008 (Te Pou, 2009b). This framework aimed to build a person-centred workforce focused on mental health recovery and it acknowledged the importance of service user involvement within the improvements to service quality. Relevant to this thesis is the *Let's get real* framework progress report published by Te Pou (2018) earlier this year. The progress report reflects recent developments within the health sector and includes updated information to ensure the framework can continue to support effective practice and service provision for people experiencing mental health problems and addiction (and their whānau). This new knowledge includes a focus on wellbeing, the acknowledgement of an evolving concept of recovery and an increasing emphasis on a strengths-based approach, among other examples.

The update to the *Let's get real* framework, which supports the direction of this research, indicates a need for more recovery-oriented approaches. However, the most recent suicide rates reveal a disturbing question: are these strategies, plans and efforts working? Certainly,

⁴ Te Pou is the Aotearoa/New Zealand centre of evidence-based workforce development.

this concern was echoed by the Chief Coroner in 2018, who, in light of the most recent suicide rates stated that: “It’s a tragedy to see the number of self-inflicted deaths increase again” (Chief Coroner’s Office, 2018, p.1). Service users could, this thesis argues, offer valuable and insightful information, which could influence future suicide prevention interventions and policy formation, in Aotearoa/New Zealand.

It is important to briefly discuss my use of the term ‘service user’ here. According to McLaughlin (2012), the term service user stems from both the consumerist tradition of the 1990s and the democratic tradition of developing participation to ensure the suitability of services. ‘Patient’, as an alternative term, has strong connections to a strictly medical-model (Brinkmann, 2018) and ‘client’ suggests the individual has paid for the service(s) they have received, which is not always the case when state-funded health and/or social care services are in question. Therefore, as described in the glossary, I have used the term service user to refer to a person who uses health and/or social care services from service providers (Mental Health Foundation, 2018b). The neutral, objective and global term can encompass any service (Pereira, 2013). This means that I myself am a service user when I visit a doctor, social worker or therapist of any description; the term has a far-reaching definition and is inclusive rather than homogeneous. The term service user is used regularly by organisations in Aotearoa/New Zealand including Te Pou, the Ministry of Health, The Human Rights Commission and the Mental Health Foundation; my use of the term is therefore current and consistent with the country’s legislative language. From discussions with a research reference group, and with the participants themselves, it was agreed that the terms service user and consumer were positive and appropriate to use and therefore the terms are used interchangeably throughout this thesis.

This research sought to find out what works according to the people who directly receive suicide prevention and intervention service provision, with an over-arching aim to contribute to the existing pool of knowledge in order to improve current treatments and services, influence those provisions in the future and reduce suicide rates in Aotearoa/New Zealand overall. The key research question, which this study aimed to answer, is:

What works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?

1.2 Professional perspectives and personal motivations

Since 2004, I have been employed within a variety of different support work roles. I began my career working in a priory centre⁵ in the United Kingdom and was then employed to create a community support service for young people with mental health challenges. Also, I have worked as an advocate and a support worker for people with mental health support needs. I have always found these roles to be extremely rewarding and positive. However, I often found that service users - the people who I supported - have not always experienced positivity regarding their own service provision. Early on in my career, I was surprised at the low level of involvement that many service users had when making choices regarding their own support, including making decisions around the recruitment of support workers, which community support service provider they would prefer access to, and what a service user involvement policy might look like for them. Also, I struggled to find examples of service users being involved in discussions of broader issues, outside of their own support, for example in reviews of service provision generally or in discussions of how better to support people with mental health support needs. In my opinion and experience, service users were the experts regarding what works/worked for them and their experiences and knowledge were a crucial source of information that was rarely heard within personal, local and/or national support provision discussions. Later on, I began to realise that service users' limited access to involvement and input into their service provision was often the norm. It should be noted, however, that this has largely improved in the past 45 years through the rights movement of disabled people (Charlton, 2000).

However, the people who access care and support services are still largely uninvolved within the legislation and policy formation that affects them. Personally, I believe that alongside the health professionals and staff members involved within care and support work, service users are also experts as they have first-hand knowledge and experience of care and support provision. This personal belief has led to the current research and its aims to gather and examine the opinions, knowledge and recommendations of service users who have accessed, or who are accessing, suicide prevention interventions and treatments in Aotearoa/New Zealand. The knowledge from these experts could be an invaluable influence on future legislation and policy formation regarding suicide prevention and intervention. It should be noted that I am not, and have not been, employed as a support worker by any of the participants or organisations involved in this research.

⁵ National well-being centres in the United Kingdom which offer support and therapy to people with mental health support needs including drug and alcohol misuse, eating disorders, depression and suicidal ideation.

1.3 Research aims and objectives

This research is placed within the context of policy design as it aims to contribute to the existing pool of knowledge relating to suicide prevention and intervention. Formed within a framework of constructionism, the research aims to give service users a voice. That is to say that the people who access the various interventions, treatments and services that are focussed on preventing suicide were asked for their opinions and recommendations regarding the personal effectiveness of such strategies, with a particular emphasis on *what works?* The valuable and insightful information provided by these experts could advise and influence future suicide prevention efforts in Aotearoa/New Zealand.

As mentioned previously, a draft version of the Strategy to Prevent Suicide in New Zealand (2017) was released for public consultation in April 2017 and consultation closed in July 2017. The Labour Party (in coalition with the Greens and the New Zealand First Party) succeeded as Government in September 2017, and in January 2018 the current Government announced a national inquiry into mental health and addiction (Prime Minister's Media Release, 2018). The policy analyst team responsible for the Strategy draft (2017) informed me (I. Ross, personal communication, August 31, 2018) that the draft is still to be referred to as 'the draft version of the Strategy to Prevent Suicide in New Zealand' and that the data obtained through the public consultation will be absorbed by the current and ongoing inquiry. The inquiry continues to seek out what works for people with lived experience regarding Aotearoa/New Zealand's current approach to mental health and addiction and what needs to change. Resulting data from the inquiry will be presented to the Government at the beginning of November 2018 and the process of writing the next strategy to prevent suicide will then begin; it is hoped that this doctoral research can contribute to that data. The inquiry aims to hear from "the voices of the community, people with lived experience of mental health and addiction problems and people affected by suicide" (Ministry of Health, 2018, p.3) regarding what is currently working well and what else can be done. Although this research was conceived prior to the announcement of the Government's inquiry, this synchronicity will hopefully be enhanced by the contribution of my thesis. For example, by including the first-hand knowledge and opinions of people with lived experience, I hope that this research will contribute information and recommendations to the Ministry of Health in order to increase the evidence base for the forthcoming Strategy to Prevent Suicide in Aotearoa/New Zealand.

Suicide is a multidimensional, complex and deeply personal phenomenon; consequently, this research used qualitative design methods to gather rich, empirical data. The fact that

relatively little is known about service users' experiences of suicide prevention interventions further validates this approach. Furthermore, the research design has also been influenced by my personal belief, borne out of my practice experience, that service users are 'experts by experience' whose voices must not only be heard, but should also be listened to and acted upon (Branfield & Beresford, 2006). As Beresford (2005) states, "including the knowledge and experience of service users is a crucial basis for practice and policy" (p. 16). The findings of this research could influence future policy, improve current interventions, influence future interventions and could help to reduce the rates of suicide deaths/attempts and/or better support people experiencing suicidal ideation.

1.4 Significance and originality

The improvement of suicide prevention and intervention service provision in Aotearoa/New Zealand is not a new area of study. The existing research, and subsequent resources, have largely been aimed towards service providers, organisations, community members and concerned family/whānau regarding how to make improvements. Examples include Suicide Prevention Information New Zealand's (SPINZ) (2005) Youth Suicide Prevention Community Information Kit as well as their 2010 document 'Responding to people at risk of suicide – how can you and your organisation help?' and the Ministry of Health (2015c) document titled 'Are you worried someone is thinking of suicide?' The recommendations in these documents are provided by health professionals, academic researchers and/or the family/whānau of deceased suicide victims. The views of service users who have accessed prevention interventions, services or treatments, and their opinions of those, do not feature. This study therefore, will contribute to the existing field of research and also aims to address the 'gap' by including service users' voices.

1.5 Theoretical framework

The qualitative research methods utilised were a reflection of my constructionist positioning. My intent for this study was to generate or inductively develop theories or patterns of meaning (Creswell, 2009) regarding the efficacy of suicide prevention interventions. A qualitative descriptive methodology guided this research as I believed that the experiences of participants were more crucial and revealing than a pre-established theory (Creswell, 2009). By conducting a qualitative descriptive study using a constructionist approach, this research aimed to explain, as well as describe, suicide prevention interventions as experienced by service users themselves.

1.6 Thesis structure

The current chapter has introduced the research by providing a background to the study, describing my personal connection to it and by outlining the aims of the research and its key research question. The significance and originality of this research were described and will be discussed in more detail in the following chapter. Chapter 1 also summarises the conceptual foundation of the thesis, leading the reader into a review of existing and significant literature in Chapter 2. This literature, both national and international, not only shaped the current research but also revealed a significant gap in the knowledge: ‘what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?’ This stark omission concerns invisibility of the service user voice.

This thesis explored the imperative that in order to find out what works for individuals in terms of suicide prevention interventions, service users of those interventions, treatments and services must be asked for their input. This research, therefore, explored human understanding and knowledge about what works through the epistemology of constructionism, as revealed through the service user voice. The philosophical perspective of constructionism is discussed in detail in Chapter 3, alongside the qualitative methods of enquiry used in this research, with a focus on a strengths-based approach to social work. Issues of transferability, usefulness and data validity which often form the basis of critiques of qualitative research are explored along with an acknowledgment of the study’s limitations. The ethical approval process through the Ministry of Health’s Health and Disability Ethics Committee (HDEC) shaped so much of this research and the journey to gain the Committee’s approval is described in detail in Chapter 3. Finally, this research uses thematic analysis and so an explanation of Braun and Clarke’s (2006) guiding six stage model leads the methodology chapter into Chapter 4.

In order to discuss the data analysis, the platform must first be set so as to guide the reader through the analysis process. This includes the use of thematic analysis that was aided by the data analysis software programme, NVIVO. The themes that resulted from this interpretation of the data were developed through the lens of the four dimensions of Mason Durie’s (1994) Te Whare Tapa Whā⁶ model of health: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Tinana (Physical Health & Wellbeing), Taha Whānau (Family & Social Wellbeing) and Taha Wairua (Spiritual Wellbeing). The appropriateness of using Te Whare Tapa Whā model, its relationship to the research and my own addition of tukutuku to Durie’s model

⁶ This translates as the house with four sides, but Durie’s framework uses the whare (house) as a metaphor that represents the four components of one’s overall health and wellbeing.

(representing overlapping psychosocial interventions/support systems) are described. Chapter 4 therefore lays the foundations of the house (te whare), prior to the data itself being presented in Chapter 5.

The research data is displayed in Chapter 5 through the use of Te Whare Tapa Whā (with the addition of tukutuku) as a framework for presentation. Twenty interviews were conducted with participants between December 2017 and April 2018 within the North Island of Aotearoa/New Zealand. Vignettes from the participants' interviews that relate to the themes, research question and literature are included in Chapter 5 and the narratives within them form the basis for the major findings of the research. Guided by a strengths-based approach, Chapter 5 explores the views of service users in regards to what works and then discusses how those interventions, treatments and services could be further promoted in order to better support people. Participants' knowledge and experience of best practice are included; what it is, how it should look and how else it could be made 'best', or at least better, practice.

The wealth of data gathered about what works for individuals regarding their experiences of treatments, services and other interventions, which they have accessed because of their suicidal attempt and/or ideation, are discussed in detail in Chapter 6. The socially constructed knowledge and unique perceptions of the twenty participants are discussed by grouping the themes into four interrelated areas, these being people, body, mind and spirit. Participants' thoughts and recommendations regarding best practice are explored and key messages from participants feature throughout the discussion.

The recommendations and implications that have resulted from this research are discussed prior to the study's conclusions in Chapter 7. This final chapter reminds the reader of the aims and objectives of the research and will summarise the findings before potential outputs of the research are suggested. The chapters of the thesis and their titles are presented below:

Figure 1.1

Thesis structure

Chapter	Title
1	Introduction
2	Putting the research into context: A review of the literature
3	Methodology
4	Developing the platform for the data analysis
5	Findings: Presenting te Whare
6	Peeling away the layers of an onion: A discussion of the findings
7	Conclusion

Chapter 2

Putting the research into context: A review of the literature

2.1 SECTION ONE: Introduction, aim and search statement

Introduction

Suicide is among the three leading causes of death in the world and the second leading cause of death among 15-29 year olds (World Health Organisation (WHO hereafter), 2018). In Aotearoa/New Zealand, suicide rates first peaked in 1998 when 577 people died by suicide and the country had the highest number of youth suicides among all OECD⁷ countries (WHO, 1999). The number of deaths by suicide has since fluctuated each year; however, recent figures show a concerning increase that exceeds those of 1998; with 606 people dying from suicide in the year from June 2016 - May 2017 (WHO, 2017). Latest figures reveal another increase; the number of deaths by suicide is now at its highest since records began with 668 people dying in the twelve months between June 2017 and May 2018 (Chief Coroner's Office, 2018). Although the rate of deaths per 100,000 people has remained fairly consistent over the past ten years, this latest figure of 668 is the highest number to date in Aotearoa/New Zealand and is the highest number of deaths by suicide since the coroner's annual provisional suicide statistics were first recorded in 2007-08.

⁷ OECD: Organisation for Economic Co-operation and Development Countries.

In response to the suicide rates that first peaked in 1998, the Ministry of Health has researched, constructed and published several frameworks, strategies and action plans, including:

- The National Youth Suicide Prevention Strategy (Ministry of Health, 1998)
- The Ministry of Health Training Toolkit (Ministry of Health, 2006a)
- The New Zealand Suicide Prevention Strategy 2006-2016⁸ (Ministry of Health, 2006b)
- Suicide Prevention Action Plan(s) (2008-2012 and 2013-2016) (Ministry of Health, 2008a; 2013)
- The 2013 Mental Health Annual Report (Ministry of Health, 2014b)
- The 2014 Māori Health Strategy ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation’ (Ministry of Health, final report published 2015a)
- Suicide Prevention Toolkit for District Health Boards in 2015 (Ministry of Health, 2015b).
- A Strategy to Prevent Suicide in New Zealand: Draft for public consultation (Ministry of Health, 2017).

These documents aim to refocus the attempts of the New Zealand Government on areas that need more attention. They intend to reduce suicidal behaviour throughout a person’s life by focusing efforts towards “integrating and coordinating services and support to prevent suicidal behaviour and help people in distress” (Ministry of Health, 2017, p.1). Also, in January 2018, the Government announced a ministerial inquiry with the aim of improving mental health services with a particular focus on equity of access to quality services and better outcomes. Prime Minister Jacinda Ardern stated that mental health services are stretched, with 170,000 people using mental health and addiction services – an increase of 71% since the previous decade (Prime Minister's Media Release, January, 2018). The Prime Minister’s aim is for the inquiry to gather feedback from the mental health sector, service users and the wider community about their experiences, expectations and the current strengths and weaknesses of the mental health system. The inquiry will report back to the Government by the beginning of November 2018.

⁸ Whilst the inquiry into mental health and addiction is ongoing, this 2006 document remains to be the guiding policy for Government on suicide prevention.

In an earlier attempt to strengthen shared understandings between service users, family/whānau and all staff working directly or indirectly within mental healthcare provision however, the Ministry of Health and Te Pou⁹ launched the *Let's get real* framework in 2008 (Te Pou, 2009b, updated version). This framework aimed to build a workforce that is person-centred and focused on mental health recovery and it acknowledged the importance of service user involvement within the improvements of the quality of services. As mentioned previously, Te Pou (2018) published the *Let's get real* framework progress report earlier this year. Reflecting recent developments within the health sector, the report includes updated information to ensure the framework can continue to support effective practice and service provision for people experiencing mental health problems and addiction (and their whānau). This new knowledge includes a focus on wellbeing, the acknowledgement of an evolving concept of recovery and an increasing emphasis on a strengths-based approach, among other examples.

However, the most recent suicide rates reveal some disturbing questions: are these strategies, plans and efforts working? Or do we need to ask new questions to another kind of expert? Certainly, these questions were echoed by the Chief Coroner in 2017, who, when publishing the 2016-2017 suicide rates stated that “While acknowledging that people are taking their own lives is important, it is only part of the conversation about suicide in the community” (Chief Coroner Press Release, 2017). This current research therefore, is placed within the context of policy design as it aims to contribute to the existing pool of knowledge relating to suicide prevention and aims to influence suicide prevention policy and legislation in Aotearoa/New Zealand.

Aim

The main objective of this literature review is to systematically identify and discuss the international and national research and literature relevant to suicide, suicide prevention, suicide prevention interventions, treatments and services and service user involvement in health and social care research; particularly suicide research. Relevant and seminal pieces are discussed and will shape the methodology of the current research.

⁹ Te Pou is the Aotearoa/New Zealand centre of evidence-based workforce development.

Search statement

The literature was searched using the following databases: Cochrane Library, Medline, PubMed, Jstor, PsychInfo, Web of Science, Index New Zealand and SSM Population Health. Additional sources searched included: major online library catalogues; World Health Organisation websites; website sources such as evidence-based and guidelines sites; international and national related health professional association and charity websites, and relevant grey literature; websites providing Aotearoa/New Zealand statistical data; and other Government websites such as Ministry of Health, Ministry of Youth Development and Ministry of Social Development. Other electronic and library catalogue sources searched included: The University of Auckland's in-house collection; Google Scholar and several internet websites that were searched to access organisations with a focus on mental health services and suicide prevention support. Searches were limited to English language material from 1980 to January 2018 inclusive, however, some earlier, seminal pieces have been included.

The following search terms were used: suicide, definitions of suicide, suicide worldwide, suicide in New Zealand, international suicide preventions interventions/treatments/services, New Zealand suicide prevention/interventions/treatments/services, research with vulnerable people, research with participants at risk of suicide, involving service users in research, service user led research, effectiveness of suicide prevention interventions/support/treatments/services/measures.

2.2 SECTION TWO: Suicide

Suicide and its definitions

The origin of the term 'suicide' stems from the Latin -sui, of oneself, and -caedere, to kill (Posner, Brodsky, Yershova, Buchanan & Mann, 2014) and dates back to the memoir 'Religio Medici' written by Sir Thomas Browne in 1642. Browne's memoir sparked debate regarding the morality of suicide. However, the focus later shifted when French sociologist Emile Durkheim conducted the first study of suicide. Durkheim (1897) argued that the act of suicide applies to every case of death that results directly or indirectly from an act, carried out by the victim, in the knowledge that death will be the result. However, Durkheim also believed that although suicide may appear to some to be a purely individual phenomenon, the causes are fundamentally social and are governed by society (Taylor, 1982).

Post-Durkheim, definitions of suicide have been developed but have remained largely similar: the Operational Criteria for the Determination of Suicide – as developed by the United States of America’s Centre for Disease Control (CDC) - defines suicide as “death arising from an act inflicted upon oneself” (Rosenberg et al., 1988, p.1445), and later, more specifically, as “death from injury, poisoning or suffocation where there is evidence (either explicit or implicit) that the injury was self-inflicted and the decedent intended to kill himself/herself” (O’Carroll et al., 1996, p.244).

The usefulness of suicide research, and the ability to interpret it, is often problematic when several, unclear definitions exist within such a large body of literature. Consistent definitions can lead to consistent data that allow researchers to study the phenomenon more effectively, to identify high-risk groups and to monitor the effects of prevention policies and programmes. With this in mind, De Leo, Burgis, Bertolote, Kerkhof and Bille-Brahe (2006, p.6) reproduced definitions of suicidal behaviours, originally from the CDC:

- Self-directed violence consists of behaviour that is self-directed and deliberately results in injury to oneself or the potential for injury.
- Non-suicidal self-directed violence refers to behaviour that is self-directed and deliberately results in injury or the potential for injury to oneself. There is no evidence of suicidal intent.
- Suicide attempt refers to a non-fatal self-directed potentially injurious behaviour with intent to die as a result of the behaviour. A suicide attempt may or may not result in injury.
- Interrupted self-directed violence occurs when a person is stopped from carrying out intentional injury, either by themselves or someone else.
- Suicide refers to death caused by self-directed injurious behaviour with any intent to die as a result of that behaviour. Importantly, intent can either be stated explicitly by the individual (in a suicide note or communication report to someone) or inferred. If an individual does not leave a suicide note, intent can be determined by talking to family or friends or by taking into account circumstantial evidence of a self-inflicted fatal act, inferred from the method or circumstance. If the only reasonable intent for the lethal act was suicide (such as jumping from a high building or shooting oneself in the head), then intent can be inferred.
- Other suicidal behaviour including preparatory acts: acts or preparation towards making a suicide attempt but before potential harm has begun e.g. buying a gun etc.

These different definitions, developed since Durkheim's time, have been essential within suicide research. Clear and consistent definitions can lend themselves to comparisons between different research and further in-depth analysis of research that uses the same definitions. Despite a large volume of research however, some researchers argue that the official acknowledgement of the complexity of suicide has only occurred in recent years (Shahtahmasebi & Merrick, 2014).

Suicide worldwide

According to McKenna, Keeney, Cutcliffe and Stevenson (2014), almost one million people die by suicide every year. This translates to a 'global' mortality rate of 16 per 100,000 people or, one death every forty seconds. With the year 2004 as an example, the number of people who died by suicide was approximately 844,000 (WHO, 2008 cited in Moscicki, 2014).

Following an increase of 65% since 1965, suicide is estimated to account for approximately 1.5% of all deaths worldwide (Pool, 2009). In fact, trend data show that suicide is now among the three leading causes of death among people aged 15-44 years in several countries and is the second leading cause of death in people aged 15-29 years (WHO, 2018). Moscicki (2014) describes suicide as a 'significant disease burden' which, according to the World Health Organisation (2009), represents 1.3% of the total burden of all diseases worldwide.

Pre-1950, suicide was more common in people over forty-five years of age. However, in the latter-half of the 20th century, suicide was more common in people aged from fifteen to forty-five. McKenna et al. (2014), state that this shift was underpinned by the widespread increase in suicide among young men in industrialised nations. For example, the rise in suicide in young men in Ireland, which is amongst the highest in the European Union, meant that the Republic of Ireland experienced one of the fastest rising suicide rates in the world from the early 1980s – 2012, and perhaps beyond, with 53 males aged 15-24 dying by suicide in 2010, compared with 32 in 2001 (McKenna et al., 2014).

Suicide in Aotearoa/New Zealand

A peak in Aotearoa/New Zealand's suicide rates during the 1990s came in 1998 when 577 people died by suicide in Aotearoa/New Zealand; this equates to 15.1 per 100,000 population (WHO, 1999). Since 1998 this figure has fluctuated and the coroner's annual provisional suicide statistics have been published each year since 2007/08 (see figure 2.1). The last four years have seen a steady incline in the number of deaths by suicide, exceeding the 1998 figure, as shown in the figure below. Although the rate of death per 100,000 people has

remained fairly consistent over the past ten years, the latest figure of 668 is not only the highest number to date in Aotearoa/New Zealand but is also the highest number of deaths by suicide since the coroner's annual provisional suicide statistics were first recorded.

Figure 2.1

Deaths by suicide per year in Aotearoa/New Zealand

Year (mid-year to mid-year)	Number of deaths by suicide
2007/2008	540
2008/2009	531
2009/2010	541
2010/2011	558
2011/2012	547
2012/2013	541
2013/2014	529
2014/2015	564
2015/2016	579
2016/2017	606
2017/2018	668

Source: (Chief Coroner’s Office, 2018)

The latest figure from 2017/2018 equates to a rate of 13.67 deaths per 100,000 population. The numbers of deaths by suicide over the last four years are particularly concerning after previously declining since 2011. Subsequently, the increasing rates have received attention from national (Flahive, 2018; Newshub, 2018) and international media (BBC News, 2017) with several reports referring to the situation as an ‘epidemic’.

Suicide deaths by age

Children as young as 10 years old have died by suicide; with eight children aged between 10 and 14 years taking their own lives during 2017/18 (Coronial Services of New Zealand, 2018). During the 1998 peak in suicide rates, Aotearoa/New Zealand had the highest number

of youth suicides (15-24 years old) among OECD countries, with young people representing 25.3% of total suicides in the country (WHO, 1999). This figure of youth suicide equated to 51.9 per 100,000 population in 1998, compared with 29.2 per 100,000 population in Australia and 13.4 per 100,000 population in the United Kingdom during the same year (WHO, 1999). Suicide was the second leading cause of death in the 15-24 age group in Aotearoa/New Zealand in 1998, after motor vehicle crashes (WHO, 1999).

Youth suicide rates remained high in Aotearoa/New Zealand, accounting for 21.6% of all suicides in 2010, and then 26% of all suicides in 2011 (Ministry of Health, 2012). For many young people, the fatal suicide was not their first attempt. According to the Ministry of Health (2008c), in 2006, 47% of fatal youth suicides were carried out by people who had already attempted suicide at least once previously. The latest data shows that youth suicide accounted for 19.45% of all suicides in 2017/18 (Coronial Services of New Zealand, 2018). The most recent statistics show that, in 2017/18, 20-24 years was the cohort with the highest number of suicides, with 76 deaths, followed by 67 deaths from within the 45-49 age cohort (Coronial Services of New Zealand, 2018).

Suicide deaths by gender

Suicide is more common amongst men than women. For example, in 2011 there were 369 male suicides (16.6 deaths per 100,00 male population) and although this figure was 30.5% below the (then) peak rate of 1998, the ratio of male to female suicide rates remained significant at 3.1 to 1 (Ministry of Health, 2014d). More recently, 2017/18 had the highest number of male suicides since 2007, with 475 males dying by suicide at a rate of 19.73 per 100,000 male population, increased from 457 male deaths the previous year at a rate of 19.36 per 100,000 male population. Male suicides in the latest data make up 71.10% of the total suicides for 2017/18 (Coronial Services of New Zealand, 2018).

The Ministry of Health (2014d) reported that in 2011, there were 109 female suicides in Aotearoa/New Zealand (4.7 deaths per 100,000 female population). The Ministry also states that the rate of female suicide has remained relatively stable since 1948, when records began. However, figures from 2017/18 show an increase in the number of female suicides (193) when compared to the previous year (149 in 2016/17). This means that in 2017/18 the number of men who died by suicide was almost two and half times higher than that of women in the same year.

Suicide deaths by ethnicity

Māori men and women are, and continue to be, disproportionately represented in suicide statistics. During the previous peak rates of 1998, 87 Māori men and 25 Māori women died by suicide, with a rate of 32.5 per 100,000 population and 8.3 per 100,000 population, respectively. In the same year, 358 non-Māori men (21.8 per 100,000 population) and 107 non-Māori women (6.2 per 100,000 population) died by suicide. In 2011 however, the total Māori suicide rate was 16.8 per 100,000 population; 1.8 times higher than the non-Māori rate (9.1 per 100,000 population) (Ministry of Health, 2014d). The trend of Māori men dominating the Māori suicide figures continued, and in 2012, 83 Māori men (25.6 per 100,000 population) died by suicide compared with 37 Māori women (10.5 per 100,000 population). Three hundred and twenty-one non-Māori men (16.3 per 100,000 population) and 108 non-Māori women (5.2 per 100,000 population) died by suicide in the same year (2012). In 2011, the rate of Māori youth suicide (36.4 per 100,000 population) was 2.4 times higher than the equivalent rate for non-Māori youth (15.1 per 100,000 population).

According to the Ministry of Health (2014d), there were 24 suicide deaths among Pacific people and 28 suicide deaths among Asian people in 2011. Rates for Pacific and Asian people were not calculated because “the small number of suicides means rates are variable and may be misleading” (p.12). However, almost half of the Pasifika population in Aotearoa/New Zealand is under twenty years old and this young population is rapidly increasing. Young Pasifika are more likely to experience mental health disorders than older people in the same population but, rates of accessing mental health services are extremely low amongst young Pasifika: 25% compared with 58% of New Zealanders overall (Ministry of Health, 2008b).

More recently, 142 of the 668 people who died by suicide in 2017/18 were Māori at a rate of 23.72 per 100,000 population (Coronial Services of New Zealand, 2018). So what is the cause of this disproportionate representation? Collings and Beautrais (2005) suggest that there may be a different pattern of vulnerabilities faced by Māori: 1) additional factors, which may have an influence e.g. ethnic bias in daily living, and/or: 2) the risk factors (such as material deprivation), which are not unique to Māori, but may in fact have a different pattern of impact on Māori, compared with non-Māori. Certainly, research by Ajwani, Blakely, Robson, Tobias and Bonne (2003) revealed a similar ethnic pattern with other causes of death in Aotearoa/New Zealand. For example, the authors stated that cancer, diabetes and chronic lung disease mortality affect more Māori than non-Māori. This is not to

say that the Māori population are genetically more likely to suffer from these diseases but that socioeconomic inequalities (such as limited access to healthcare and disparities in the quality of healthcare provision) place Māori at a higher risk of these diseases, meaning that they are over-represented in mortality statistics relating to certain diseases (Robson & Harris, 2007; Simpson et al., 2017).

However, Collings and Beautrais (2005) warn against looking for explanations for suicide when referring to a general ‘cultural’ risk for Māori: “potential protective factors may be overlooked” and, “implicit in the model of cultural risk as most commonly applied at present is the assumption of cultural homogeneity among Māori, whereas Māori are a diverse group” (p.9). Collings and Beautrais (2005), state that, after all, culture refers to age, gender, ethnicity and upbringing.

The consequences of suicide

Aside from the obvious loss of life for the suicidal individual, there are many other consequences that result from suicide. Each death represents a tragedy for families, whānau and significant others involved in the person’s life. Beautrais (2004) claimed that approximately six individuals can be affected by each suicide death, which equates to 65,000 individuals in the twenty years from 1984-2004, “with an additional 3,000 people newly bereaved each year” (Beautrais, 2004, p.3). However, this commonly cited figure of six individuals has been criticised as a “gross underestimate” (Agee, 2010, p.489) with others suggesting that anywhere between 6 and 600 people may be affected after a suicide depending on how survivor-hood is defined (Jordan & McMenemy, 2004). This means that many thousands of people who are bereaved by suicide may require medical and/or psychosocial treatment themselves that may also result in a loss of earnings to themselves and to society.

The psychological ‘costs’ of bereavement can include risks of mental disorder, personal adjustment and potential suicidal behaviour among close family members; these risks can last from six months to eighteen months, with some individuals experiencing these affects for many years after the death (Beautrais, 2004). In 2013, the World Health Organisation’s Mental Health Action Plan described how deaths from suicide, and suicide attempts, result in:

...a significant social and economic burden for communities due to the utilisation of health services to treat the injury, the psychological and social impact of the behaviour on

the individual and his/her associates and, occasionally, the long-term disability due to the injury. (WHO, 2013, p.25)

Direct financial costs associated with suicide include costs of autopsies and investigations, expenses associated with emergency intervention and medical treatment, hospital and inpatient physician costs, coroners and funeral costs. Indirect financial costs include: (for premature mortality and years of potential life lost for suicide fatalities) lost earnings and productivity due to suicide attempt-related disabilities and lost productivity of loved ones grieving a suicide death (Moscicki, 2014). In 2005, The Ministry of Health published a document that detailed the costs of suicide to society. The document explains that the 460 deaths from suicide, which occurred in 2004, resulted in a total cost of \$206.2 million. The majority of this figure is made up of lost production, which equates to \$201.5 million, whilst the remaining \$4.7 million includes costs such as victim support, police and coroners (O’Dea & Tucker, 2005). According to the World Health Organisation (2001), the consequences of suicide are particularly negative for low-income countries where suicide is among the highest causes of death in individuals aged 15-44 years. This disproportionately affects young people and adults “in their most productive years of life” (p.38).

2.3 SECTION THREE: International suicide prevention efforts

The history of international suicide prevention

Individual efforts to prevent suicide, which were often inspired by philanthropic, humanitarian or religious principles, were first documented as early as 1906 in both London (Suicide Prevention Department of the Salvation Army) and in New York (National Save-a-Life League) (Miller & Gould, 2013). The emergence of international prevention programmes for suicidal behaviour in the public health arena can be traced back to a seminal document titled: Prevention of Suicide: Guidelines for the Formulation and Implementation of National Strategies. These guidelines were jointly produced by the World Health Organisation (WHO) and the Economic and Social Council (ECOSOC) of the United Nations in 1996 (Bertolote, 2014). According to Bertolote (2014), the guidelines served as the basis for the development of national strategies for the prevention of suicidal behaviour in several countries including Norway, Sweden, Australia, the United Kingdom, Finland, Estonia, France, the United States of America, Brazil and Aotearoa/New Zealand.

The publication of this document was the first time that international organisations acknowledged that suicidal behaviours were indeed major economic and social problems.

The guidelines did not stem from extensive research or evidence-based recommendations but they did state that further research would be required (United Nations, 1996). Two years later, the WHO released its Suicide Prevention Programme (SUPRE), which it stated, was based on expert opinion and best practices from members of the WHO International Panel of Experts on Suicide Prevention (Bertolote, 2014). Based on the limited research data available at the time, three strategies were considered to be effective for preventing suicidal behaviours: 1) treatment of mental disorders; 2) restriction of access to methods used in suicidal behaviours (guns, poisons etc.) and 3) responsible media reporting (WHO, 1998).

Recent international suicide prevention legislation

In 2013, the sixty-sixth World Health Assembly implemented the first ever Mental Health Action Plan (2013-2020) of the World Health Organisation. Suicide prevention is an integral part of this plan that has the goal of reducing suicide in countries by 10% by 2020. The report accepted that suicide is too often a low priority for Governments and policy-makers, despite the evidence that many deaths are preventable. The aim of the Action Plan was to “prioritise suicide prevention on the global public health and public policy agendas and to raise awareness of suicide as a public health issue” (p.7). Interestingly, this report was developed through a consultative process, based on systematic reviews of data and evidence and includes input from professional stakeholders and suicide prevention experts. However, service users (those individuals who have indicated suicidal ideation and/or who have made suicide attempts and who have presented themselves to healthcare providers) were not sought for consultation or input.

The 2013 WHO Action Plan argues that “many suicides happen impulsively and, in such circumstances, easy access to a means of suicide – such as pesticides or firearms – can make the difference as to whether a person lives or dies” (p.7). Subsequently, the WHO recommends that a key element of worldwide suicide prevention efforts must include the restriction of access to the means of suicide such as “limiting access to pesticides and firearms or putting barriers on bridges” (p.7). However, it should be noted that Aotearoa/New Zealand has relatively limited access to firearms when compared to other countries. In fact, the estimated rate of private firearms ownership (both licit and illicit) in Aotearoa/New Zealand is 22.6 firearms per 100 people compared with the United States of America for example, where the estimated rate is 101.5 firearms per 100 people (gunpolicy.org, 2017). In Aotearoa/New Zealand, the method of hanging, strangulation and suffocation has been the most common method of suicide from 2007-2018 (Chief Coroner’s

Office, 2018). Other areas of strategic action proposed by the WHO include engaging the media, conducting evaluation research and engaging key stakeholders, including health professionals, professional researchers and academics.

Mental health and suicide

Public mental health experts consider suicide to be a behavioural process that begins with vague considerations about death and dying (suicidal ideation), which may become fixed (persistent or fluctuating), may evolve into the elaboration of a plan (suicide plan) and may end in a suicidal act (Bertolote, 2014). A model of prevention, which became widely accepted in the United States of America, was developed by Leavell and Clark in 1965 as part of their Community Health Program (Leavell & Clark, 1965). The authors took recommendations from treatments that had been used to address infectious diseases and applied them to chronic degenerative disease and mental illness. Although it may not have been the intention of the authors, this model of prevention became extremely influential within the field of suicide research and promoted the link between suicide and mental health (WHO, 1993).

Leavell and Clark's (1965) model consisted of three levels of prevention: primary, secondary and tertiary. Primary prevention refers to general health promotion and specific protection against specific diseases; secondary protection consists of the early detection and intervention (treatment) in order to deter or reverse the condition and finally, tertiary prevention encompasses the measures taken to restore an individual to their optimum functioning level once the disability or disease has been stabilised, or to avoid premature death (Leavell and Clark, 1965). A criticism of this model, however, is that it is too general to apply to suicide prevention, as suicide is a particularly broad and comprehensive matter. As Shahtahmasebi and Merrick (2014) explain, adopting a single model to prevent suicide limits our ability to understand the factors that lead to an individual's decision to die.

Suicidology research

It was Edwin Shneidman who first coined the term 'suicidology' in the 1950s, when his research compared notes made by suicidal individuals and non-suicidal individuals (Shneidman, 1991). In 1958, Shneidman and colleagues founded and created the first suicide prevention centre in Los Angeles, in the United States of America. Much of Shneidman's work has shaped suicidology and suicide prevention research today, including the use of: new theoretical frameworks; empirical suicide-related research; and recommendations and

guidelines for researchers to use when working with suicidal individuals (Shneidman, 1952; 1984; 1993).

Modern suicidologists, however, describe suicide using a stress-vulnerability model; as a multifaceted interaction between traumatic life experiences, sociocultural factors, psychiatric history, genetic vulnerability and personality traits (Mann, Waterneaux, Haas, & Malone, 1999; Wasserman, Sokolowski, Wasserman, & Rujescu, 2009). Combined, all of these factors can be seen as risk or as protective factors, depending on the circumstances.

Duberstein and Heisel (2014) suggest a person-centred approach to prevention, “one that focuses less on biomedical concepts such as ‘disease’ and more on decision-making concepts related to personologic and motivational processes, such as risk detection, treatment-seeking and treatment adherence” (p.113). The authors argue that a person-centred approach to prevention could work better than the usual approaches, for example, primary prevention, which is guided by a behavioural versus biomedical model of health, and includes decisions about smoking, alcohol, drug use and healthy diet; or secondary prevention, which is guided by a biomedical vs behavioural model of health, and includes clinical treatments for clinical conditions and diseases linked to suicide risk, e.g. major depression.

Critique of suicide prevention approaches

According to Duberstein and Heisel (2014), standard prevention approaches have not yet been implemented in a sensitive manner, that is, sensitive to self-determination, particularly the need for autonomy. For example, primary prevention initiatives, with negative cost-benefit ratios, have been implemented without acknowledging those options, which are just as effective, yet less restrictive of autonomies. Similarly, secondary prevention tools, including prescriptive manual-based treatments and screening instruments, “present challenges to the autonomy of the provider-patient relationship” (p.122). Duberstein and Heisel (2014) claim that health care providers desire freedom to use professional judgement and provide personalised solutions to their patients’ problems with little interference from third parties. When providers sense a challenge to their autonomy, service users are likely to suffer according to Duberstein and Heisel (2014).

Related to this is the way in which critical social work approaches challenge those personalised solutions and the ways in which health care providers (and their approaches) overlook systemic factors and social and political discourses. For example, prescribing antidepressant medication to an individual who is experiencing suicidal ideation may be effective in the short term but it does not address other areas of support-need in their life

which may be adding to their feeling of depression and their suicidal ideation. These areas can include housing, employment, education, family support, financial stresses and/or poor physical health, for example. Critical social work approaches explore this further by examining ways in which wider social structures and systems shape individual experiences. Gray (2018) highlights the links between the strengths-based perspective (which this research advocates for) and contemporary neoliberalism, and she suggests the need to go ‘back to basics’ to achieve some distance from the harsher aspects of welfare reform policy that affect most areas of social work practice. Gray (2018) states that a strengths-based approach to social work glosses over the structural inequalities that hinder personal and social development and she suggests that more than a focus on individual and community capacity is needed to deliver the transformatory agenda that a strengths-based model promises (Gray, 2018).

Therefore, this critique can also be seen as a limitation of this research as the focus of the thesis is on individual experiences and the interpretation of these was mainly carried out at the individual level (although with participant input and guidance from research reference group members). The structural and systemic factors which affect service users’ lives therefore may *feature* in participants’ stories but the effects of these discourses are not examined in great detail. As a critique of this research, examining such discourses in relation to suicide prevention in further detail would have provided a powerful critique of existing suicide prevention approaches.

Targeted interventions worldwide

As Collings and Beautrais (2005) argue, the need remains for more targeted interventions. An example of a successful, direct intervention comes from Montreal, Canada, where a comprehensive police suicide prevention programme consisted of training on suicide for all the officers in the police force. The training focussed on risk identification and how to help fellow police staff. Mishara and Martin (2011) evaluated the programme and found that it had “led to a significant decrease of 79% in suicide rates among police in Montreal” (p.39).

Worldwide, more men die by suicide than women (WHO, 2014). Research by Morrell, Payne and Taylor (2007) examined whether interventions targeted at males could be effective in reducing male suicides. The authors traced a reduction in suicide by young men in Australia back to a specific programme implemented by the National Youth Suicide Prevention Strategy (NYSPS) (1995-1999) that targeted young males living in remote rural

communities. This strategy made sure that health and social care providers were resourced to deliver a wide range of local and national interventions.

A systematic review of suicide prevention interventions targeting indigenous peoples in Australia, New Zealand, Canada and the United States of America was conducted by Clifford, Doran and Tsey (2013). The review aimed to examine the methodological quality of evaluations of suicide prevention interventions directed at indigenous populations, particularly because suicide rates in these four countries are disproportionately high. Indigenous people in each of the four countries face an increased risk of suicide compared with non-indigenous peoples. According to Clifford, Doran and Tsey (2013), there are several different reasons for this: firstly, factors embedded in their history including racism, social exclusion and loss of land and culture; and secondly, risk factors for suicide including mental health disorders, substance abuse and stressful life events all occur at disproportionately high rates in indigenous populations, putting them at significantly higher risk of suicide.

Clifford, Doran and Tsey (2013) reported that the main intervention strategies employed in the four countries included community prevention initiatives, gate-keeper training and education programmes. Although the authors were positive about the intentions of these programmes, they stressed that the efficacy of these programmes was questionable, particularly as suicide rates among the indigenous peoples of each of the four countries continued to be higher than the general population. However, from the data, two different community prevention interventions (both provided in the United States of America; one in New Mexico and one in rural Alaska) reported reductions in rates of suicide or suicidal behaviours (life-threatening self-inflicted injury). Regarding worldwide suicide prevention programmes aimed at indigenous peoples, it is clear that more needs to be done. More evidence based suicide research is needed as, without this evidence, there is “an increased likelihood that ineffective interventions will be implemented to prevent suicide in indigenous peoples...reducing the likelihood of achieving significant reductions in rates of suicide in these [indigenous] populations” (Clifford, Doran & Tsey, 2013, p.10).

International influences

Worldwide suicide prevention efforts and international research can help to influence future suicide prevention in other countries. For example, crisis helplines are public call centres that people can telephone when professional care or the support of their friends or family is not preferred or available. The call centre operatives have received comprehensive training in

being a ‘listener’ to people who may be experiencing suicidal ideation or who are experiencing an urge to take their own life. In 2007, the United States of America’s Department of Veterans Affairs implemented a national, free telephone helpline: the Veterans Crisis Line for United States Military Veterans. Research carried by Gould, Kalafat, Harrismunfakh and Kleinman, (2007) reported the crisis helpline to be effective in reducing suicide risk in subsequent weeks following the initial call. At the beginning of the telephone call, the operative would carry out a baseline assessment; during the call they conducted a suicide risk-assessment with callers who stated that they were thinking of taking their own lives. At the end of the telephone call, the operative then conducted another assessment, similar to the first, asking the caller particular questions to ascertain whether they felt differently or similar to when they had first telephoned. Then, callers were asked if they would be willing to receive a follow-up call in 2 or 3 weeks; 35% of the initial callers participated in the follow-up calls. These follow-up calls were then carried out by research interviewers who reported that participants had described significant reductions in suicidal feelings and intent to die, hopelessness and psychological pain since their first, initial call to the helpline. In 2009, the crisis line service was extended in order to be accessible to the rest of the military community.

This research influenced the *Summary of Research and Evaluation of Crisis Helplines* document, produced by the (Australian) Lifeline Research Foundation in 2013. The United States of America’s veteran crisis line had “provided genuine grounds for promise by demonstrating evidence of service benefit, while also highlighting the need for significant service improvement and development” (Lifeline, 2013, p.4). Similarly, Gould et al.’s (2007) work influenced Belgian researchers and this led to a study of telephone and chat helplines in Belgium. Pil, Pauwels, Muijzers and Annemans (2013) reported that the popularity of helplines in Belgium should be developed further and improved in order to address suicide prevention more specifically, and that this was a very cost-effective way to address it.

Summary

Suicide prevention approaches have evolved as countries and communities have changed their beliefs and attitudes regarding suicide. Stigma against seeking help for suicidal ideation has decreased in many countries and in many contexts. According to the WHO (2014), the challenge now for policy-makers and other stakeholders is to “embrace the increase in public dialogue about suicide and take advantage of the environment to implement a response” (p.66).

Since the seminal guidelines document, produced by the WHO and the ECOSOC of the United Nations, in 1996, many countries have: developed policy areas, objectives and formulations of national strategies; implemented reviews and appraisals of national guidelines; and collected, published and disseminated evidence-based research that aims to contribute to suicide prevention. Certainly, there now exists an extensive amount of literature regarding worldwide suicide prevention. Nationally, this can be extremely valuable to us, and lessons can be learnt from international research. Positive changes around the world can also help to support countries to feel united in suicide prevention awareness and efforts. For example, in 2003, the first World Suicide Prevention Day was celebrated, and has been held on the 10th of September every year since then (IASP, 2016).

2.4 SECTION FOUR: Aotearoa/New Zealand suicide prevention

Government policies and legislation

In response to the peak suicide rates in 1998, the New Zealand Government released a National Youth Suicide Prevention Strategy (Ministry of Health, 1998) that aimed to provide a “framework for understanding suicide prevention” and that signalled the steps that “a range of government agencies, communities, services, hapū and iwi must take to reduce suicides in the 15-24 year old age group” (p.6). Since 1998, the Strategy has grown and been developed; the focus shifted from youth-only and it influenced a Suicide Prevention Toolkit for District Health Boards (DHBs) in 2001. By 2004, both the 1998 Strategy and the 2001 Toolkit helped to influence an all-ages brief that informed the New Zealand Suicide Prevention Strategy (2006-2016)¹⁰ as well as a set of guidelines to manage risk (Ministry of Health (2006a).

The Ministry of Health later released Suicide Prevention Action Plans (2008-2012 and 2013-2016). The 2008-2012 Action Plan was supported by two Progress Reports in 2009 and 2011. The following documents were published in relation to the 2013-2016 Suicide Prevention Action Plan: the 2013 Mental Health Annual Report (Ministry of Health, 2014b); the 2014 Māori Health Strategy ‘Kia Piki Te Ora Suicide Prevention Programme Evaluation’ (final report published 2015a) and the second Suicide Prevention Toolkit for DHBs in 2015 (Ministry of Health, 2015b). Co-ordinated by the Ministry of Health, eight Government agencies are responsible for implementing the actions listed in the 2013-2016 Suicide Prevention Action Plan; these are: The Ministries of Health; Education; Justice; Social

¹⁰ This document remains to be the Government’s guiding policy for suicide prevention.

Development; Youth Development; Child, Youth and Family; the Department for Corrections and finally, the New Zealand Police. Implementation agencies regularly meet through the Inter-Agency Committee on Suicide Prevention to “co-ordinate and support implementation of suicide prevention activities” (Ministry of Health, 2006b, p.3) and a Ministerial Committee on suicide prevention receives six-monthly updates regarding the progress of the Action Plan (Ministry of Health, 2006b).

The Suicide Prevention Strategy (2006-2016), and the supporting Suicide Prevention Action Plan (2013-2016), provided a framework for understanding how various activities within a range of sectors fit together to prevent suicide. The aim of these documents was to “reduce the rate of suicidal behaviour and its effects on the lives of New Zealanders” (Associate Minister of Health, 2006, cited in SPINZ, 2010, p. 16). The seven goals of the current Strategy are to:

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

(Ministry of Health, 2006b, p.2)

The New Zealand Suicide Prevention Action Plan (2013-2016) supports the goals of the Suicide Prevention Strategy with its aims to:

1. Support families, whānau, hapū, iwi and communities to prevent suicide, and reduce the impact of suicide.
2. Improve the range, coverage and targeting of suicide prevention services.
3. Lift the quality of information and evidence for effective suicide prevention.

(Ministry of Health, 2013, p.3)

For many people, the fatal suicide was not their first attempt. For example, in 2001, Beautrais studied 302 individual ‘suicide-attempters’ and found that 24% had made previous attempts. This means that there are many people, still alive, who have attempted suicide and/or who have experienced (or still do experience) suicidal ideation. Individuals who seek help from services as a result of their suicidal ideation could provide some of the most valuable and influential data. Their opinions and experiences of accessing suicide prevention intervention services in Aotearoa/New Zealand can provide first-hand knowledge of those services. And this rich data could be vital to the Ministry of Health when reviewing current suicide prevention intervention treatments and by informing the various policies, legislation and research aimed at addressing suicide prevention (particularly the current inquiry into mental health and addiction).

Goal number 7 of the current Suicide Prevention Strategy (2006-2016) aims to expand the evidence about effective interventions (as well as rates and causes). Individuals who currently use these intervention services or treatments (or who have recently used them) are surely one of the most important sources of information regarding the efficacy of those interventions. To expand the evidence within this area then, the Ministry of Health (as well as other service providers and other service users) would, it is hoped, find the recommendations, knowledge and opinions of service users who have experienced those interventions to be valuable.

Summary

Each of the policies and pieces of legislation discussed in this chapter have been informed, researched and written by health professionals, academic researchers, the Ministry of Health, professional researchers and sometimes with input from bereaved families/whānau and significant others. With regards to the 2006-2016 Strategy (Ministry of Health, 2006b) for example, the Associate Minister of Health at the time described how the document “brings together the work of researchers, academics, community organisations, providers of health and social services and multiple Government agencies” (p.2). He also describes how, “as a Government, we owe it to New Zealanders to address this matter with determination and commitment” (p.2).

However, the many pieces of legislation listed in this chapter, which predate 2017, including the current Strategy (2006-2016), do not include the opinions and knowledge of service *users* - the people who use/have used those suicide prevention intervention services described in the documents. The service users are represented only by quantitative data - those lives lost

to suicide. Obviously, it is not possible to talk to a person who has died by suicide; this presents a major problem in suicide research as the subject is not able to comment. However, this doctoral research suggests an alternative: to talk to people who have experienced suicidal ideation and/or attempt and whose experiences can shed light on which interventions, treatments or services have worked well for them in their recovery and as part of their ongoing wellness.

2.5 SECTION FIVE: Suicide prevention services, interventions and treatments in Aotearoa/New Zealand

Introduction

Suicide is a complex and deeply personal matter. There is no one single intervention or treatment that is completely effective in preventing a death by suicide or decreasing suicidal ideation. Given the multiple factors involved in suicide and suicidal ideation, and the many pathways which may lead to suicidal behaviour, suicide prevention efforts too must be broad in their scope. These efforts require a “multisectoral approach that addresses the various population and risk groups and contexts throughout the life course” (WHO, 2014, p.30). The WHO (2014) distinguishes between universal, selective and indicated interventions:

1. Universal prevention strategies are designed to reach an entire population in an effort to maximise health and minimise suicide risk by removing barriers to care and increasing access to help, strengthening protective systems such as social support and modifying the physical environment.
2. Selective prevention strategies focus on vulnerable groups within a population based on characteristics such as sex, age, occupational status or family history. Individuals, who may not currently express suicidal behaviours, may be at a heightened risk of psychological, behavioural or socioeconomic risk.
3. Indicated prevention strategies focus on specific vulnerable individuals within the population e.g. “those displaying early signs of suicide potential or who have made a suicide attempt”.

(WHO, 2014, p. 30)

Since the peak in suicide rates in 1998, universal, selective and indicated interventions in Aotearoa/New Zealand have grown dramatically with an array of services, treatments,

interventions and support systems now available. For example, psychological treatments include counselling and other ‘talking therapies’ whereas pharmacologic interventions consist of antipsychotic, anti-anxiety and anti-depressant medications. Some specific services in Aotearoa/New Zealand are targeted at Māori and Pasifika populations whilst other psychosocial interventions may include education in schools, support groups and family/cultural support systems. The range of suicide prevention treatments and interventions will be discussed in further detail in this chapter.

There are a number of examples of national campaigns and initiatives that aim to contribute to suicide prevention. The National Depression Initiative for example, is a website that provides resources and information online regarding depression and anxiety. The website also promotes media campaigns regarding depression including television adverts of celebrities sharing their personal experiences. Like Minds, Like Mine is a national campaign that aims to reduce stigma and discrimination faced by people with experience of mental illness. SPINZ (Suicide Prevention Information New Zealand) is a national information service that provides information to promote suicide prevention activities and ASIST (Applied Suicide Intervention Skills Training) is a two-day evidence-based suicide first aid training programme that is available nationally, to anyone over 16 years of age.

Health service structure and service providers

The Ministry of Health provides ring-fenced funding for state services and for some Non-Governmental Organisations (NGOs) in Aotearoa/New Zealand. The Ministry operates through twenty District Health Boards (DHBs), which in turn fund local Primary Health Organisations (PHOs), these are the local structures for co-ordinating and delivering primary health care services (Buckley et al., 2013). Each DHB funds an adult mental health service and a community child and adolescent mental health service (CAMHS). Youth mental health services are delivered by both the state and the NGO sector. According to Buckley et al. (2013), specialist youth services are directed towards people with severe needs, whilst services to address mild and moderate needs are more likely to be provided by community-based services, general practitioners, schools, families; through child, youth and family services or within the private sector. Voluntary services, NGOs and community services play a significant role in the areas of mental health awareness and suicide prevention. They provide support and clinical services and many cater for young people with low, moderate and high support needs (Ministry of Health, 2014c).

Psychological treatments and therapies

There is an extensive amount of literature that argues that mental health issues and suicide are closely linked to each other (Appleby, Cooper & Amos, 1999; Cavanagh, Carson & Sharpe, 2003; Phillips, Yang & Zhang, 2002). However, some authors are critical of how a large proportion of the literature focuses on mental illness as a single perspective (Shahtahmasebi & Merrick, 2014). From their own research, Shahtahmasebi & Merrick (2014) revealed that “out of the ten suicide cases examined, only five appeared to have had some contact with the mental health services” (p.25).

Nonetheless, according to Buckley et al. (2013), if someone who experiences mental health concerns, including suicidal ideation, *does* present themselves to the health service, then their first point of contact is usually a primary health worker, usually within a PHO. This could be a nurse, emergency department staff, general practitioner (G.P.), health worker, Māori community health worker or, with regards to children and young people, this could be a school guidance counsellor or nurse, youth transitional programme staff or an iwi-based youth health service. Following assessment, the psychological treatments that may follow can include: hospitalisation; different types of inpatient treatments; continuity of care (regularly seeing a G.P., for example); brief problem-focussed interventions (particularly sessions of cognitive behavioural therapy); intensive problem focussed treatment (such as regular home visits from health professionals and/or 24 hour phone access to a health professional); intensive treatment with an additional outreach service (for example, intensive treatment in a hospital followed up by visits or phone calls from a health professional).

According to Te Pou (New Zealand centre of evidence-based workforce development for the mental health, addiction and disability sectors) (2009a), psychotherapies (or ‘talking therapies’) are also known as therapy, psychological treatments or therapies, talking treatments or counselling. Te Pou (2009a) states that there are twelve different psychotherapies available in Aotearoa/New Zealand including multisystemic therapy, psychotherapy with children and computerised cognitive behavioural therapy. However, in order to remain focussed on suicide prevention treatments, only those therapies, which according to Te Pou (2009a) target suicide prevention, will be discussed.

According to the New Zealand Association of Psychotherapists (2016), psychotherapy is a range of different techniques designed to treat emotional and mental health issues and some diagnosed mental health conditions. Psychotherapy helps an individual to understand themselves better by exploring how their early life experiences and personality affect their

current thoughts, relationships, feelings and behaviours. Psychotherapy can be extremely beneficial to people who wish to understand the meaning of their experiences, thoughts and behaviours and to make changes to become more satisfied in their life (Te Pou, 2009a). Donaldson, Spirito and Overholser (2003) advocate the use of psychotherapy in suicide prevention and state that it can help to identify low levels of sadness that can be addressed and managed before they reach unmanageable levels. The individual can gain a level of control, learning how to cope effectively with negative mood states, stressful life events and pessimistic expectations. “By the end of the treatment, the suicidal individual would hopefully be able to move away from their reliance on maladaptive coping strategies and can learn how to manage difficult situations more effectively” (p.318). However, others argue that more research needs to be done into the efficacy of psychotherapy for suicide prevention (Brown & Jager-Hyman, 2014).

Counselling is a broad term that covers many individual needs; it can be provided by school counsellors, telephone counsellors or face-to-face counsellors who often specialise in specific areas of expertise such as alcohol issues, marriage difficulties, depression, sexual abuse or suicidal ideation. Counselling sessions can be with individuals, couples, groups or family/whānau. According to Te Pou (2009a), counselling can help people to “increase their understanding of themselves and their relationships with others, to develop resourceful ways of living, and to bring about change in their lives” (p.25). Counselling can be flexible and person-centred; it is offered in many different formats and has received praise for its ability as a method of suicide prevention (Coveney, Pollock, Armstrong & Moore, 2012; King, Nurcombe, Bickman, Hides & Reid, 2003).

Cognitive behavioural therapy (CBT) refers to a group of interventions that share the idea that psychological distress and mental disorders are maintained by cognitive factors (Hofmann, Asnaani, Vonk, Sawyer & Fang, 2012). The treatment approach, as established by Beck (1970) and Ellis (1962) states that maladaptive cognitions contribute to the maintenance of behavioural problems and emotional distress. According to Beck (1970), these cognitions include general beliefs about the world, one’s self and the future; therefore, the goal of CBT is to reduce these systems, improve cognitive functioning and reduce the disorder. This is attempted through engaging the individual as a participant in a collaborative problem-solving process to challenge and test the validity of their maladaptive conditions and to modify maladaptive behavioural patterns (Hofmann et al., 2012).

Acceptance and Commitment Therapy (ACT) is a mindfulness-based cognitive behavioural therapy that focuses on forgiveness, values, compassion, acceptance and living in the present moment “alongside commitment and behaviour change strategies to enhance psychological flexibility” (Flaxman, Blackledge & Bond, 2010, p.1). According to Flaxman et al. (2010), ACT targets ineffective control strategies and avoidance, that is, the unwillingness to accept negative emotions, thoughts and feelings. Although it is worth noting that ACT is a therapy with quite specific characteristics, and it is seldom used to respond to severe depression and suicidal ideation, there is strong evidence in support of the therapy as a way to dismantle negative thoughts or feelings including anxiety and/or violent thoughts (Ruiz, 2010).

Dialectical behavioural therapy (DBT) is another psychological treatment. However, it was specifically developed for “suicidal, difficult-to-treat clients” (Ward-Ciesielski & Linehan, 2014, p. 371). The therapy consists of weekly individual psychotherapy consultation with a mental health professional, regular phone consultation between service user and practitioner, regular (often weekly) group psychotherapy sessions as well as skills training in four primary areas of deficit: emotion regulation, distress tolerance, interpersonal effectiveness and mindfulness. Occasionally, some practitioners introduce a fifth area – family skills, that involves validation and family behaviourism – if this is thought to be an area of deficit (Linehan, 1993).

DBT, developed by Marsha Linehan in the late 1970s, is a manualised treatment developed for suicidal clients who may not have had positive outcomes from other treatments and, according to Verheul et al. (2003), it has been recognised as the gold standard psychological treatment for individuals experiencing depression, suicidal ideation, bipolar disorder and post-traumatic stress disorder. According to Ward-Ciesielski & Linehan (2014), DBT is “the intervention with the most empirical support for the reduction of suicidal behaviours to date” (p.372). There exists extensive research that shows it to be an effective intervention for suicidal behaviours (and other extreme behaviours) (Koons et al., 2001; Turner, 2000; Van den Bosch, Koeter, Stijnen, Verheul, & Van de Brink, 2005 and Verheul et al., 2003).

Interpersonal Psychotherapy (IPT) is a short, step-by-step course of therapy that identifies and addresses problem areas in relationships with others. IPT is designed to support communication skills and to improve roles and relationships between, for example, a husband or wife, father or mother, employer or employee (Te Pou, 2009a). Initially used as a control treatment for studies that examined the efficacy of antidepressant medications (Klerman, Weissman, Rounsaville & Chevron, 1984), IPT has, over many years, become

valued as an effective time-limited treatment for a range of conditions with an array of evidence based research to support it (Robertson, Rushton & Wurm, 2008; Stuart & Robertson, 2003).

Problem Solving Therapy (PST) is a cognitive behavioural intervention that focuses on improving an individual's ability to cope with stressful life experiences. According to Nezu and Nezu (2009), the therapy supports individuals to adopt a realistically optimistic view of coping, helps them to understand the role of emotions and creatively develop an action plan to reduce distress and enhance wellbeing. The therapy, provided by a clinician, involves interactive problem-solving exercises and motivational homework assignments. The step-by-step, personalised process aims to help individuals with problem solving skills (Te Pou, 2009a) and has been shown to be as effective, and in some cases more effective than antidepressant medication for major depression and suicidal ideation (Bell & D'Zurilla, 2009; Mynors-Wallis, Gath, Day & Baker, 2000; Mynors-Wallis, Gath, Lloyd-Thomas & Tomlinson, 1995).

Summary of psychological treatments and therapies

Many psychological treatments for individuals at risk of suicide and/or suicidal ideation involve identifying difficult (or potentially difficult) situations, problem solving, and when in crisis situations, developing procedures for crisis management. To enact this in clinical settings, providers are required to generate a plan with the service user prior to a crisis situation, who will then be able, it is hoped, to use that plan in a crisis situation. The plan may include skills to cope with the crisis and to tolerate its intensity (Ward-Ciesielski & Linehan, 2014). The plan may also include other resources such as phone contact with the provider or social support. According to Ward-Ciesielski & Linehan (2014), above all, it is vital that providers teach patients alternative ways to cope with difficult and stressful situations. The authors suggest that if we imagine suicidal behaviours as responses to unbearable circumstances, then “the role of the provider is to teach, model and practice new ways of managing these circumstances” (p.380).

With regards to the over-representation of particular populations within suicide statistics, it is worth noting that culture-specific talking therapies also exist. Te Pou has published several talking therapy guides aimed at different populations including Asian people; people with problematic substance use; older adults; refugees, asylum seekers and new migrants; Pacific peoples and for Māori. The talking therapy guide (He Rongoa Kei Te Korero) aimed at

Māori is designed to assist practitioners working in mental health and addiction services. The guide promotes practices and values from Te Ao Māori to assist Māori and their whānau to access and benefit from talking therapies (Te Pou, 2010).

Although the majority of research referenced in this section, and that found in a search of the literature, reports successful and positive evidence regarding psychological therapies as treatment for suicidal ideation and attempt, there is a need for further research to be conducted in this area. For example, when comparing the numbers of Randomised Control Trials (RCTs) listed in the Cochrane Central Register of Controlled Trials (2014), researchers in the United States of America, Ward-Ciesielski and Linehan (2014), found that there were just 60 (medication-related) trials listed for suicide, (which is the 10th leading cause of death in the United States of America), 547 trials listed for liver damage (12th leading cause of death) and 670 trials listed for AIDS – a cause of death not listed in the top 15 causes of death in the United States of America. Interestingly, there were 431 trials listed that had not involved medications and perhaps this highlights the psychological nature of suicidal behaviours as opposed to disease.

Pharmacologic treatments and therapies

Introduction

Although suicide in an individual is not always predictable (Large & Nielssen, 2012), particular variables have been found to be risk factors for suicide, including: behaviours such as impulsivity, drug and alcohol misuse and disengagement from services; feelings of helplessness, hopelessness, worthlessness and severe depression; psychosis and severe anxiety disorders (Fawcett & Busch, 2014). Recognising these risk factors in time therefore, is vital but also extremely difficult for clinicians, regarding pharmacologic intervention (medications).

While the overall ratio of suicide attempts to death is 30:1, the ratio has been found to be 3:1 for individuals with bipolar disorder, and for those with major depression (Baldessarini, 2004; Baldessarini, Pompili & Tondo, 2006). Fawcett and Busch (2014) argue that pharmacologic treatments, that is, drug medications, are an important part of suicide prevention. In contrast, some research states that medications, which are prescribed to address feelings of major depression and suicidal ideation, in fact may increase the aforementioned risk factors for suicide (Hammad, Laughren & Racoosin, 2006). Separately, it could be argued that medications that are aimed at broader mental health challenges could

potentially (indirectly) prevent suicide and therefore could be prescribed alongside other interventions such as psychological treatment and/or psychosocial support.

Antipsychotic medications

Primarily used to manage psychosis, which can be a symptom of bipolar disorder, severe (psychotic) depression or of schizophrenia, antipsychotic medicines aim to improve a patient's quality of life by reducing (but not curing) symptoms (Agency for Healthcare Research and Quality, 2013). Common, 'typical' antipsychotic medications include chlorpromazine, perphenazine and fluphenazine, whilst more recent, 'atypical' antipsychotics include risperidone, clozapine, olanzapine and lurasidone (National Institute of Mental Health, 2016).

Research by Meltzer et al. (2003) reported the use of antipsychotic medication (clozapine) to be a successful suicide prevention treatment. The two-year randomised study compared the risk for suicidal behaviour in 980 patients with schizophrenia, some treated with clozapine compared with others treated with olanzapine. Patients were assessed for feelings of suicidality on a weekly basis for 6 months and then biweekly for 18 months. The authors conclude that clozapine demonstrated superior results in preventing suicide attempts in patients with schizophrenia when compared with olanzapine. Fewer clozapine-treated patients attempted suicide, required hospitalisations or rescue interventions to prevent suicide. However, it should be noted that the clinicians could make any interventions necessary to prevent the occurrence of suicide attempts and the results also stated that 5 patients who were taking clozapine had died by suicide during the study whereas 3 patients treated with olanzapine had died by suicide.

Anti-anxiety medications

Anti-anxiety medications aim to reduce the symptoms of anxiety, such as panic attacks, or extreme fear and worry. The most common type of anti-anxiety medications are benzodiazepines and include alprazolam, lorazepam and clonazepam (National Institute of Mental Health, 2016). Although anti-anxiety medications are sometimes prescribed for issues of fear and extreme worry, they are seldom prescribed to patients experiencing suicidal ideation, and when they are, their effect is often limited, according to Pfeiffer, Ganoczy, Ilgen, Zivin and Valenstein, (2009). However, it should be noted that fear and extreme worry can lead to severe anxiety and rumination that may increase the risk of suicidal ideation.

Antidepressant medications

Fawcett and Busch (2014) describe antidepressant medications as “those that increase the availability of serotonin in the postsynaptic cleft such as tricyclic antidepressants (TCAs), monoamine oxidase inhibitors (MAOIs)...[and] specific serotonin reuptake inhibitors (SSRIs)” (p.389). The most common types of antidepressant medication are SSRIs that include citalopram, fluoxetine and paroxetine (National Institute of Mental Health, 2016). Although some research warns of the links between taking antidepressant medications and an increased feeling of depression, suicidal ideation and even suicide attempts (O’Keane & Marsh, 2007), Fawcett and Busch (2014) argue that antidepressant medications have been shown to significantly and positively affect suicidal behaviours. Research that supports this, carried out in Aotearoa/New Zealand by Mulder, Joyce, Frampton and Luty (2008), concluded that “antidepressant treatment is associated with a rapid and significant reduction in suicidal behaviours” (p.116). The aim of this study was to measure changes in suicidal behaviours during six months of treatment using antidepressant medications. One hundred and ninety-five participants with depression were assessed for suicidal behaviours prior to treatment and then were prospectively assessed for suicidal behaviours during the six months of treatment. Prior to the treatment, there were 39 participants who made suicide attempts; this fell to 20 participants during the treatment. Also, significant suicidal ideation in participants reduced from 47% at baseline to 14% at three weeks into treatment – remaining below this for the rest of the treatment (Mulder, Joyce, Frampton & Luty, 2008). However, the authors acknowledged that there is no guarantee that the reduction was completely due to the use of medications and that the outcome could have been affected by the support and monitoring that participants experienced. This included regular assessments with a psychiatrist at 3, 6, 9, 13, 20 and 26 weeks during their treatment.

Summary of pharmacologic treatments and therapies

There are many people who die by suicide who had no contact with mental health service providers before their death, nor did they appear to have had any mental health concerns. In fact, some research shows that up to 78% of patients who die by suicide, deny any suicidal intent before doing so (Busch, Fawcett & Jacobs, 2003; Isometsa & Lonnqvist, 1998). The common link, therefore, which is often made between mental health issues and people who are suicidal, is not a consistent or truly representative one (Shahtahmasebi & Merrick, 2014).

Evidence regarding the efficacy of pharmacological medication, as successful treatment for suicidal ideation and suicide attempt, is mixed. There is certainly a call for further research into this (Kumpula & De Leo, 2012). Whilst some authors state that appropriate pharmacological treatment has already proved its efficacy in decreasing suicidal behaviours (Bertolote, 2014), others argue that pharmacotherapy initiatives have not yet shown sufficient or consistent enough evidence to be classed as ‘strong’ suicide prevention interventions at an international level (Mann et al., 2005), or at a national level (Beautrais et al., 2007).

Targeted interventions and treatments

Introduction

According to the Ministry of Health (2012), in 2010, there were 104 Māori deaths by suicide, 21 deaths by suicide among Pacific people and 28 among Asian ethnic groups in the same year. The rate of Māori deaths by suicide in 2010 was 16.0 per 100,000 population compared with 10.4 non-Māori deaths per 100,000 population¹¹. More recently, the disproportionate representation of Māori within suicide rates has continued, with the Ministry of Health (2013) declaring that one in five people who die by suicide are Māori, and suicide rates for Māori youth are 54% higher than for non-Māori. In the year of that publication (2013), Aotearoa/New Zealand’s population was made up of the following ethnic groups¹²: European 74%; Māori 15%; Asian ethnic groups 12%; Pacific 7%; Middle Eastern/Latin American/African 1% (stats.gov.nz, 2016). Most recent data revealed that Māori continue to have the highest suicide rate of all ethnic groups in 2017/18 at a rate of 23.72 per 100,000 population (Coronial Services of New Zealand, 2018).

Research into the prevalence of mental disorders among young people in minority ethnic groups in Aotearoa/New Zealand has revealed that “Māori children and adolescents are estimated to be 1.5 to 2.0 times more likely to suffer from a mental disorder than non-Māori” (although this appears to relate to disadvantage rather than ethnicity per se) (Denny, 2015, p. 12). The (Youth 2000) National Youth Health and Wellbeing Survey study stated that more Pacific young people reported depressive symptoms than New Zealand Europeans (18% compared with 11%) and significantly more Pacific youth had attempted suicide in the

¹¹ The Ministry of Health (2012) notes that deaths from suicide by Pacific and Asian people were not calculated or presented as per 100,000 population because the small numbers of suicide deaths for Pacific and Asian peoples meant that rates for these groups tend to be highly variable and may be misleading.

¹² The percentages per ethnic group total more than 100% because some people identify with more than one ethnic group, and so may be counted more than once.

previous year. Finally, more Asian¹³ young people showed depressive symptoms than New Zealand Europeans (16.8% compared with 11.7%) (Denny, 2015).

Pacific people (of all ages) are more likely to have a mental disorder than the rest of the Aotearoa/New Zealand population, with a 12 months' prevalence of 25% compared with 20.7% (Ministry of Health, 2008b). However, even if their mental disorder is severe, Pacific people have the lowest rate of access to mental health services, compared with all ethnic groups. According to a paper written for the Pacific health and disability action plan review (2008), Pacific people, particularly young people (16-24 years), have the highest rates of suicide planning and attempts. However this is not the case for deaths by suicide where Pacific people make up figures similar to Asian people and New Zealand Europeans (Ministry of Health, 2008b).

Interventions and treatments targeted towards Māori, Pasifika, Asian and youth populations

Western models of suicide prevention interventions and mental health services generally, have long been criticised for their cultural-insensitivity towards Māori (Durie, 1994). According to Shahtahmesebi and Merrick (2014), a lack of understanding of suicide, coupled with cultural differences has meant that “a solution is beyond reach” because the western model of suicide prevention does not work for the general population (p.170). Shahtahmesebi and Merrick (2014) call for suicide prevention that is inclusive of all cultures and will “complement Māori culture perfectly” (p.170). However, approaches to address Māori suicide in culturally responsive ways were presented in the New Zealand Suicide Prevention Strategy 2006-2016 (Ministry of Health, 2006b). These approaches (guided by previous frameworks¹⁴) use the concept of whānau ora (Māori family health) and aim to support whānau to achieve their maximum health and wellbeing in the context of suicide prevention through four pathways:

1. Whānau, hapū, iwi and community development: focusing on promoting community development and participation, led by Māori, where whānau can manage their own health. Services must be organised around the needs of the whānau rather than the individuals' needs.

¹³ A diverse population with Indian and Chinese people making up the largest groups

¹⁴ Found in He Korowai Oranga: The Māori Health Strategy (Ministry of Health, 2002a) and Te Pua-waitanga: The Māori Mental Health National Strategic Framework (Ministry of Health, 2002b).

2. Māori participation: refers to building effective partnerships with iwi, increasing the scope and capacity of Māori service providers and increasing the Māori workforce within the health and disability sector so that Māori providers can support Māori service users, whānau and hapū in holistic ways.

3. Effective service delivery: consists of reducing health inequalities for Māori by “ensuring mainstream services accept increased responsibility for Māori health, and deliver services in ways that are culturally appropriate and of the highest quality” (p.11). This includes high quality research and information to inform Government and to assist whānau to provide for their own needs.

4. Working across sectors: refers to government sectors working in partnership to address further Māori health issues, including economic, social and cultural frameworks by “sharing a common interest and achieving improved co-ordination and service integration” (p.11).

(Ministry of Health, 2006b)

When addressing Māori suicidal behaviour, it is vital to recognise that, because of Māori social structure, suicide affects hapū, iwi *and* whānau. However, as Beutrais (2004) and others (Agee, 2010; Jordan & McMenemy, 2004) have commented, the numbers of people who are affected by suicide may be considerable. If the social structure of hapū and iwi are functioning, then the impact of a death from suicide also reverberates through this social structure. Perhaps, the number of people affected in this way could provide necessary points for prioritised intervention.

Concepts of hauora (a Māori philosophy of health and wellbeing) and whānau ora (family health) must be supported when providing mental health services generally, but suicide prevention interventions especially, to Māori communities. In 1984, Mason Durie developed Te Whare Tapa Whā model of health that encapsulates the concept of hauora. The model has four dimensions: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Tinana (Physical Health & Wellbeing), Taha Whānau (Family & Social Wellbeing) and Taha Wairua (Spiritual Wellbeing) (Durie, 1994). According to Durie (1994), the over-representation of Māori in health services has implications for the language, world views, ways of knowing, education, technology, workforce and overall service provision used within health services.

This holistic approach to health would see Māori defining their own health priorities and then “weaving a course to realise their collective aspirations” (p.90). For example, Te Whare Tapa Whā model sees family and social wellbeing as having equal importance to mental and emotional wellbeing, and so, if treatment procedures are designed to address an ongoing mental health issue such as suicidal ideation, but the issues of limited access to education, or inadequate housing are not addressed, then the holistic wellness of an individual will continue to falter. Durie (1994) describes the futility of addressing one health need whilst ignoring others and advocates for Māori health models to be used in health care provision, as he reminds us that, in Te Ao Tawhito (the world before European arrival), an integrated view of health was central to the successful functioning of Māori society.

Māori health services have in fact been advocated for since the 1980s, and by 2008 there were 100 NGO youth service providers within Aotearoa/New Zealand delivering services based on needs such as crime prevention, eating disorders and suicide prevention; these included 21 Kaupapa Māori (community approach) and 5 Pacific NGOs. By 2010, there were 275 Māori health provider groups contracted to DHBs (WHO & Ministry of Health, 2012); it was hoped that treatment of Māori by Māori would decrease ethnic inequalities in health services. By 2013, there were six DHBs providing funding of Kaupapa Māori youth services and funding of Pacific youth services (Buckley et al., 2013). According to Tiatia-Seath (2015), this has had particular resonance regarding suicide prevention and intervention strategies given that evidence for social and relational triggers among Māori and Pacific youth is so strong.

According to the Kia Piki te Ora Suicide Prevention Programme Evaluation final report (Ministry of Health, 2015a), a Kia Piki Te Ora (Māori Suicide Prevention Service) operates in nine DHB regions and is one part of the health and social care sector’s longer-term goals to reduce suicides and suicidal behaviours in Māori communities. Kia Piki te Ora works towards these goals by promoting mental health and wellbeing for Māori; by reducing access to means of suicide for Māori; by increasing the safe reporting of suicide by the media and by contributing to improved mental health services for Māori (Ministry of Health, 2015a). The aforementioned evaluation report stated that generally, stakeholders felt that Kia Piki Te Ora’s contributions to Māori suicide prevention were good, when providers engaged with the community, but that stakeholders were also often unclear on the role and responsibility of the service.

More recently, Te Rau Matatini (the national Māori health workforce development organisation) and Le Va (the national hub for Pasifika mental health and addiction workforce development) have collaborated as Waka Hourua to deliver the National Suicide Prevention Programme for Māori and Pasifika communities (Le Va, 2014). Since 2014, Waka Hourua has used its \$2 million community fund to finance 42 Māori and Pasifika community-based suicide intervention projects or initiatives throughout Aotearoa/New Zealand. These have included: Taikura Trust in Auckland (a collaborative project between several charitable groups to explore suicide prevention with Māori and Pacific young people); Kahungunu Wairarapa in Wellington that has overseen the development and implementation of the Wairarapa Whānau and education and awareness action plan addressing suicide prevention (2014-2016); Pacific Trust in Canterbury that has been developing a Pacific youth suicide prevention programme for Canterbury; and Te Hau Ora Whānau Services in the Southland that has established an interagency cluster group and a series of noho marae (community buildings offering overnight stays) to raise awareness of suicide and young people at risk of suicide (Waka Hourua, 2014).

In 2004, the Clinical Research and Resource Centre team at Waitemata DHB in Auckland produced a report titled 'Pacific models of mental health service delivery in New Zealand' (Agnew et al., 2004). The research team spoke to many Pacific people; some were consumers of mental health services. The recommendations, which resulted from this report, included the use of many different models of health beliefs (including the Fonofale model; the Faafaletui model and the Te Vaka model among others) and a call for service delivery to involve the 'Traditional Healing Model' (Clinical Research and Resource Centre Team, 2004). In fact, a large number of the Pacific population in Aotearoa/New Zealand have accessed traditional healers for their mental health needs for many years. This has put pressure on mainstream mental health services to recognise the significant role that traditional healers could play in Pacific communities (Tiatia, 2008). Since the early calls for Pacific mental health services to be delivered in a more culturally-sensitive way, Pacific Mental Health Teams have been established within many of the District Health Boards. However, according to Le Va (2017), more research is needed into the quality of care for Pacific mental health service users and regarding the efficacy of these services for this ethnic group.

Young people, as a group of service users of suicide prevention services, demonstrate a high level of need. For example, the 2004 Mental Health Survey in New Zealand reported that

young people aged 16-24 had the highest 12-month prevalence of any mental disorder, among all age groups in Aotearoa/New Zealand, at 28.6%. This statistic includes anxiety (17.7%); mood disorders (12.7%); substance use disorders (9.6%) and eating disorders (0.6%), (Oakley-Browne, Wells & Scott, 2006). According to Buckley et al. (2013), more than one in four young service users in Aotearoa/New Zealand access general adult services, adult alcohol and drug services and other speciality adult mental health services. Buckley et al. (2013) argue that this is because there are more young people in need than can be provided for within youth service teams. Research by Youthline (2014) reported that depression and anxiety is linked to suicide and therefore recognising early signs of depression and anxiety is vital to potentially preventing suicide. However, there is no single solution or strategy for preventing youth suicide; rather, the research states that young people benefit most from a “combination of simultaneous intertwined and overarching prevention strategies” (p.7) and that this targeted, ‘wrap around’ support for young people must be individually and culturally tailored if it is to be effective.

Summary of targeted interventions and treatments

Some authors have criticised the above strategies (Shahtahmasebi & Merrick, 2014) and other Government policy legislation regarding suicide prevention, stating that they are all “more of the same” (p.147) and that these repetitive policies each year keep hidden the realities of suicide from the Aotearoa/New Zealand public. For example, Shahtahmasebi and Merrick (2014) claim that the public are rarely exposed to suicide data and that anecdotal information suggests that many people are not aware that suicide is one of the leading causes of death in Aotearoa/New Zealand. The authors warn against Government designed policies, claiming that as long as we allow politics to govern suicide prevention, “the cost of suicide will increase year upon year and cycles in suicide trends will continue their pattern...prevention starts at home, in school and in the community at the earliest age possible” (p.1).

It is certainly questionable as to whether the strategies and policies discussed are as effective as they aim to be when the Māori rate of suicide continues to be disproportionately high and youth suicide rates have been referred to as “a national tragedy” (Bateson, 2015). Something needs to change; a different kind of expert needs to be asked what is working and why and what is not working and why. Service users can provide this vital information. For example in 2011, Aotearoa/New Zealand’s Chief Coroner at the time, in the face of rising suicide

rates, stated that “these statistics clearly show that what we have done in the past is not bringing the toll down so we must look for new solutions” (Chief Coroner releases NZ suicide statistics, 2011).

Psychosocial suicide prevention interventions, treatments and support

Introduction

Due to the complex and deeply personal nature of suicide, there appears to be no one single solution or prevention strategy. According to the youth counselling service, Youthline (2017), people of all ages, but particularly young people, benefit most from a combination of intertwined and all-encompassing prevention strategies. Evidence suggests that ‘wrap-around’ prevention strategies can also be effective within suicide prevention (Feltz-Cornelis et al., 2011; Isaac et al., 2009). These strategies involve several different methods such as improving access to psychotherapy and pharmacotherapy treatments and/or training gatekeepers (those people who have regular contact with the individual ‘at-risk’). These wrap-around strategies are further strengthened when they work in an inter-disciplinary way, that is, with multiple healthcare professionals liaising together and working comprehensively to achieve the same goals.

To aid inter-disciplinary working in Aotearoa/New Zealand, Te Pou, together with the Ministry of Health launched *Let’s get real* in 2008 (Ministry of Health, 2008d). This framework set out the expectations of people working in mental health and addiction services and it provided tools, guidance, and support relating to seven *Real Skills* areas including working with service users and working with Māori. Importantly, this framework was developed in consultation with service users, along with whānau and workforce members. An additional framework focusing on Pacific peoples was published in May 2009 (Te Pou, 2009b) and an updated overview of the original framework was released in August 2016 (Te Pou, 2016). These frameworks set out to strengthen shared understandings between service users, family/whānau, healthcare staff and workforce members not directly involved with service delivery, for example, planners and funders, by building a mental health workforce that is person centred, recovery focused and culturally capable with an ongoing commitment to improving the quality of services. The framework sets the scene for wider holistic mental health treatments and interventions and the inclusion of service user perspectives.

As well as strategies from stakeholders and service providers, interventions can also be beneficial when provided by less formal individuals and groups. Psychosocial interventions for example, are a cluster of non-pharmacological therapeutic interventions that address the psychological, personal, social, relational and vocational problems associated with mental health disorders. Psychosocial interventions address both the primary symptoms of a mental health problem and the secondary experiences that occur as a consequence of the mental health problem: that is, they are a person-based intervention rather than an exclusively symptom-based treatment (Turton, 2014). Psychosocial interventions can come from several different sources, for example: education in schools; support groups; religious support through the church; family, social and cultural support systems; peer support; online resources and telephone helplines. The unique, comprehensive and person-centred support offered by these sources is essential to their efficacy when supporting someone with suicidal ideation.

Education in schools

In Aotearoa/New Zealand, several documents have been produced that address the issue of how education providers can prevent and respond to suicide (Canterbury District Health Board, 2013; Ministry of Education, 2013; Ministry of Youth Affairs, 2003). These documents provide guidelines for suicide prevention, emergency checklists, guidelines for responding to suicidal behaviours, suggested prompts for school counsellors, ideas for curriculum-based programmes addressing suicide prevention, as well as sources for further information and resources.

Education programmes and guidelines for schools, which are both aimed at suicide prevention, have been praised by some authors. Beautrais et al. (2007) for example, support their ability to improve the identification and referral of people at risk of suicidal behaviour. Others are cautious and critical, arguing that some programmes may in fact add to the stigmatisation of suicidal individuals, decreasing the likelihood of schoolchildren to seek help. The Center for Mental Health in Schools, UCLA, (2007) goes on to suggest that this may also contribute to a 'suicide contagion' among students.

Support groups

Various support groups exist throughout Aotearoa/New Zealand with various issues at their centre. For example, a support group can be set up by an individual, a community,

practitioners or health professionals and may focus on anything from depression, mild anxiety, ante-natal distress or social phobias. Many of these groups will address suicidal ideation and attempts as a support issue, whilst some groups exist that focus solely on suicide prevention. The Southern District Health Board, for example, had six community-led suicide prevention support groups in operation in 2014 (Martin, 2014). Essentially, support groups are a group of people with similar experiences or concerns who provide encouragement, advice and comfort to each other. According to Turton (2014), support groups have an added benefit over individual support or therapy as they also involve a social context; the feeling of empathy from others in a similar position.

Religious support

Within Christianity in Aotearoa/New Zealand, Catholicism is the largest followed denomination, followed by Anglican (Statistics New Zealand, 2014). The church plays a large role within Māori and Pasifika communities as a place of prayer, worship, education, social activities and it is the basis for many moral decisions, guidance and advice. In 2013, 78% of the Māori population identified as Christian and in the 2013 census¹⁵, more than three quarters of Pacific people said that they were Christians, compared with just half of all Aotearoa/New Zealanders (Statistics New Zealand, 2014).

A church can provide a feeling of security away from difficulties that may exacerbate feelings of suicidal ideation. Individuals who work within churches can also provide support, which may be particularly welcomed, if a young person finds it difficult to talk to their peers or family members (Fuka Lino, 2015). A church therefore, can provide support that addresses suicide prevention in many different ways including support groups, worship, one-to-one counselling and spiritual guidance as well as programmes with a specific focus. Toko, for example, is a suicide prevention programme that works primarily with Tongan Communities in Auckland. Free, bilingual youth suicide prevention workshops are delivered by clinical psychologists to Tongan young people and their families within churches, workplaces, events and schools (Toko Collaboration Group, 2016). According to Tiatia-Seath (2015), churches have a large part to play within suicide prevention currently, and will have in the future, as more ethnic-specific initiatives are needed to raise awareness and increase education around 'knowing the signs', churches can advise on these initiatives, promote them and also facilitate them.

¹⁵ The most recent census results available at the time of writing.

Family, social and cultural support systems

Outside of therapies that involve a person's family, such as family CBT or DBT and family therapy, an individual's family unit can also be a source of suicide prevention. The family can play an important role in the prevention of suicide if that family does not hold any myths about suicide that restrict their support and understanding of the issue (Barrero, 2008). According to Tiatia-Seath (2015), many Tongan youth struggle to speak to their family members about mental health issues, or thoughts and feelings generally. There is a yearning however, and a need for family members to engage with each other and professional mental health services, if needed (Tiatia-Seath, 2015).

If able, then the family can provide effective support to prevent suicide; by maintaining regular check-ins amongst family members. More culturally sensitive examples have been suggested; for Pasifika populations for example, prayer time followed by talanoa (similar to storytelling, it carries a sense of dialogue and conversation) is also recommended as a way of uniting family members and potentially maintaining connections that could reduce the risk of suicide. Although some cultural beliefs exist around feelings of depression and suicidal ideation bringing shame and dishonour to a family, in the Aotearoa/New Zealand context, this is reducing, according to Tiatia-Seath (2015). Several studies have reported the ways in which families can provide support in ways effective enough to prevent suicide (Heikkinen, Aro & Lonnqvist, 1994; Magne-Ingvar, Ojehagen & Traskman-Bendz, 1992; Trout 1980). Also, the Youth Suicide Prevention Community Information Kit published by the organisation SPINZ (Suicide Prevention Information New Zealand) in 2005, advocated for family/whānau and parent connectedness as effective protective factors for young people at risk of suicide.

Peer support workers

In a similar way to support-groups, peer support workers can offer a sense of empathy and understanding that may help people experiencing suicidal ideation to feel less alone. As Mead, Hilton and Curtis (2001) explain, peer support workers provide and receive help based on "key principles of respect, shared responsibility and mutual agreement of what is helpful" (p.6) rather than a system based on diagnostic criteria and psychiatric models. Through understanding another person's situation empathetically, through a shared experience, people may feel that the peer support worker is 'like' them. This deep connection builds a holistic

understanding and can lead to more 'relaxed' and less formal support as offered in traditional methods (Mead, Hilton and Curtis, 2001).

The mental health, addiction and disability workforce development group agency in Aotearoa/New Zealand, Te Pou, was cautious regarding the efficacy of peer support programmes within suicide prevention, claiming that, in 2012, there was an insufficient body of evidence to support any claims of success (Te Pou, 2012). However, research that predates this concern reported that peer support is an effective suicide prevention intervention that has previously resulted in reduced suicide rates (Doughty & Tse, 2010; O'Hagan, 2011). Peer support work, as a form of mental health support, has received much attention and praise (O'Hagan, Cyr, McKee & Priest, 2010; Solomon, 2004; Webel, Okonsky, Trompeta & Holzerner, 2010).

The number of peer support workers in Aotearoa/New Zealand has grown dramatically over recent years, resulting in many different NGOs now employing peer support workers (Mind and Body in Auckland, Key We Way in Wellington and MHAPS: Mental Health Advocacy and Peer Support in Canterbury, for example). In 2005, there were 35 organisations providing peer support services (Doughty & Tse, 2005) and this grew to 41 organisations in 2016 (Mental Health Foundation, 2016b). According to Doughty and Tse (2005), despite difficulties in finding funding, these organisations provide peer support services to give people another choice - "the choice to have our mental health and advocacy services delivered by our own experts - people with experience of mental illness" (p.3). After all, service users are experts in their own right and their experience, knowledge and opinions are vital within suicide prevention. As Gordon, Stevenson and Cutcliffe (2014) argue, this frequently "untapped resource" is not only helpful in overcoming stigma and a sense of being alone, but the attunement between a person who has "survived the ambivalence and darkness of a close encounter with death" and a person who is experiencing suicidal ideation, is reassuring for the distressed person as an emotional connection but also as "proof that life after suicidality is possible" (p.48).

Online resources and telephone helplines

Young people experiencing suicidal ideation are the age group least likely to seek mental health help and support (Carlton & Deane, 2000). Online sources and telephone helplines are therefore a vital way to try and reach young people. Research by Barker (2007) evidences the preference of young people to seek information and help via the internet and telephone. Since

the first ‘listening service’ was established by the Samaritans in London in 1953, the number of international, free, 24hour telephone helplines for people experiencing suicidal ideation has continued to grow; with *Suicide Écoute* in France and *Crisis* operating in the USA. Crisis helplines continue to “empower individuals by providing accessible prevention services” (Pil, Pauwels, Muijzers & Annemans, 2013, p.278). Nationally, telephone counselling helplines are offered by *Lifeline*; *Suicide Crisis helpline* and *Youthline*.

According to Youthline (2010), telephone helplines contribute effectively to suicide prevention through the empathetic approach used by their ‘listeners’ and through a mix of “directive and non-directive support, for example collaborative problem-solving and active listening” (p.9). With regards to the effects of telephone helplines on suicidal callers, Mishara and Daigle (1997) reported mixed results ranging from positive outcomes to no effects. Research into the efficacy of telephone helplines as a method of suicide prevention is difficult, however, due to the anonymous nature of the caller’s identity and the subsequent inability (and inappropriateness) of listeners to ‘follow up’ with callers at a later date. Nonetheless, telephone helplines are clearly an important provision, identified by the need for service according to Lifeline (2016) which received a phone call every five minutes in 2016. Research conducted by Youthline (2015) reported that helplines are a vital tool for suicide prevention and whose capacity to provide is outstripped by demand: the service received 142,349 text messages between October 2014 and September 2015 and responded to 112,704 of them. In the same 12-month period, Youthline received 39,672 telephone calls with staff only able to answer 22,268 of them.

Besides telephoning the aforementioned helplines, people can also email or text the organisations for help, advice or support. In 2014, around eight percent of the young people who contacted Youthline’s text counselling service had done so to talk about suicide (Youthline, 2014). Other online sources and resources are an effective way to connect with young people experiencing suicidal ideation and who may be hard to reach. In Aotearoa/New Zealand for example, thelowdown.co.nz is a website dedicated to helping young people to recognise and understand depression and anxiety. The website includes videos of real people telling their stories of depression, sources of further information and help and a moderated online forum for young people to share their experiences and to provide peer support.

Similarly, commonground.org.nz is an online place of support and advice for family, whānau and friends in order to help the young people in their lives to enjoy positive mental health

and wellbeing. Finally, sparx.org.nz is a computer program that helps young people with mild to moderate depression, stress and/or anxiety. The program guides its users through CBT techniques and problem-solving strategies. Outside of these organisations, research has been conducted into the importance of online resources and telephone helplines as tools for suicide prevention. A study by Riddle (2009) for example, involved data from youth-focussed groups in North Carolina. Riddle reported that the majority of the 65 participants stated their preferences for receiving mental health information regarding mental wellness and suicide prevention support via websites, cell phone, text messaging and social media sites.

Summary of psychosocial suicide prevention interventions, treatments and support

As discussed in this chapter, the diverse range of suicide prevention treatments and interventions that exist, include treatments that focus on a particular group, grassroots interventions and specific, medical-model therapies. The variety of these interventions and treatments reflects the complexity of suicidal ideation itself. According to Bertolote (2014), despite the specific efficacy of stand-alone interventions, they each obtain their full potential only when integrated into a national or regional strategy. The recovery focus of mental health service delivery in Aotearoa/New Zealand, for example from the *Let's get real* framework, sets the scene for wider psychosocial, indigenous, holistic and service user inclusive perspectives and encourages interventions in a broader sense.

According to Bertolote (2014), however, medical treatments, the control of access to firearms and the education of gatekeepers are among the interventions that have systematically demonstrated their efficacy in reducing suicide mortality rates. At a national level, earlier research had reported similar findings. For example, a summary of the literature and a review of the strategies for suicide prevention in Aotearoa/New Zealand were carried out by Beautrais et al. in 2007. The authors stated that those initiatives, for which strong evidence of effectiveness exists, include: gatekeeper education and reduction of access to suicide methods. These two initiatives showed consistent evidence of efficacy through randomised control trials.

Pharmacotherapy, psychotherapy and psychosocial interventions, as described in this section, were, according to Beautrais et al. (2007), programmes that showed some effectiveness, although were not yet consistent or efficient enough to categorise them as 'strong' initiatives.

There also exist initiatives for which no evidence of efficacy exists but which may be valuable within suicide prevention. These include: community support groups, family support and general public awareness and education. Finally, Beautrais et al.'s (2007) research concluded that, initiatives for which evidence of harmful effects exists include: public health messages about suicide and media coverage of suicide issues; no-harm and no-suicide contracts; recovered or repressed memory therapies and school-based programmes that focus on raising suicide-awareness. According to the authors, concerns have been raised regarding the ethics, safety and appropriateness of these initiatives; increasing the belief that they may in fact risk increasing rates of suicidal behaviour. Bertolote (2014) states that although many of the initiatives listed by Beautrais et al. (2007) have saved thousands of lives there is not much strong evidence for the efficacy of most suicide prevention initiatives that are usually not evaluated, despite strong claims about their effectiveness.

2.6 SECTION SIX: Service user involvement in health and social care research

Introduction

According to Benson, Boden and Owens (2014), the majority of suicide research is targeted to help professionals to identify individuals at risk and to find ways to respond. The majority of suicide research, suicide prevention research and suicide prevention legislation and policies, particularly the Ministry of Health Strategies and Action Plans discussed earlier, are produced with contributions from: health and social care staff including clinicians, nurses and social workers; community members; bereaved family/whānau members and friends; NGO staff; and academic researchers. The opinions of these experts are regularly referenced, quoted and subsequently often used in policy formation regarding suicide prevention.

Another group of experts, however, who have not been asked to contribute to the knowledge base or the formation of suicide prevention policy in Aotearoa/New Zealand to date, are the service users who in fact *access* the suicide prevention interventions, treatments and services discussed in the previous section. For example, if health and social care provision is to improve the lives of service users, then it is essential to involve service users within the research that informs policy and practice (Beresford, 2005).

Since the 2006-2016 Suicide Prevention Strategy however, things have started to change. The Strategy to Prevent Suicide in New Zealand (draft version) was released for public consultation in April 2017 and in the foreword, Dr John Crawshaw (Director of Mental Health) stated: "Many people and organisations have contributed to the development of this

draft strategy – from people in the community (including people who have attempted suicide and people who are bereaved by suicide)” (Ministry of Health, 2017, p.iii).

Public consultation on this draft closed in July 2017 and in September 2017 a newly-elected Labour Government took over. Before this draft, however, service users had not been asked for their input and knowledge into the legislation that affects them; this change therefore, is a huge step forward for the Ministry of Health. Subsequently, by including the first-hand knowledge and opinions of service users, the current research hopes to contribute knowledge and information to the Ministry of Health in order to increase the evidence base for the current Inquiry into Mental Health and Addiction (Ministry of Health, 2018a) that aims to inform the forthcoming Strategy to Prevent Suicide in New Zealand.

The history of service user involvement in health and social care research

The call for service users to be involved in research is not a recent idea however; it can be traced back more than fifty years to the rights movement of disabled people in the UK. Historically, due to the medical model of disability, disabled people had been ‘subjects’ to be researched *on* rather than researched *with*. During the late 1960s and the 1970s, however, this began to change as disabled people became politicised. In the United Kingdom, the Union of the Physically Impaired Against Segregation (UPIAS) for example, was pivotal in the rights movement of disabled people. The UPIAS criticised research into disability and demanded that disabled people must reflect on their own experiences if they were to contribute to developing theory. As stated by Finkelstein (1985, quoted in Barnes and Mercer, 1997, p. 6), “the response of disabled people is quite simple: no participation without representation.”

The mid-1970s saw the empowering of many disabled people and by 1983, a new social model of disability dominated discussions; the model explains how it is society and its barriers that disable people and that the removal of those barriers is the responsibility of society, not that of the disabled person (Oliver, 1990). The ‘shift’ for disabled people from subjects to co-researchers led to a new paradigm of research that maintained that disability and mental health research should be co-operative experimental inquiry (Kiernan, 1999). This new way of ‘doing’ research has led to several forms: narrative, emancipatory, inclusive (participatory) and action research among others. Nationally, for example, and with input from other service users, Mary O’Hagan’s research offers guidance to the Ministry of Health’s mental health plans and services (O’Hagan, 2014).

Why is service user involvement in health and social care research important?

Beresford (2005) argues that, generally, most people want to have a say over what happens to them within health and social care provision and that this is no less true of people facing difficulties in their lives including, for example, mental health un-wellness. Of course, ethical issues are extremely important within research with people who may be 'at-risk' or vulnerable in other ways. However, there is also a point to argue that to *not* include people deemed 'vulnerable' or 'at-risk' is in fact *unethical* (Steel, 2005).

Involving service users in health and social care provision has been well advocated for and documented in the success of peer support workers (Gordon, Stevenson & Cutcliffe, 2014; Mead, Hilton & Curtis, 2001). The effectiveness of those mental health services, which involve service users in their provision, was examined by Doughty and Tse (2005). The research highlighted the importance of service user input into service-user-run initiatives and services within the mental health sector and reported very positive outcomes for clients.

As Beresford (2005) claims, involving service users in research should only happen when the primary aim is to improve that service. The involvement of that user must make a discernible difference in the experience of that person's service use; this is the 'acid test' in that it should lead to positive improvements in people's lives and in the support and treatment which that user receives individually and others receive generally (Beresford, 2005). A successful example of this was seen in 2001/02 when the Southampton Behaviour Resource Centre (SBRS) in the United Kingdom conducted focus groups with young people with mental health difficulties who were users of the SBRS service. The aim was to examine and improve the support services that the young people received and, although the young people were deemed to be vulnerable, the research was effective in its aim of improving service provision. The work also empowered the young service users and represented a form of campaigning, promoting the interests and needs of the people using the service (Waldman, Powell & Storey, 2002). Although the young people included in this research were not experiencing suicidal ideation, nor did they have a history of attempting suicide (at least not disclosed in the research report), the example does serve to show how people who are deemed vulnerable can, and should, be involved in the research and policy formation that affects them.

When we ask *why haven't service users been involved in Aotearoa/New Zealand Government suicide prevention research to date?* the answer could be two-fold:

1. Suicide prevention service users are assumed to have died.

Several documents briefly discuss the difficulty of not being able to ask the individual for their input regarding the reasons why they felt suicidal; obviously because the individual had passed away (Beautrais 2001; Ministry of Health, 2006b). Instead, these documents included the knowledge and opinions of researchers, academics, community groups, providers of health and social services and 'suicide survivors' (family/whānau and friends bereaved by suicide). The only way in which service users are included within these documents is as quantitative suicide rate statistics. Existing policy and legislation regarding suicide prevention refer to service users as people who have passed away and do not mention service users who may have experienced suicidal ideation or suicide attempt, but who are still alive.

2. Service users may be seen as 'too vulnerable' to be included in research and policy development.

People who access suicide prevention interventions and treatments are often assumed to be extremely vulnerable and usually suffering from a mental health disorder (Shahtahmasebi & Merrick, 2014). It may be presumed by some people that asking individuals who are experiencing (or who have experienced suicidal ideation, or who have attempted suicide) to participate in research about their suicidal ideation/attempt is extremely risky and may lead to participants acting on their suicidal thoughts. Similar to this is the way in which media guidelines have, until recently, explicitly prevented journalists from reporting attempted or completed suicides (Parliamentary Counsel Office, 2016). Changes included in the 2016 Amendment Act, however, are part of a larger societal change in which more open acknowledgments of mental health challenges and wellbeing can happen. For example, public awareness campaigns such as the National Depression Initiative fronted by Sir John Kirwan (a New Zealander and a former member of the All Blacks rugby team) have made it more acceptable for New Zealanders to talk about mental health problems and to seek help (Mental Health Foundation, 2017).

However, it is also important to state that there are wider issues that may restrict people with a mental health disorder from participating in such research. For example, suicidal ideation and attempt is not a standalone matter; rather it is often subsumed within other mental health challenges. And so, those people with experience of suicidal ideation may be less likely, or less able, to participate in research, which asks about their experience, not simply because

they are vulnerable but also because their mental health limits their opportunity or ability to participate through, for example, social anxiety disorders or severe depression.

Conducting research with vulnerable people

Previous research studies, which have successfully used focus groups to explore suicide with young people 'at-risk', report that the method "generated a wealth of rich data regarding discussions of suicide" (Thornton, Tynan, Robinson & Skehan, 2012, p.31). The risk of participants re-attempting suicide because of their participation in suicide-discussion is an unsupported presumption, and without their active input, research that affects vulnerable people will risk being irrelevant and perhaps even flawed (Steel, 2005). Many studies have conducted suicide research with vulnerable, 'at-risk' participants regarding their own suicidal ideation and reasons for suicide attempt (Biddle et al., 2012; Coggan, Patterson & Fill, 1997; Gibson, Benson & Brand, 2012; Røn & Scourfield 2005; Smith, Cokrowicz & Poindexter, 2010; Thornton et al., 2012). Each of these studies reported positive outcomes, provided valuable data and reported that no participants described increased levels of suicidal ideation as a result of the study. In fact, Biddle et al. (2012) found that 'at-risk' participants reported a positive change in wellbeing after discussing their suicidal ideation and attempts within focus groups. The researchers wrote "that a tendency to overstate risks has hampered research, especially qualitative research seeking to explore the suicidal experience" (p.357).

Restricting qualitative research (where the aim is to facilitate the detection and mitigation of risk of suicide through empathetic understanding) has a negative impact on the development of treatments (Gibson et al., 2012). As Steel (2005) argues, researchers obviously have a responsibility for the safety of vulnerable participants. However, whatever the level of vulnerability that person has, they still have the right to information, the right to express their views and to have these views listened to and acted upon regarding their health and social care service provision. With regards to suicide prevention research, Ward-Ciesielski and Linehan (2014) explain how excluding vulnerable participants who are at-risk of suicide, because they are "currently or have experienced suicidal ideation, has arguably crippled the field of suicide intervention research as much as any other limitation" (p.369). Investigators often exclude 'at-risk' individuals from research into evidence-based treatments and "operational definitions and reliability data on the measures they used for exclusion are rarely included" (p.369). Therefore, although certain treatments may have been reported as effective when treating depression, anxiety or panic disorder, they cannot be confidently reported with a suicidal individual. The ethical costs of not learning how to include suicidal

individuals in research is seldom discussed and their exclusion is detrimental to future suicide prevention (Ward-Ciesielski & Linehan, 2014).

Service user involvement in suicide research: A strengths-based approach

There exists an extensive amount of research into the efficacy of suicide prevention programmes (Crawford, Thomas, Khan & Kulinskaia, 2007; Gunnel & Frankel, 1994, for example). However, these studies have been criticised for their serious limitations, including their use of meta-analysis (Bertolote, 2014; Rudd, 2007). An actual understanding of service users' experiences is limited, particularly in relation to in-depth qualitative research, within which, it has been argued, "participation could be therapeutic or otherwise beneficial" (Biddle et al., 2012, p.356).

However, a research practice within social work that focuses on service users' own experiences and then focuses on the strengths of the individual (or family, group or organisation) to aid recovery and empowerment is the strengths-based approach. Pattoni (2012) explains how the aim of the strengths-based approach to focus on health and wellbeing is to embrace an asset-based approach where the goal is to promote the positive. Hammond and Zimmerman (2012) describe the strengths-based cycle as a holistic process that includes an emphasis on a person's strengths and resources in the process of change: "when challenges are experienced, problems and issues are acknowledged and validated and strengths are identified and highlighted" (Hammond & Zimmerman, 2012, p.4).

According to Rapp and Goscha (2006), using a strength-based approach involves a different way of thinking about service users and of interpreting their patterns of coping with life challenges. Relevant to this research, the approach attempts to identify the positive basis of the person's resources (or what may need to be added) and strengths that will form the basis to address the challenges resulting from the problems. Subsequently, this research reflects a strengths-based approach as it seeks to find out participants' positive resources (the intervention treatments, services or other factors) that were effective for their mental wellness and recovery. The discussion section of this thesis (Chapter 6) will identify those positive resources and strengths and will present them as a basis to address the challenges of suicidal ideation and attempt.

Whilst involving service users in strengths-based suicide research is important, it is also ethically challenging. For example, this doctoral research went through a rigorous process to gain ethics approval; a process that will be described in detail in the following methodology

chapter. Understandably, people become concerned when ‘at-risk’ individuals are directly involved in participatory research. There exists a reasonable fear that discussing sensitive and personal issues of trauma (past and present) may exacerbate negative feelings and/or lead to harmful actions. This concern is also felt by some health practitioners. For example, Stoppe, Sandholzer, Huppertz, Duwe and Staedt (1999) interviewed 170 general practitioners in Germany; 23% of the doctors stated that they would not conduct a suicide risk assessment of elderly patients who had depression for fear of inducing suicidal thoughts and behaviours. Similarly, in the United Kingdom, a cross-sectional survey was sent to general practitioners regarding screening for suicidality. One third of the 103 general practitioners who responded felt that asking any patient about suicidal behaviour could potentially trigger suicidal ideation or harm (Bajaj et al., 2008).

Although it should be stated that not every individual who experiences suicidal ideation and/or who dies by suicide will be, or will have been, a service user, those who *are* accessing suicide prevention treatments or support remain a vital source of knowledge and experience. Shahtahmasebi and Merrick (2014) reported from their own research that only five people out of the ten suicide cases examined had had some contact with mental health services before their death. In conflict with this research, however, is a report from SPINZ (2010), which states that roughly 75% of people who die by suicide have contact with a care provider in the year prior to their death, and around one third have contact with mental health services. Collings and Beautrais (2005) argue that this indicates a vital opportunity for suicide prevention and improvements to those prevention interventions and treatments. It could also be an important opportunity to gain invaluable knowledge from service users.

The risks of discussing suicide with individuals experiencing suicidal ideation are not to be ignored. As the *Best Practice Evidence Based Guideline* (Ministry of Health, 2003) reminds us, the mental state of a person experiencing suicidal ideation can fluctuate significantly over time. Concerns such as this have shaped guidelines that aim to inform and encourage best practice from healthcare staff who are involved with discussing, identifying and treating suicidal behaviours. As well as the 2003 *Best Practice* document, the Ministry of Health (2008e) also published a set of guidelines later titled *Identification of Common Mental Disorders and Management of Depression in Primary Care*. This document includes questions to ask when screening for suicide risk and advises healthcare staff of their responsibilities towards people at risk of suicide. Whilst the 2003 guidelines state that there is no evidence to suggest that discussing suicide with people who are experiencing suicidal ideation increases the risk of suicide attempt or worsens the feelings of being suicidal, and

that a calm discussion of suicidality may allow people to discuss thoughts they previously thought were ‘taboo’, the 2008 document reminds us that people who are experiencing severe depression are more at risk of developing suicidal thoughts and so caution should always be taken.

When these guidelines are followed, and when ethical approval is sought and adhered to, then suicide prevention research with service users can be invaluable. For example, Benson, Boden and Owens (2014) carried out research with and for the United Kingdom-based mental health charity SANE, with the aim to make its services better: that is, to improve the way their helpline and email staff recognised and responded to suicidal distress. Of the 54 people interviewed, 25 were people bereaved by suicide, 14 were people who had attempted suicide within the last 5 years and 15 were friends/family of those people who had attempted suicide. Understanding suicide from a first-person perspective enabled SANE to make changes to its service delivery including the promotion and provision of compassionate but immediate and informed support. The findings also guided the charity when creating web-resources, sending research and suggestions to policymakers and informing journalists who report on suicide in the media and when collecting relevant information to send to service providers with recommendations (Benson, Boden & Owens, 2014).

If we restrict the ways in which we conduct suicide research, then we will arguably restrict what we know about suicide. As echoed by Gibson et al. (2012), if we want to understand suicide, reduce suicide rates and improve policy, practices, treatment and interventions in the future, then we need to listen to those people directly involved. These experts can inform research and create change but this is only possible if having service users participating in research is seen as less risky and more beneficial. Shahtahmasebi and Merrick (2014), for example, criticise the way in which decisions and policies regarding suicide prevention are made in Aotearoa/New Zealand without input from service users. The authors argue that the current top-down approach to suicide prevention decision making suits “political parameters and evidentiary support is sought after policy implementation” (p.5).

Since the latest suicide figures in Aotearoa/New Zealand are the highest to date, it is hard not to find resonance with the call by the Chief Coroner to “look for new solutions” (Chief Coroner Press Release, August, 2018). Current efforts to reduce suicide and suicidal ideation have indeed been met with criticisms: “accurate and appropriate information is crucial in supporting policy formulation. It is the uncritical thinking and acceptance of poor evidence without question that has led to policies that produce ‘more of the same’ ” (Shahtahmasebi & Merrick, 2014, p.5).

Summary

There exists an extensive amount of research into suicide: from addressing the cause of suicide from the point of view of the individual, to how we can discuss suicide more effectively, and further to discussions of how suicide prevention and post-vention processes could be improved from the point of view of bereaved family/whānau members (Martin, 2014). However, there has not yet, to my knowledge, been any research regarding the efficacy of suicide prevention interventions and treatments in Aotearoa/New Zealand, from the service users themselves. Suicide prevention and intervention research has generally excluded people who have had a history of suicidal ideation or attempt or who may be at risk currently (Pearson, Stanley, King & Fisher, 2001). However, researchers agree that empirical investigations are required to better understand suicide and to help to develop effective prevention treatments and interventions (Fisher, Pearson, Kim & Reynolds, 2002; Lakeman & Fitzgerald, 2009; Pearson et al., 2001). Nonetheless, a reluctance to include individuals who may be at risk still exists, with presumed suicidal crises, legal and ethical implications and potential consequences often being cited as reasons to exclude high-risk participants from research (Jobes, Bryan & Neal-Walden, 2009; Lakeman & Fitzgerald, 2009). This is paralleled by a perception among health care professionals, academic researchers and the public that discussing suicide will surely increase the likelihood of an ‘at-risk’ individual attempting suicide (Bajaj et al., 2008, Stoppe et al., 1999).

However, there are several studies that have been mentioned in this chapter which challenge these common perceptions and presumptions. Similarly, research by Reynolds, Lindenboim, Comtois, Murray and Linehan (2006) reported no increased risk to the participants involved in their study. For the 63 high-risk chronically suicidal women with Borderline Personality Disorder, suicidality and distress varied with each individual. According to the authors, no significant differences regarding increased or decreased feelings of suicidality were reported from the participants when in-depth questions were asked about suicide, with 46% of participants reporting no change at all.

Clearly, there is a need for further research into what works for service users who access suicide prevention interventions, treatments and services. Their expert, first-hand knowledge could shape the future of effective suicide prevention efforts in Aotearoa/New Zealand. This previously untapped source of information can also influence the future knowledge base, policies and legislation including the forthcoming Strategy to Prevent Suicide in New Zealand. The ways in which this doctoral research was conducted, in an attempt to gather

such information, will be described next. Chapter 3 discusses the research methodology in detail by describing the epistemology, theoretical perspective, ethical considerations and the ethics application process that all shaped the research considerably. The qualitative methods used and the subsequent methodological modifications that were made will be explained as well as the input from a research reference group that enriched the study. Finally, questions of transferability and usefulness of the data will be discussed and how issues of data validity were addressed.

Chapter 3

Methodology

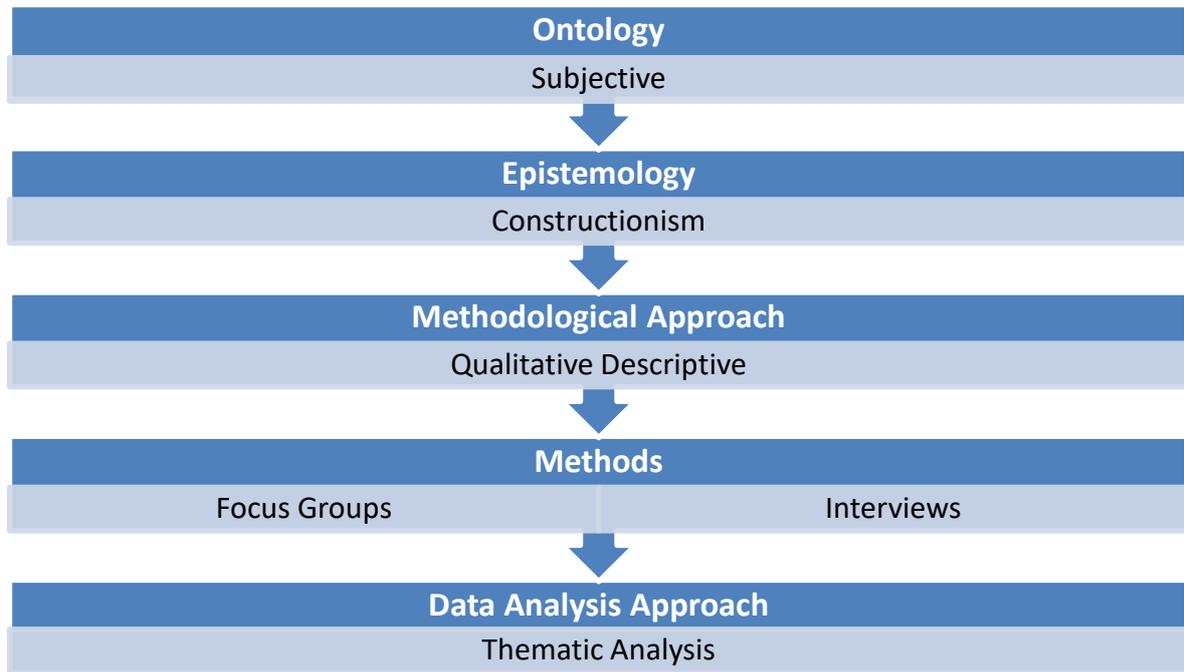
3.1 SECTION ONE: Introduction

In contrast to positivist research, this study operated inductively to produce theory from the empirical data. This is more crucial than a pre-established hypothesis when trying to find out what works for mental health consumers because no assumptions are made before the study and so there are no hypotheses to prove or disprove. Rather, it is the participants' responses (the data) that have directly informed the findings and this approach will be explored in further detail. Subsequently, the qualitative descriptive methodology and related qualitative methods used in this research will also be explained in this chapter before a discussion of the strengths-based approach to social work. A description of the research reference group will follow: this provided guidance from service users, peer support workers, academics and health professionals who have key expertise and knowledge relating to the research. After this, the potential transferability and usefulness of the data are discussed in order to suggest changes and recommendations and the steps taken to ensure data validity are explained.

MacIntosh and O'Gorman's (2015) Methods Map informed the methodology of this research and my own adaptation of the map, relevant to this research, is demonstrated in Figure 3.1. The techniques listed in this map, which were originally chosen, included a mixture of focus groups made up of service users and semi-structured interviews with key informants. Reasons for these methods (and the later methodological modification to omit the use of focus groups) will be explained in this chapter following a discussion of the aims and objectives of the research. An extensive process through the Ministry of Health's Health and Disability Ethics Committee shaped so much of this research; the journey to gain ethical approval will be described before matters of the subsequent access, sampling, selection and setting are explained and the limitations of the study are acknowledged. Finally, the use of thematic analysis will be presented with reference to Braun and Clarke's (2006) six stage model of the method before the outputs of the research are described.

Figure 3.1

Methods Map



It is also important to include my own personal *mihimihi*¹⁶ here, particularly as this thesis shares other peoples’ stories. I was born in Kent in the United Kingdom to a white-British mother and a Turkish-Cypriot father. Before moving to Aotearoa/New Zealand in 2015 to attend University, I lived and studied in several different areas of the United Kingdom. My career in mental health began in 2004 where I worked in a priory centre¹⁷. Since then I have been employed within a variety of different support-work roles; from creating and providing a community support service for young people with mental health challenges to working as an advocate and a support worker for people with mental health support needs. My own mixed heritage has led me towards an interest in other cultures and languages. I was not very well educated in Aotearoa/New Zealand’s cultures before my studies began. My limited knowledge was a restrictive issue as a foreign researcher, particularly in relation to issues to do with Māori, and so I am immensely grateful to my friends, supervisors, colleagues and the many people I have met during my research journey for increasing my awareness and continuing to develop my knowledge of Aotearoa/New Zealand’s cultures since I arrived.

¹⁶ A greeting and introduction in Māori culture through which people describe their culture, lineage and their background.

¹⁷ National wellbeing centres in the United Kingdom that offer support and therapy to people with mental health support needs including drug and alcohol misuse, eating disorders, depression and suicidal ideation.

3.2 SECTION TWO: Conceptual considerations

A constructionist epistemology

Constructionism is the epistemology most appropriate for this study as it is the participants' responses that have constructed the knowledge (the data) from which meanings (the findings of the research) will result. For example, participants will construct their own unique perceptions of *what works* regarding suicide intervention treatments and services.

Constructionism focuses on the process by which meanings are created, conveyed, maintained and then adapted (Steedman, 2000). Schwandt (2003) states that constructionists are able to understand the world of lived experience from the perspective of those who live in it. According to Whittaker (2012), epistemologies such as constructionism (and interpretivism) challenge traditional scientific methods that are inappropriate for the study of social phenomena "because they do not take into account the viewpoints of the social actors involved" (Whittaker, 2012, p.9). As Steedman (2000) explains, most of what is known about the world and most of the knowing that is undertaken is concerned with trying to make sense of what it means to be human, including what a particular social phenomenon *means*. Within this study, the social phenomenon is suicidal ideation and attempt and as opposed to scientific knowledge, it is individuals (or groups of individuals) who define this reality.

Constructionism and constructivism are terms often used interchangeably with regards to how we construct reality. However, according to Crotty (1998), constructivism is a meaning-making process, which applies only to an individual, whereas constructionism applies to a collective process. Constructionism therefore resonates more with this research as, collectively, several participants' experiences are informing the meaning of *what works* regarding suicide prevention and intervention. As echoed by Fisher (1991), it is therefore not only practically relevant to use a constructionist positioning within social work research but also ethically appropriate. The *constructivist paradigm*, which Denzin and Lincoln (2005) use as an alternative term for *constructionist*, includes the researcher's interpretations of the participants' data and states that these interpretations will form the findings of the research (Denzin & Lincoln, 2005).

Constructionism has been a guiding epistemology used within research into psychology (Nightingale & Cromby, 1999), education (Sabelli, 2008) and suicide research (White, 2014). Constructionism complements research into these disciplines as it is based on the belief that personalities, behaviours and societies are organised by the way in which individuals attribute meanings to events and then act upon those meanings; for example, meaning is constructed rather than discovered. My own epistemology resonates with Bryman's (2001) explanation of

constructionism that “social phenomena and their meanings are continually being accomplished by social actors. It implies that social phenomena and categories are not only produced through social interaction but that they are in a constant state of revision” (Bryman, 2001, p.16).

Under the ontological umbrella of subjectivism, my own epistemology is constructionist. As previously mentioned, I have worked within the field of mental health support work for almost 15 years and I am passionate about advocating for service users and about the promotion of their involvement as experts within their own support provision and also their involvement within national mental health strategies and/or health and social care legislation, for example. Listening to, and acting upon, the advice of service users who have relevant experience and knowledge is invaluable for academics, health professionals and policy makers if they are to improve services in a meaningful and effective way. Input from service users, however, is seldom included within policy review or discussions of national strategies and, from my experience as a support worker, is often omitted from discussions of and plans for their own support.

Service user involvement in social work research is vital to inform high quality research that can then bring about real benefits for service users - present and future. The extensive benefits of service user involvement in research were discussed in the previous chapter. However, despite the benefits, service users are rarely included in health and social care research. According to McLaughlin (2012), reasons for this can vary from concerns regarding a lack of representativeness, to fears of the extra time and financial costs needed and can also include anxieties regarding the safety of participants. In suicide research, in particular, fears around participant safety include concerns about whether participants are well enough to take part, if their mental wellbeing will be negatively affected by the research and/or whether or not their responses are credible. Other reasons, as explained in Chapter 2, include the belief that suicide research participants are often assumed to have died or that those who are still alive are too vulnerable to take part in research about suicide (Shahtahmasebi & Merrick, 2014).

Qualitative descriptive methodology

The intention for this study was to generate or inductively interpret and structure meanings (Creswell, 2009) regarding *what works* for service users, with regards to their mental health wellness following suicidal ideation/attempt. A qualitative descriptive methodology, as well as ethical concerns for sensitivity, guided this research as the experiences of participants are more crucial and revealing than a pre-established theory.

The goal of qualitative descriptive studies is to produce a comprehensive summary of specific events experienced by individuals or groups of individuals, therefore, data collection within qualitative descriptive studies focuses on discovering the nature of the specific events in question (Lambert & Lambert, 2012). Data analysis within qualitative descriptive research does not use a pre-existing set of rules; rather, analysis is purely data-derived in that codes are generated from the data in the course of the study (Thorne, 2000). A qualitative descriptive methodology is often used within health and/or social care research where the everyday events of individuals or groups are being described using the participants' views. The approach is ideal when information is required directly from those experiencing the phenomenon under investigation and where time and resources are limited (Bradshaw, Atkinson & Doody, 2017).

Qualitative research design and methods

According to Hjelmeland (2010), the majority of research into suicidal ideation and effective intervention uses quantitative methodology. This has led to repetitious research and findings, and instead, Hjelmeland (2010) argues for an increased understanding of suicidal ideation and effective intervention through the extended and essential use of qualitative methodology in order to bring forward the field of suicidology. O'Connor, Platt and Gordon (2011) encourage the use of qualitative methodology when conducting suicidology research in order to facilitate a deeper understanding of the plethora of suicide risk factors and the range of possible, effective interventions.

O'Connor, Platt and Gordon's (2011) advocacy is supported by Fulford, Sallah and Woodbridge (2007) who state how important it is to use qualitative methodology within mental health research as:

...phenomenology and related disciplines, as rigorous approaches to analysing experience supported by detailed theoretical frameworks, provide tools for more effective and inclusive ways of understanding differences not only between individuals but also between cultures and the way they experience the world. (Fulford, Sallah & Woodbridge, 2007, p.39)

Qualitative methods are linked to the interpretivist view of philosophy. For example, they are "especially interested in how ordinary people observe and describe their lives" (Silverman, 1993, p.170). As a support worker and advocate, qualitative methods reflect my own interest in seeking out and interpreting the meanings that people ascribe to their actions and they also complement

my personal belief that knowledge and reality are socially constructed. Relevant to this research, qualitative methods are often chosen when working with smaller samples to look for depth and detail of meaning with a less general and abstract level of explanation. Further to this, qualitative methods are seen as ‘natural’ as opposed to ‘artificial’ and they can also contribute to the evolution of new theories (McLaughlin, 2012), possibly providing new ideas of what else could work in the future with regards to suicide prevention interventions, treatments and services and the overall goal of reducing suicide rates.

To try and find answers to the key research question, qualitative methods were felt to be essential as a way to sensitively explore this personal phenomenon. As discussed in the previous chapter, influential literature (Biddle et al., 2012; Coggan, Patterson & Fill, 1997; Gibson, Benson & Brand, 2012; Røn & Scourfield 2005; Smith, Cokrowicz & Poindexter, 2010; Thornton et al., 2012) shaped this decision, as these researchers reported the use of qualitative methods as the most appropriate tool to gather sensitive data from vulnerable participants. Admittedly, a survey that gathered quantitative data around *what works* may have been effective in retrieving a large amount of data but this method would have been inappropriate and insensitive for the topic and it would also have restricted the ability of myself, as the researcher, to ask further questions and to gain deeper explanations from participants. Closed questions and pre-determined responses would not be an effective way to gather data as so many different suicide prevention interventions, treatments and services exist - too many to be listed and limited by a survey. Also, the research sought to find out the experiences and knowledge of participants - this rich and extensive data required a face-to-face interview so that open, qualitative questions can be asked and detailed, personal responses can be given.

Face-to-face, semi-structured interviews as a qualitative method were used as they have both practical and ethical strengths. Interviews offer first-person access to participants’ experiences and the subject being investigated, whilst also enabling the interviewer to ask personal questions about a topic as sensitive as suicidal ideation in a forum more appropriate than a survey or phone call, for example. As a method, interviewing participants face-to-face was essential to the ethical considerations of this research. Extremely personal experiences were discussed in great detail during this research and this could only have been carried out by using a method as ‘human’ as interviewing. Although the research did not advertise itself to participants as a potentially therapeutic experience, many of the participants reported the interview to have been a positive, cathartic experience - a finding echoed by Biddle et al. in their 2012 study of vulnerable individuals’ experiences of participating in research interviews that focussed on suicide and self-harm. From a practical perspective, interviews also provide a relatively simple way of gathering

rich and detailed data. Smith (2009) discusses how interviewing as a method resonates within social work research because it is closely related to core professional skills and it coincides with key values such as enabling service users to be heard.

A strengths-based approach

The strengths-based approach used within social work, as discussed in the previous chapter, resonates with this research as the practice offers a new paradigm that focuses on the strengths of an individual in order to promote their recovery; that is, finding out what works and supporting this to then happen. Pulla (2014) describes the differences between the conventional social work approach in mental health care and the strengths-based approach: the former is service centred, values-free and the practitioner takes responsibility. The latter approach however, is client-centred, values-centred and the service user is responsible for deciding on the approach/es to explore whilst the practitioner supports them to make this/these happen.

Within social work, the aims for any practitioner are to build a collaborative relationship with the person who they are supporting, to seek the highest possible client participation in their problem solving, to value the person's self-determination and to respond to their particular strengths and wishes with meaningful and effective support (Aotearoa New Zealand Association of Social Workers, 2014). However, according to Pulla (2014), the conventional social work approach to mental health care, coupled with the historical use of crippling labelling and stigmatising language can obscure a practitioner's awareness of personal responsibility. Instead, Saleebey (2002) (one of the original advocates for the strengths-based approach) suggests that practitioners should listen to the narratives of the client and let them tell their story, instead of reading through an assessment protocol. "Stories and narratives often contain within their plots and characterizations evidence of strengths, interests, hopes and visions" (Saleebey, 2002, p.88). As this research aimed to do, listening to an individual's story in detail allows that person to reveal their knowledge of what works for them. The strengths and effective areas of support that are identified then allow the practitioner to promote those areas and encourage the individual to reach their goals and retain their independence.

Evidence of a strengths-based approach can be seen in Aotearoa/New Zealand through organisations like Youthline within its 2014 document *Best Practice Strategies for the Prevention of Youth Suicide*. The organisation stated that callers to its help and advice telephone line appeared to "appreciate a person-centred, strengths-based approach rather than a solution-based approach" (Youthline, 2014, p.5). Similarly, Ball's (2010) review of

evidence focussed on the effectiveness of strengths-based mental health promotion and youth development interventions. The research concentrated on strengths-based initiatives that were designed to promote mental health and wellbeing at the population level. Unfortunately, suicide prevention interventions and mental illness prevention interventions were specifically excluded from the review. However, the review did report that strengths-based interventions, which aimed to build core competencies in young people, can be successful in preventing specific risk behaviours such as school failure and early school leaving, high risk sexual behaviour, youth violence, and substance use. These risk behaviours may be both a cause and a consequence of poor mental health (Pollett, 2007, cited in Ball, 2010). Therefore, with regards to suicide prevention interventions, the author admits that “knowledge about ‘what works’, although increasing, remains limited” (Ball, 2010, p.6).

I hope that this doctoral research can contribute to knowledge about what works for service users with regards to suicide prevention interventions by showing how a holistic focus on recovery has contributed to effective mental health service delivery (and how it could continue to do so) through the use of a strengths-based approach. The current mental health inquiry in Aotearoa/New Zealand (Prime Minister's Media Release, 2018) seeks to find out what works for people with lived experience regarding Aotearoa/New Zealand's current approach to mental health and addiction, and what needs to change. By sharing my findings, this research will go on to advocate for the use of a strengths-based approach. Reflective of my own view, and described so accurately by Saleebey (1992), individuals as consumers of mental health services “have vast, often untapped and frequently unappreciated reservoirs of psychical, emotional, cognitive, interpersonal, social, and spiritual energies, resources and competencies” (Saleebey, 1992, p.6).

As this research promotes a strengths-based approach through listening to individuals’ narratives, it seemed appropriate to seek advice during the research process itself from people with lived experience of suicidal ideation as well as people who have experience of conducting research within this area. Therefore, it was decided early on by my supervisors and I that input from a research reference group could offer vital guidance when researching the phenomenon of suicidal ideation, complementing the academic support provided by my supervisors. The group included individuals with experience relevant to the research and their involvement will now be explained.

Research reference group

The research reference group was established in order to help advise and guide me through the research process. This group was necessary because of my own inexperience of conducting research with vulnerable people, my initially limited knowledge of mental health services in Aotearoa/New Zealand and also because of my initially limited knowledge of Māori culture. Consisting of service users, peer support workers, academics and health professionals, the group members have key expertise and knowledge relating to the research including knowledge regarding Māori culture, Pasifika culture and clinical psychology. Members were sent an invitation and information sheet (Appendix A) and we met four times between August 2017 and September 2018. Advice was also provided via email by some of the members during this time. The research reference group members were: Dr Matthew Shepherd (Ngāti Tama) (Clinical Psychologist & Senior Lecturer at University of Auckland); Ms Taimi Allan (CEO at Changing Minds); Ms Tamara Waugh (The Happiness Experiment, Changing Minds); Miss Sonia Pope (Tuākana Mentoring Programme, University of Auckland) and Ms Sheree Veysey (Counsellor with Mind and Body Consultants).

Each of the group members signed a confidentiality agreement (Appendix B) as a way of safeguarding against the sharing of private information provided by participants. Some of the group members are service providers and, although the data was de-identified, may have been able to recognise participants as service users. The confidentiality agreement therefore detailed the expectations of group members to not share any of the information that we discussed in the research reference group. Input from the group members was valuable and helped to shape the research from its initial stages as well as during the process and finally in the form of a discussion of the resulting (de-identified) data. It should also be noted that three of the reference group members were also interview participants.

Transferability, usefulness and data validity

Lietz and Zayas (2010) discuss how the power of qualitative data can be measured when we look at its transferability and usefulness. By looking at the data in this way, changes and recommendations can be confidently put forward. Although this research can only be seen to reflect the experiences of the twenty people interviewed, it is hoped that their stories are transferable to other people and to other settings. For example, the effective interventions, services and treatments discussed in this research may provide new ideas to other service users who read it. It is hoped that the plethora of approaches which participants have said

work for them can be useful for other people who may be looking for further ways to support their own recovery following a suicide attempt and/or alternative ways in which to contribute to their ongoing mental health wellness. At a wider level, this research has implications for national policy and will be disseminated through key processes for feedback to the Ministry of Health with a particular focus on providing input into the Government's current Inquiry into Mental Health and Addiction (Ministry of Health, 2018a). Participants' experiences will provide the Government with a current understanding of what is working, for example, those interventions, treatments and services which *are* effective and which therefore require further funding and resourcing; which forms of treatment are less effective and *why*; and, ideas of what else could be promoted nationally which isn't already happening. Similarly, the recommendations for best practice are suggested so that service providers can check whether their practice aligns with what service users are saying they want it to include.

According to Silverman (2013), validity is the extent to which researchers are able to accurately describe and interpret the participants' views. The difficulty here comes when researchers try to ensure authenticity whilst also 'cherry picking' preferred data to analyse and subsequently preferred findings from the analysis to present. The existing beliefs, theories and assumptions held by the researcher can threaten data validity, as Creswell (2009) explains: "however much one tries to stay objective one will always have pre-conceived ideas, culturally designed beliefs and possibly pre-judgements of the issue" (p.190). Although triangulation (in which two or more methods are applied to the same research question) was considered as it can be a useful tool when measuring data validity, it is not always the most helpful or necessary. According to Morgan (1996), triangulation is "an expensive and time-consuming enterprise...and using multiple methods can lead to multiple interpretations" (p.226). For example, people's experiences and/or views of the intervention service they receive may change between the first and second piece of research. There could also be other outside interferences, which alter the follow up data from the initial data, but that do not make the initial data any less valid (Alston & Bowles, 2003). Member checking was therefore used in the form of respondent validation in order to check the transcripts for accuracy before analysis took place (Birt, Scott, Cavers, Campbell & Walter, 2016).

The assistance of the research reference group aimed to reduce the risk of researcher bias by checking transcripts for obvious mistakes, through a discussion of the subsequent, (de-identified) data and also during the thematic analysis process. This type of discussion also helps to ensure the validity of the coding scheme (Coggan et al., 1997) by ensuring that there is not "a shift in the meaning of the codes" (Creswell 2009, p.191). Similarly, input from the

research reference group was fruitful because their analysis revealed points which I may have missed; highlighting the benefits of reflexive discussion.

While researcher bias is a risk, immersing oneself in one's research is beneficial, as Knodel (1993) writes, "the accuracy of the interpretative analysis is also enhanced if the analysts are intimately involved with the actual data collection" (p.17). And although attempts can be made to reduce researcher bias, their success is not always possible. As Whittaker (2012) explains, "once you have become actively involved in analysing your data, you realise that it is an active process in which you must make choices and to which you bring your previous experience" (p.98). Whilst positivists may see this as bias that needs to be removed in order to obtain an objective view, qualitative data analysis requires a more reflexive approach. Seeing patterns and interpreting meanings in the data inevitably requires the researcher to exercise their judgement (Whittaker, 2012). The rigid rules of quantitative data analysis are not necessary or appropriate for the in-depth data that result from personal disclosures within qualitative research, no less for the personal phenomenon of suicide.

Qualitative research often comes under scrutiny regarding its validity and instead, often focuses on trustworthiness and authenticity. The disclosure of participants' experiences alone should provide sufficient authenticity. This research uses a constructionist approach to highlight the importance of hermeneutic underpinnings within qualitative social science research. There is no better validation of authenticity than to explore the dialogue of those people who are the object of the study (Smith, 2009). The positivist view of analysis as 'hard facts' that need to be discovered to reveal the absolute truth, which can be scientifically measured, is incompatible with the immeasurable, qualitative data obtained from this research.

3.3 SECTION THREE: Research aims, design and methods

Research aims and objectives

Using a qualitative descriptive methodology, guided by constructionism, this research aimed to explain, as well as describe, suicide prevention interventions, treatments and services as experienced by service users themselves. By sharing a summary of the recommendations from the research within mental health forums, and through key processes for feedback, I hope that the findings from service users' lived experiences and opinions can provide knowledge and information to the Ministry of Health. I aim for this research to contribute to the implementation of the findings of the Government's current Inquiry into Mental Health

and Addiction (Ministry of Health, 2018a). The inquiry will report back to the Government by the beginning of November 2018 with data to inform and create the next Strategy to Prevent Suicide in New Zealand. An aim of the research is to provide additional information to the Government and therefore, the empirical data gathered during this qualitative study includes participants' opinions of the following:

- What worked regarding the treatment/ intervention they received?
- How has their experience of mental health service provision affected their wellness?
- What else helped?
- What could have been done differently?
- What are their key recommendations regarding best practice?
- What are their ideas regarding suicide prevention efforts overall and what else could work?

The key research question, which this study aimed to answer, was 'what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?'

Research design and methods

The sensitivities of suicide and the ethical concerns of suicide research (discussed in the previous chapter) informed the choice of methods within this study and a constructionist epistemology also guided the design. Originally, a combination of focus groups with service users and, separately, interviews with key informants (individuals working within the field of mental health who had experienced suicidal ideation previously) was planned and subsequently approved by the Ministry of Health's Health and Disability Ethics Committee (HDEC). It was hoped that focus groups would encourage service user participants to "feel more comfortable about expressing their views" (Smith, 2009, p. 119) as empathy with other group members may have helped the setting feel less uncomfortable. Biddle et al. (2012) for example, found that 'at-risk' participants reported a positive change in wellbeing after discussing their suicidal ideation within focus groups.

It was hoped that talking about something as personal as suicide may be made easier if discussed within a group with other people who had similar experiences, as opposed to a one-to-one interview with a researcher who was unknown to the participant. As Morgan (1996) states, groups can provide comparisons that lead people to talk about a wider range of experiences and opinions, more so than those that occur in individual interviews. Interactions

in groups can provide “more accurate accounts of what people actually *do*” (Morgan, 1996, p.232). Also, the researcher-researched relationship changes within focus groups and can “shift the balance of power in favour of the participants” (Barbour & Kitzinger, 1999, p.18) leading to more natural discussions and sharing of rich data within a setting less rigid than interviews.

Focus group dynamics can also be a useful tool for developing a new politics of knowledge regarding suicide intervention treatments and services. By encouraging participants to explore issues, identify common problems and suggest potential solutions through sharing and comparing experiences, personal experiences can be transformed into ‘public issues’ to initiate grass roots change for future treatments (Barbour and Kitzinger, 1999). Similarly, encouraging people to talk openly about suicide could help to change the way the issue is seen as an often private and ‘taboo’ subject.

With reference to the fear of a suicide contagion discussed in Chapter 2 (Center for Mental Health in Schools, UCLA, 2007) and the health professionals who felt that asking any patient about suicidal behaviours may trigger suicidal ideation (Bajaj et al., 2008; Stoppe et al., 1999), some may assume that the focus group method is inappropriate for discussing suicide. It could also be argued that discussing suicidal ideation is too personal for many people to do in a group setting. Morgan (1996) states however, that these assertions are based more on intuition than data. Focus group research has shown that people may be more, rather than less, likely to self-disclose or share personal experiences in groups rather than dyadic settings (Farquhar, 1999). Previous research studies (Biddle et al., 2012; Coggan, Patterson & Fill, 1997; Gibson, Benson & Brand, 2012; Røn & Scourfield 2005; Smith, Cokrowicz & Poindexter, 2010; Thornton et al., 2012) that have successfully used focus groups to explore suicide with people ‘at-risk’ report that the method “generated a wealth of rich data” (Thornton et al., 2012, p. 31). After using focus groups, Coggan et al. (1997, p.1568) praised the method and urged other researchers to do the same, reporting that “some people do not want suicide to be a ‘taboo’ subject...contrary to the views expressed in many published papers”.

Methodological modifications

Despite my initial beliefs that focus groups would be a method that provided participants with a supportive environment in which to share their experiences, only one participant¹⁸ expressed an interest to take part in a focus group. During the recruitment process, 19 of the 20 individuals who contacted me to participate requested to take part in an interview rather than a focus group, stating that they would feel more comfortable sharing their experiences with one person (myself) rather than a group. Naturally, I wanted the participants to feel as reassured as possible and conducting an interview instead of a focus group was not a difficulty. As shall be discussed later, the HDEC had approved both interviews (with key informants) and focus groups as suitable methods and so there were few implications of this change (these will, however, be discussed further when the HDEC's approval process is described in detail).

Although I had originally assumed the opposite, on reflection, interviews worked extremely well as a method, better than I had initially expected when compared with focus groups. Interviews gave the participant the opportunity to share their personal stories and to talk for extended periods of time; their responses often led on to other, deeper reflections of what else had worked for them. This provided me with extremely rich and subjective data and meant that I could focus on the participant entirely, asking related questions and observing their behaviour for potential distress more easily. This would not have been as feasible in a focus group setting as one participant's responses may have been influenced by others in the group, others may not have spoken at all and potential distress may have been more difficult to monitor.

Therefore, originally planned for key informants only, interviews were subsequently used to gather data from service users as well. According to Elam and Fenton (2003), in-depth, face-to-face semi-structured interviews are best suited to investigating sensitive topics. The method involves human interaction as a way of exchanging and being face-to-face allows the interviewer the opportunity to build a rapport with the participant, an advantage that presumably would not have been as possible or as effective within a focus group. Karnieli-Miller et al. (2009) suggest that building a rapport is the most important element of interviewing participants about sensitive topics. Echoed by Seidman (2000), I also

¹⁸ Clearly, one participant is not sufficient for a focus group and so this individual was asked if they would prefer an interview or to revoke their expression of interest. They chose to participate in an interview and stated that they were happy with this.

discovered that developing a rapport during the interviews enhanced the access I was given into the participants' life stories, helping them to share their experiences, as I will discuss next.

Semi-structured interviews

To answer the key research question, semi-structured interviews were used as a method of discussion with service users (past and present) and also, separately, with key informants. The key informants included people who have lived experience of suicidal ideation and/or attempt and who now work within an organisation that provides mental health support to people who may be experiencing suicidal ideation. Therefore, the key informants were peer support workers, consumer advocates/advisors or counsellors who will have been service users at some point (and several were still service users). It is important to acknowledge the aforementioned connection that three of the key informants who were interview participants were also members of the research reference group.

As previously mentioned, face-to-face interviews are the most appropriate method of data collection when discussing sensitive topics, according to Elmir et al. (2011) and Taylor et al. (2009). Using interviews for sensitive research must be carefully done so that they can be used to yield meaningful and rich data whilst also allowing participants to feel safe and at ease (Knox & Burkand, 2009). Therefore, guidance was taken from Dempsey, Dowling, Larkin and Murphy (2016) when planning and conducting the interviews. The authors' *Framework of Essential Elements in Qualitative Interviewing* (Appendix C) provided me with guidance on preparing for interviews, interacting with gatekeepers of vulnerable groups, planning for interview timing and location, building relationships and conducting therapeutic interactions, protecting ethically vulnerable participants, and planning for disengagement (Dempsey et al., 2016). An example of how I used this framework came during the debriefing with participants after the interview had ended. As suggested by Dempsey et al. (2016), positive closure techniques were used towards the end of the interview such as asking hope-inducing questions and giving the participant time to reflect on the interview experience.

Contact numbers were provided for relevant support services and follow-up phone calls/emails were carried out after the interview to see how the participant was feeling post-interview. This was an effective way to establish any risk of distress after the interview and also acted as a method of gaining feedback from participants about how the interview was

carried out. None of the participants in this study reported any distress following the interviews and many of them instead described the interview as being therapeutic and beneficial to their mental health with several participants remarking how the experience had reminded them “just how far they had come”, with others stating that the experience had led to positive disclosures of their mental health experiences to loved ones and to health professionals.

In keeping with the constructionist epistemology of this research, semi-structured interviews reflect my own ontological belief that it is people's understandings, experiences and interpretations that form knowledge. As described by Mason (2002) this qualitative method of inquiry allowed for an interactional exchange of dialogue in a relatively informal style. The interview was topic-centred with the use of an interview guide (Appendix D) but the flexible and fluid structure allowed informants the freedom to express their views in their own terms.

A defining characteristic of semi-structured interviewing is the ability for the researcher to prepare an interview guide ahead of time that includes a pre-determined set of open questions. These questions prompt discussion and guide the participant through the interview, ensuring that they remain as focussed on the topic as possible while simultaneously allowing the interviewer to explore particular themes or responses further (Mason, 2011). Using an interview guide of pre-determined questions also means that participants' responses (the data) can be more easily recorded, coded and analysed later on (Smith, 2009). Semi-structured interviews therefore, provided reliable, comparable qualitative data whilst enabling participants to talk in depth about an intensely personal and sensitive subject and by giving myself, as the researcher, first-person access to their experiences and reflections.

Twenty interviews were carried out throughout the North Island of Aotearoa/New Zealand. Guest, Bunce and Johnson (2006) found that in most qualitative research enterprises, which aimed to understand common perceptions and experiences of a particular social phenomenon, twelve to fifteen interviews were often sufficient to provide enough data before saturation. However, according to Fawcett and Garity (2009), an acceptable sample size for research which uses a qualitative descriptive methodology is one that sufficiently answers the research question, the goal being to obtain cases considered rich in information. Although saturation is an ‘elastic concept’ according to Morse (1994), Green and Thorogood (2009) suggest when little ‘new’ comes out of transcripts, then saturation point has been reached. With this research, it was felt that saturation point was reached after the eighteenth interview.

It should be noted that, despite extensive recruitment processes, only twenty individuals expressed an interest in participating; a limitation of the research that I will discuss further on.

Before the interview took place, participants were provided with an invitation and information sheet (Appendix E), an informed consent form (Appendix F) and a copy of the interview guide (Appendix D) so that they could prepare any responses before the interview and hopefully feel more at ease. Participants were reminded of the aim to consult with them as individuals who have expertise in the area of suicide prevention and intervention in order to inform and influence best practice. During the interview, participants were asked a range of questions that were divided into two themes: *What worked?* and *Best Practice Recommendations*. Using Dempsey et al.'s (2016) framework as guidance, these themes included questions of what had contributed to the person's wellness and what worked for them with regards to their experience of recovery. Participants were asked about the suicide prevention interventions, treatments and/or services they had accessed, how they found out about these services, what they found to be beneficial about them and why, and perhaps why they had not, worked so well. This theme explored psychological and pharmacological treatments such as dialectical behavioural therapy and medication. It also allowed participants to share their experiences of psychosocial interventions and support including religious beliefs and those that I had not previously considered, such as the therapeutic benefits of the arts.

The part played by the mental health services in the participants' wellness and recovery was also explored and this was met with a variety of positive and negative responses. Some people advocated for the importance of peer support work with its focus on lived experience whilst others questioned the limited availability of psychological therapies in their rural area. Through open-ended questions, participants were also asked for their recommendations of best practice based on their knowledge and experience. Ideas of what best practice should look like and key messages for health professionals within mental health yielded detailed examples and opinions of the practice(s) that had been effective for the individual and what needed to change. Finally, participants were asked for their thoughts on suicide prevention and intervention in Aotearoa/New Zealand more generally, what is being missed and how we can better respond to this problem.

Sending the interview guide to participants before the interview also meant that they could prepare their responses. Some participants came to the interview with notes prepared whilst others sent further information and opinions via email following the interview. These notes

were included along with the interview transcriptions during the data analysis process and will be presented via vignettes in Chapter 5 and discussed in more detail in Chapter 6.

3.4 SECTION FOUR: Research ethics

Before I describe the formal ethics approval process, it is important to first state the considerable contributions of others to my cultural competency. When I first arrived in Aotearoa/New Zealand, my awareness and understanding of all things Māori was limited. To conduct research in Aotearoa/New Zealand therefore, it was essential for me to seek guidance from relevant Māori advisors. Many people contributed to this, including members of the research reference group, my friends, many Māori health practitioners and my colleagues at the University of Auckland. Seeking their advice not only enhanced my awareness but also enriched the research and this thesis. Although my understanding of Te Ao Māori (the Māori world) is always developing (and this will be discussed later in the next section as a potential limitation of the research), I am extremely grateful for the education, guidance and blessings provided to me by so many tāngata whenua¹⁹.

Following these improvements to my cultural competency, approval was then sought, and gained, from the Ministry of Health's Health and Disability Ethics Committee (HDEC). The HDEC state that research that aims to include one of the points below (or *all* - as in the case of this research) must seek full review from the HDEC²⁰:

- Participants will be identified as vulnerable or potentially vulnerable during the research.
- Service users' contact information will be accessed by the health professionals who support them to share information about the research.
- The 'case reports' are reports of cases from health or disability services.
- The mental health services/treatments in question include District Health Board-run services (as well Non-Governmental Services (NGOs)).

¹⁹ A Māori term that literally means 'people of the land'; it is often used when referring to the original inhabitants of Aotearoa/New Zealand.

²⁰ A committee that supersedes The University of Auckland's Human Participants Ethics Committee in regard to research in health matters.

The HDEC full review process

In early September 2016 I completed the HDEC's online screening questionnaire through their *Online Forms* for research system. As this research aimed to include each of the points listed above, the results of the screening questionnaire stated that full review was required before the research could be carried out. I started the application for full review in mid-September 2016; this required the completion of an extensive administrative section online in which I was asked to describe how the research aimed to produce benefits and to give a detailed description of the safeguards and safety procedures that minimised and managed risk. Explanations of how the research would respect people, cultures and environments and how the research aimed to be fair were also written about in depth within this initial section. Documents were uploaded including: a cover letter, my own curriculum vitae and those of my supervisors, evidence of scientific review, the poster advertising recruitment to be used, the letter I planned to send to organisations/stakeholders, the participant information form and consent form for the (service user) focus group participants (as originally planned), the participant information form and the consent form for the (key informant) interview participants, copies of the questions I planned on asking all participants and a lengthy research protocol.

Many safeguards were already in place prior to application and several more were added during the ethics application process including the addition of two psychologists to offer support to participants within the focus groups (this is explained in more detail in Appendix G). The initial application included the steps in the table below that were taken as attempts to limit risks to participants:

Figure 3.2

Steps taken to safeguard participants

1. When recruiting participants, organisations were asked to only consider individuals who were aged over 18, not currently experiencing suicidal crisis (and to not have experienced crisis for at least the past six months) and who were able to discuss their mental wellness in a healthy way, in the service providers' assessment.
2. Participants were invited to bring a support-person with them into the interview (however, it was requested that this support person's role be purely supportive and not vocal so that the participant's voice remained dominant).
3. Participants were informed via the participant information sheet and the informed consent form (and were reminded during the interview itself) that they were free to not answer any of the questions during the interview and they were free to leave at any point.
4. Participants were also reminded that they could request the digital recorder be turned off at any point during the interview.
5. Within the participant information sheet, and again following the interviews, participants were provided with contact details for relevant helplines and resources for further information and support (including the contact details for two psychologists).
6. Participants were contacted subsequent to the interview as a follow-up in regard to their wellbeing.

Participants could withdraw from the research process after the interview had taken place and this was made clear to them in the information sheet and informed consent form. Following the interview, participants were sent their transcripts for clarification and to check for accuracy – they were then given a three-week window in which to request any changes be made to their transcript. Participants then had an additional three-week window during which they could decide to no longer be involved in the research process and to have their data

removed from the study. Non-responses during this three-week period were taken as agreement for continued use of the data. Each of the participants was offered the opportunity to use a pseudonym in the research.

Between the initial application and the final approval in July 2017 (see Appendix I), the HDEC's review process required several meetings, additions to the proposal and alterations to be made to the application. These are explained in further detail in Appendix G. The HDEC's systematic procedures meant that the application and the safeguards received a great amount of attention to detail. With input from knowledgeable individuals, the applications were refined and improved and subsequently were made more ethically robust, culturally aware and more detailed regarding the safety of participants. As required by the committee's protocol, an extensive progress report was sent to the HDEC in July 2018 and a final report of the study will also be sent to the HDEC within one year of its conclusion. This summary must include information on whether the study achieved its objectives, the main findings and arrangements for the publication or dissemination of results.

The ethical challenges and the sensitive nature of this research contributed to the delay in its approval. The HDEC full review process took 10 months and the locality approval processes from each of the four District Health Boards (DHBs) which followed (explained further on) then took an additional four months. Following this, the research could start to be conducted from December 2017. However, during the recruitment process as previously discussed, individuals who contacted me to participate requested to take part in an interview rather than a focus group. When asked if they would like to join a focus group, all except one individual stated that they would feel more comfortable in an interview setting (the exception-participant agreed to an interview stating that they were happy with either method).

Focus groups were subsequently not used in this research and instead, one-to-one face-to-face interviews took place. It seemed that my original beliefs formed from previous research had been incorrect and that participants in this situation believed they would feel less comfortable in groups when compared with dyadic settings. The HDEC's approval already included authorisation to carry out both focus groups and interviews and so I did not need to reapply for their approval. The methods had changed though from the original proposal and this was communicated to the HDEC and subsequently included in the progress report submitted in July 2018. Interview questions were updated depending on whether I was interviewing a key informant or not, that is, questions relating to their experience as a key informant were not included if the participant was a service user only, rather than a key

informant. As mentioned earlier, this methodological modification was a positive one which worked well for the research. Conducting interviews, as opposed to focus groups, provided each of the participants with a safe space in which they could focus on their own story whilst also supporting in-depth dialogue between participant and interviewer.

It should be noted therefore that the psychologists I had invited to support participants during the research were not needed as the focus groups did not happen. The HDEC had previously feared that a focus group setting could encourage a contagion of distress among participants and the psychologists should be there to safeguard against this. The psychologists' names and telephone numbers however *were* included in the resources given to participants (and verbally highlighted to them) before and after the interview. Participants were also invited to bring a support person along with them to the interview (only one participant chose to do this).

3.5 SECTION FIVE: Research access, sampling, selection and setting

Access, sampling and selection

Following approval from the HDEC, nine DHBs in the North Island were contacted to request their locality authorisation in order for me to conduct research in their district. This process involved an online application through the HDEC 'Online Forms' submission system to a Research Advisor within each of the DHBs. A cover letter was sent to the Research Advisors within each of the nine DHBs along with the research protocol and the HDEC approval form. Three of these DHBs did not respond to the request and two others only allow research to be conducted by their employees. Attempts were made to work with an employee as an internal facilitator but these attempts were unsuccessful.

Four of the nine DHBs responded to the request which meant that the process for their own DHB ethics committees' approval could then begin. The ethics committees for each of these four DHBs then invited me to apply for their locality authorisation via their own online application system. This process involved sending documents such as a detailed application form (available from their website(s)), examples of the participant information sheet and consent form as well as examples of the poster I planned to use for advertising and a detailed information sheet for the DHB services themselves. Once these documents were received, I was invited to present my planned research and to answer questions from the committee(s). During this time I was also invited by each of *Te Puna Oranga Māori* (The Māori Research Review Committees) of the four DHBs to attend a pōwhiri and then to give a presentation of

my proposed research. After these meetings, and the subsequent locality authorisation approval from the DHB ethics committees and approval from each of the respective Māori Research Review Committees, I was then able to contact mental health service leads/managers in each of the four DHBs to arrange a meeting. In these meetings I presented my research plans and requested their help with the recruitment of potential participants. Non-governmental organisations (NGOs) were also contacted to ask for their support with recruitment. This was possible because of the locality authorisation gained from the four DHBs which also included approval to work with NGOs in the same DHB area.

The sample design used purposive sampling - recruitment through links with existing agencies. For example, the service managers/leads of each of the DHB services and the NGO services kindly helped to advertise the research to potential participants through the use of Facebook pages/groups, displaying posters (Appendix H) around their service buildings and by emailing the poster to their colleagues to share with service users (and staff) who met the criteria. Some service managers also agreed to send letters of invitation and information (Appendix E) to their service users (past and present) (as well as an informed consent form (Appendix F)), on my behalf, who met the following criteria:

- Individuals aged over 18 years who are English speakers.
- Individuals who were not currently experiencing suicidal crisis (and who had not experienced crisis for at least the past six months) and who were able to discuss their mental wellness in a healthy way, in the service providers' assessment.

From the group of people who met the (essential) criteria above, staff members were then asked to identify:

- Individuals who were using mental health services for their mental wellness
- and/or people who had used mental health services in the past for suicidal ideation/attempt and who had since been discharged
- and/or people who were accessing mental health services and were ready to be discharged
- and/or people who had used the services as above and who were then working in a professional capacity with lived experience of suicidal ideation and/or attempt such as consumer advocates/consumer advisors/peer support workers.

Recipients of these letters were invited to contact me directly if they wished to participate. Contacting potential participants in this way meant that I adhered to confidentiality rules as I did not have access to the DHB's service users' names and addresses and this prevented undue coercion. Individuals were able to choose whether to take part or could simply discard the letter if they did not wish to.

The invitation and participant information sheet asked individuals to contact me if they were interested in participating in the research once they had read the supporting information. Individuals were informed that they could bring a support person along with them on the day; however, it was requested that their role be supportive and not vocal. The invitation also stated that participation was voluntary and participants were thanked for their time with a \$20 Countdown gift card (Countdown is a supermarket in Aotearoa/New Zealand).

Each of the twenty participants lived in the North Island of Aotearoa/New Zealand and were all aged between 18 and 70 years. Other demographics of the participants are presented in figure 3.3. The information is purposefully limited so as not to reveal the participants' identities as per their requests (many of whom chose to use pseudonyms).

Figure 3.3

Demographics of participants

Characteristic:	Number of participants (out of 20)
Gender	
Female	16
Male	4
Ethnicity	
Māori	4
NZ European	4
Pacific Peoples	2
Asian	1
NZ other	5
Other	2
Preferred not to disclose	2
Role	
Consumer Advisor (and current service user)	2
Consumer Advocate (and current service user)	2
Mental Health Support Worker (and current service user)	3
Service User (not employed)	6
Mental Health Practitioner (and current service user)	1
Peer Support Worker	2
Other employment (and current service user)	4

Research setting

Interviews took place between December 2017 and April 2018 and were often conducted in the participants' homes as per their request. Some interviews were carried out in neutral (but private) areas such participants' workplaces or in a meeting room within The University of Auckland's buildings. Each interview lasted approximately one hour and refreshments were provided. Participants were sent a copy of the interview questions (Appendix D) before the interview took place so that they knew what to expect. The research was limited to the North Island due to restrictions on time, travel and cost. Further limitations of this research are described below.

Limitations of the study

The experiences shared in this research can only represent the twenty participants who took part in the research. These participants were living in the North Island of Aotearoa/New Zealand, specifically located within the four District Health Boards (DHBs) which responded to (and approved) a request for DHB research locality authorisation. Although nine DHBs throughout Aotearoa/New Zealand were sent requests for their locality approval, only four responded to and approved the request. Also, twenty DHBs exist within the whole of Aotearoa/New Zealand but I was only able to apply to nine of them for their locality approval. This was due to restrictions of travel, time and cost. Therefore, service users from the South Island of Aotearoa/New Zealand were not recruited. This limitation of the research reveals a potential for other, similar research to be conducted in the South Island, particularly Canterbury, where suicide rates are among the highest in the country (Coronial Services of New Zealand, 2018).

The number of participants may also be seen as a limitation of the research. Although an extensive amount of data was gathered from the twenty participants' interviews, having a higher number of participants may have resulted in further insight into what works and/or yielded other recommendations for best practice. After extensive recruitment processes, only twenty individuals expressed an interest to participate. This may be reflective of the recruitment process itself or of the personal and sensitive nature of the research. Other important voices are therefore missing from this research, for example, individuals from the LGBTI community who may have shed light on those interventions and services that are effective for people who identify as lesbian, gay, bisexual, transgender and intersex in their

recovery following a suicide attempt and what else can be done to reduce the discrimination and social exclusion experienced by the rainbow community as a risk factor for suicide (Mental Health Foundation, 2016c). Similarly, the recruitment of more young people could have led to discussions of online support programmes and of what else could be effective for the youth population – a group at high risk of suicide. Only four of the twenty participants in this study identified as Māori, which, as a limitation of the research, means that voices from the ethnic group so disproportionately represented in suicide statistics are only partially represented. Further input from these communities may have highlighted other (current) effective approaches and could have suggested further recommendations in terms of best practice and support services focused on these groups.

Being a novice researcher, interviewer and analyst, I am grateful for the suggestions and support provided by my supervisors, the participants themselves (through the validation of their transcripts) and by the members of the research reference group. Similarly, whilst my cultural awareness of Aotearoa/New Zealand continues to grow, particularly with regards to Māori culture as previously mentioned, my limited understanding of the country's culture when I arrived may have also acted as a limitation of the study. It is difficult to know whether participants may have felt more at ease and may have divulged more information, or if I may have picked up on more nuanced information, if I as the researcher were from Aotearoa/New Zealand.

The lengthy delay caused by the HDEC process also contributed to a restriction on time to carry out the research. Finally, this research can only reflect the views of a certain group of people at a certain time. Although the data could be highly relevant post-2018, the thoughts of service users and the array of suicide prevention interventions and treatments available is likely to change.

3.6 SECTION SIX: Data collection and analysis

Data collection, storage and confidentiality

As the interviewer, I recorded the discussions using a digital recorder (the consent form contained participants' agreement to be recorded) and field notes were taken to support the audio data. A transcriber was used and was asked to sign a confidentiality and non-disclosure agreement. The digital recorder, recordings, typed transcripts and the thesis itself are kept on my password-protected computer. A copy of the recordings is stored on a data-stick which is kept in my PhD supervisor's desk drawer in a locked office at the University of Auckland.

All data and health related information will be kept securely for a minimum of ten years. Finally, summaries of the research will be sent to the relevant parties, as explained in the next section.

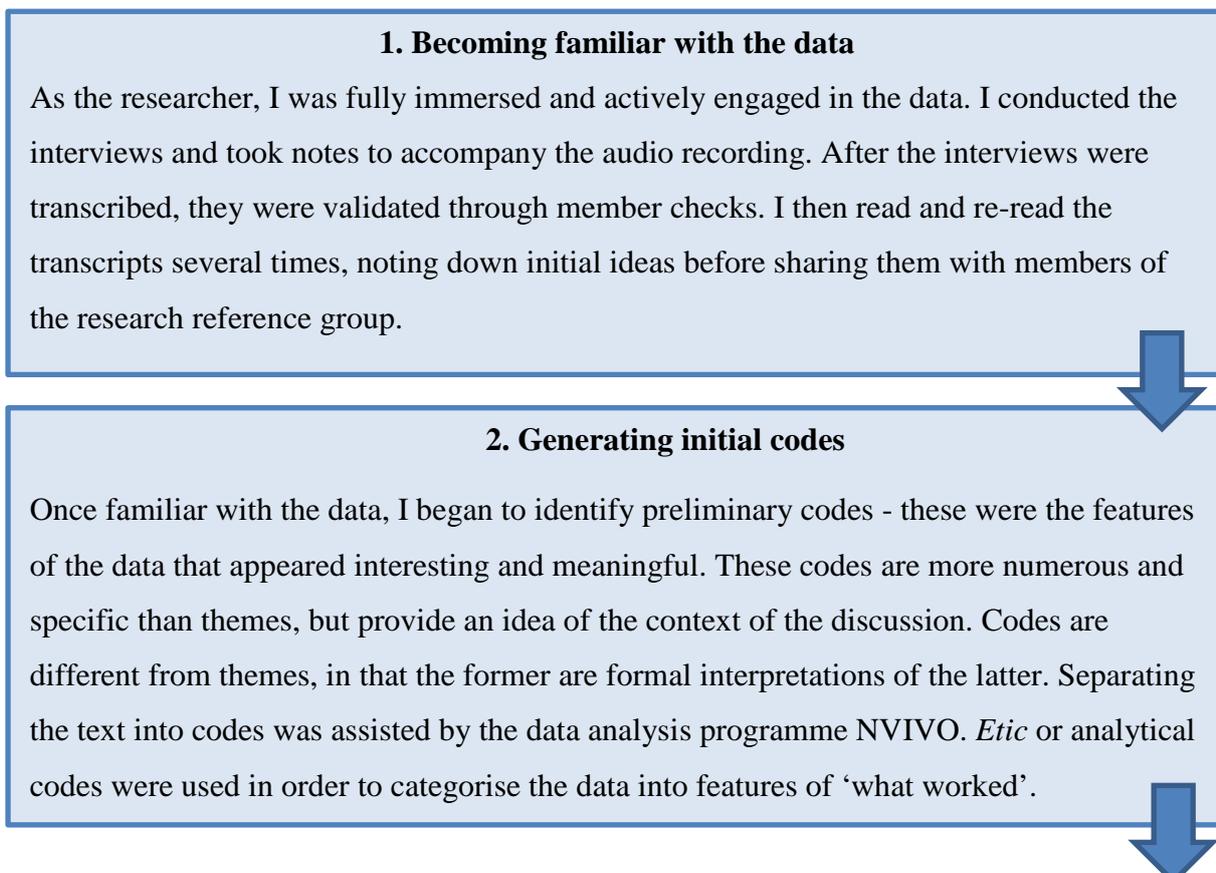
Approaches to Data Analysis

Thematic analysis was chosen as the model for analysing data in this research; it is a systemic process, compatible with constructionist approaches and it provides an easily interpretable and concise description of the themes and patterns within a dataset (Boyatzis, 1998). Braun and Clarke (2006) define thematic analysis as “a method for identifying, analysing and reporting patterns (themes) within data” (Braun & Clarke, 2006, p.79).

The authors’ six-stage model guided the process of data analysis within this research as follows:

Figure 3.4

Six stages of the thematic analysis process



3. Searching for themes



Data extracts were arranged and the codes were grouped together into broader themes to see how these themes related to each other. Categories of these codes emerged as “some level of patterned response or meaning within the data” (Braun and Clarke, 2006, p.10). By focussing through the lens of the four themes of Mason Durie’s (1994) Te Whare Tapa Whā model of health, these categories have provided the themes of the data, capturing vital information in relation to the overall research question. Ryan and Bernard (2003, p.87) define themes as “abstract (and often fuzzy) constructs that link expressions found in text” and which “come in all shapes and sizes”. Eventually, themes should be able to be linked to points of data, that is, they should be able to provide evidence of a given theme within the text being analysed. In Chapter 5 these resulting themes will be named and each theme will receive a detailed analysis in Chapter 6 including how they fit the overall research narrative.

4. Reviewing themes



The identified themes were then reviewed in detail to see if all of the extracts within that theme were coded properly and whether that theme includes data that is relevant and fitting. Some data in a theme were found to have an insufficient amount of similarity and so were split into two separate themes. As suggested by Braun and Clarke (2006), the themes were then reviewed overall in order to check whether they actually reflected what participants had said.

5. Defining and naming themes



This step involved ‘refining and defining’ the themes and subthemes within the data. Names were given to the themes which reflected what the theme was about; rather than paraphrasing the data, key features were identified. In Chapter 5 the data will be presented and explored; vignettes from the participants’ interviews that relate to the themes, research question, and literature are included- these form the major findings of the research. As this research has been formed within a framework of constructionism, the discovered themes will be discussed further on (in Chapter 6) as will questions of how and why participants construct meanings and actions in specific situations whilst also acknowledging that the results are an interpretation and represent only the 20 participants interviewed.



6. Producing the report

When the final set of themes was decided, the last stage was to present them in a report (in the case of this research, in Chapter 5). The story told by the data is discussed in detail in Chapter 6 including what has been found and what I think it all means. Implications of the data will also be explored and it is hoped that the narratives present an argument about how the data responds to the research question.

Source: Adapted from Braun and Clarke (2006, p.79)

Outputs

Following successful completion and defence of this PhD, the research findings, key themes, interpretations, implications and recommendations will be disseminated through various processes including approaches to key stakeholders, conference presentations and possibly journal articles. A summary of recommendations from the research will also be shared within mental health forums and through key processes for feedback to the Ministry of Health. The Health and Disability Ethics Committee, DHB locality committees, service providers and the research participants themselves also stated that they would like to receive a summary of the study's results; this will subsequently be sent to them with de-identified data included.

Summary

This study, through the use of its qualitative strategies of inquiry and its descriptive methodology, sits underneath a constructionist epistemological umbrella. It is guided by a strengths-based approach to find out and promote *what works*. My own belief of seeing service users as experts also shaped the aims of the research. The strength-based approach to social work research resonates with the aims of this study to find out what works for service users and then to promote those strengths in order to better support people. As a supporter of the strengths-based approach Ball (2010), states that little is known about what works with regards to suicide prevention interventions and it is this gap in knowledge which the current research aims to fill.

Following the thorough ethical approval application via the HDEC as well as the in-depth locality authorisation processes *and* the change from the mixture of focus groups and key informant interviews to interviews alone, the methodology of the research was comprehensively shaped and then re-shaped to include a great amount of detail and systematic planning for issues of ethical concern, participant recruitment and of the analysis process. However, the key research question remained: ‘what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?’

The data gained from the twenty interviews was checked for accuracy by the participants and discussed with members of the research reference group. Following this, the process of thematic analysis was carried out according to Braun and Clarke’s (2006) six stage model and was aided by the data analysis software programme NVIVO. As Whittaker (2012) states, through its theoretical freedom, thematic analysis provides a flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account of data. By using thematic analysis, the data was developed into initial codes - a building block of the raw data which identifies a feature of interest to the research (Braun and Clarke, 2006). Categories of these codes have provided the themes of the data as the findings of the research.

The following chapter develops the platform for the data analysis by guiding the reader through the thematic analysis process and also by discussing the framework which will be used to present the data in Chapter 5: Mason Durie’s (1994) Te Whare Tapa Whā model. Following the presentation of the data, each theme will receive a detailed analysis in Chapter 6 including how they fit the overall research narrative, thus capturing vital information in relation to the overall research question.

Chapter 4

Developing the platform for the data analysis

4.1 Introduction

By describing the thematic analysis process used, and through an explanation of Te Whare Tapa Whā model of health with my addition of tukutuku, this chapter will lay the foundations of te whare which will follow in Chapter 5. The interviews were transcribed and then checked by participants before being entered into the data analysis software programme, NVIVO. Braun and Clarke's (2006) six-stage model of thematic analysis then guided the process of data analysis as a way in which to identify, analyse and report themes. The themes which resulted from this interpretation of the data were developed through the lens of the four themes of Mason Durie's (1994) holistic model of health, Te Whare Tapa Whā. A detailed explanation of this model, and my reasons for choosing it, are described in this chapter. My own addition of tukutuku (woven panels or carvings) has been made to this model as the fifth theme of the data. Te Whare Tapa Whā model (and tukutuku) will be used to present the data in the next chapter.

As described in the previous chapter, purposive sampling was used in this research via recruitment through links with existing agencies including the service managers/leads of each of the authorised DHB services and the NGO services. Advertisement through letters, posters and online posts via social media invited potential participants to express their interest. The individuals who took part were aged over 18 years and all had experience of accessing mental health services for their mental wellness. Some of the participants had used mental health services in the past for suicidal ideation/attempt and had since been discharged, others were still accessing mental health services and were ready to be discharged and many continued to access mental health services and were able to discuss their mental health in a safe way. Finally, some of the participants had used/were still using mental health services and were now working in a professional capacity with lived experience of suicidal ideation and/or attempt, for example, as a consumer advocate, consumer advisor or peer support worker.

4.2 Interpreting the data

Figure 4.1

Braun and Clarke's (2006) six-stage model of thematic analysis:



Source: Adapted from Braun and Clarke (2006, p.79)

After a detailed explanation of my use of the model in the previous chapter, a simplified version of Braun and Clarke's (2006) six-stage model of thematic analysis is summarised above in figure 4.1. By following the model, the interviews were transcribed and validated through participants' checking of their transcripts. Each participant was sent their transcription to check for accuracy and were each given a three-week window in which to respond with any alterations or queries. Several participants made alterations to their transcriptions including changes to words or phrases which had been misheard. Also, several participants sent additional notes by email following their interview; these notes were added to their transcription. Once the final version had been received from the participant, I then read and re-read the transcripts several times, noting down initial ideas before sharing them (de-identified) with members of the research reference group.

Sharing the transcripts with the research reference group also helped to reduce the risk of researcher bias by checking for misinterpretations or unwitting biases. The initial codes I had noted were then discussed with the group, some were added and others were altered to better represent the data. This type of discussion also helped to ensure the validity of the coding scheme (Coggan et al., 1997) by ensuring that there was not "a shift in the meaning of the codes" (Creswell, 2009, p.191). Input from the research reference group was also rewarding because their analysis revealed points that I may have missed; highlighting the benefits of

reflexive discussion. Similarly, discussing the coding process with my supervisors provided additional insight into the data and the meanings I had attached to the codes.

Assisted by the data analysis software programme, NVIVO, the data was divided into initial preliminary codes. Each code represented a building block of the raw data which identified a feature of interest to the research (Braun & Clarke, 2006). Segments of data were categorised into codes with a short name which summarised and accounted for each piece of data. As Charmaz (2014) explains, coding is the crucial link between collecting data and developing an emergent theory to explain these data. Through coding, I began to understand what the data meant and the themes that emerged from it. Early attempts resulted in 13 separate codes of *what did work* for the participants, 8 separate codes of *what did not work well* as well as codes of *best practice findings and recommendations* and of *key messages* from the participants. During the coding process, Charmaz's (2014, p.120) 'code for coding' was followed:

- Make your codes fit the data rather than forcing the data to fit the codes.
- Remain open.
- Stay close to the data.
- Keep your codes simple and precise.
- Construct short codes
- Compare data with data.

Through thematic analysis, general qualitative coding by topics which emerged from the data was used. According to Charmaz (2014), this process helps the researcher to define the range of variation in the data and provides leads for conceptualising it further and for themes to be focussed upon. The process of coding - building one's analysis step-by-step from the ground up - strengthened the study by providing answers to the key research question using data which have directly informed the findings.

After recoding some data and merging together other codes, the next stage was interpretative analysis of the organised codes. As this research used a qualitative descriptive methodology, there were no hypotheses for the data to prove or disprove. Rather, using this approach allowed me to ask questions such as "what was it about employment which helped this participant in terms of their wellness following a suicide attempt?" and "why was it that mindfulness [for example] was an intervention which helped to reduce feelings of suicidal ideation and severe depression?" Further questions including "why did a particular form of psychotherapy with a practitioner work for some participants and not others?" were raised.

Certainly, using an approach which was not restricted by a hypothesis meant that further questions could be asked; I could construct my own inquiry as a researcher and participants' social constructions could be understood.

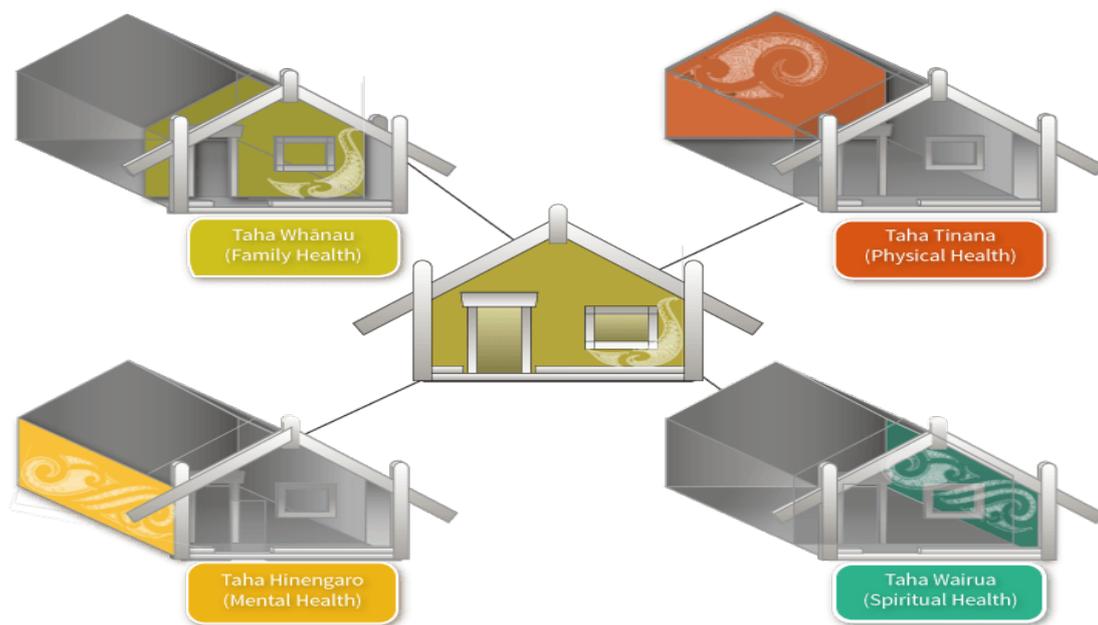
During my own process of analysis, data extracts were arranged and the codes were grouped together into broader themes, which were developed by focussing through the lens of the four themes of Mason Durie's (1994) Te Whare Tapa Whā model of health. From grouping the codes, these themes emerged as "some level of patterned response or meaning within the data" (Braun and Clarke, 2006, p.10) whilst capturing vital information in relation to the overall research question. Stage four of Braun and Clarke's (2006) model is the reviewing of the themes. Some data in a theme were found to have an insufficient amount of similarity, other data were moved to a different theme and all of the extracts within each of the themes were reviewed to ensure that the data included in that theme were relevant and fitting. The themes were then reviewed overall in order to check whether they actually reflected what participants had said. This step led smoothly into the defining and naming of the themes. Adapted from Durie's model, the themes which had resulted were named as using the four dimensions described in the following section. These themes form the major findings of the research and are presented in the following chapter with vignettes from the participants that relate to the themes, research question, and literature in order to increase validity. Stage six of Braun and Clarke's (2006) model of thematic analysis is to produce a report of the findings. The authors suggest that this report should provide an interesting account of the story told by the data. In Chapter 5, my report of the data as findings is presented as a response to the research question and in Chapter 6 the report is discussed in further detail.

4.3 Te Whare Tapa Whā: A holistic model of health

Te Whare Tapa Whā as a model of health has been used in Aotearoa/New Zealand across a variety of sectors, including education (Hay & Campbell, 2012), health (Glover, 2005) and the restorative justice process (Pointer, 2017). According to Durie (1994), all four of the walls of te whare (the house) are equally necessary to ensure strong health, and addressing one health need whilst neglecting the others is futile to our overall hauora (health and wellbeing). As shown below in figure 4.2, the model presents as a house with four walls, each wall represents an essential part of our health: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Whānau (Family Health & Social Wellbeing), Taha Tinana (Physical Health & Wellbeing) and Taha Wairua (Spiritual Health & Wellbeing):

Figure 4.2

Te Whare Tapa Whā model of health



Source: Tāne Ora Alliance (2018)

Te Whare Tapa Whā model sees family and social wellbeing as having equal importance to mental and emotional wellbeing. And so, the model suggests that if treatment services are designed to address an ongoing mental health issue, for example suicidal ideation, but the issues of limited access to education, or inadequate housing are not addressed, then an individual will struggle to achieve holistic wellness. Together, all four dimensions of Te Whare Tapa Whā are vital to our overall health and wellbeing. Each dimension is also intertwined with the others and so, for example, poor physical health can impact negatively on our mental health (Durie & Kingi, 1997).

In order to achieve the best outcomes for Māori and non-Māori, it is important that each of the dimensions are recognised and addressed. According to Cherrington (2009), Te Whare Tapa Whā model of health is beneficial for Māori *and* non-Māori as the importance of a holistic approach to health is not limited to Māori alone. Examples of this can be seen in the Ministry of Health's use of the health model as a holistic approach to best support Māori and non-Māori with disabilities (Turia, 2014) and also as a basis for the development of a care plan for both Māori and non-Māori clients in certain areas of physical health rehabilitation (Turia, 2010) as part of the commitment to care. Similarly, Careerforce (the New Zealand

Industry Training Organisation²¹) promotes a linking between a strengths-based model and Te Whare Tapa Whā. In the teaching of their service delivery models, the training organisation encourages the application of Te Whare Tapa Whā to both Māori and non-Māori as a strength of the model (Careerforce, 2017).

As Hammond (2010) reminds us, a strengths-based model of health takes into consideration a holistic view of health including mental health and recovery by focusing on the strengths of an individual in order to promote their recovery; that is, finding out what works and supporting that to then happen. This philosophy has clear links with Te Whare Tapa Whā model and its four dimensions, which each influence and support the others in order to holistically support our overall health and wellbeing. The strengths-based model acknowledges if something is not working well in someone's life and works to promote that which is. Similarly, if one of the walls of the house is weakened, Te Whare Tapa Whā model recognises that if the wall is not supported effectively then the person's wellbeing may be compromised. As stated by Durie (1998), there is no single indicator that can accurately reflect the state of our health and wellbeing. Evidence of this is presented in the next chapter with powerful examples from participants who describe how the shift to viewing their health holistically has been vital for their overall health, wellness and recovery.

Durie's (1994) model, which encapsulates the concept of hauora (overall health and wellbeing), was chosen as a framework through which to present the data. Originally developed in 1984 as a conceptual framework, Durie's aim for Te Whare Tapa Whā was to support health practitioners to improve their engagement with Māori and for Wairua (spirituality) to be acknowledged and upheld (McNeill, 2009). Te Whare Tapa Whā model of health was chosen as a framework for data presentation because of its compatibility with holistic, strengths-based focussed perceptions of mental health.

As Durie (1994) reminds us, in Te Ao Tawhito (the world before European arrival), an integrated view of health was central to the successful functioning of Māori society. Durie and Kingi (1997) therefore advocate for Māori health models to be used in health care provision. According to Rochford and Signal (2009), Te Whare Tapa Whā is an influential model for describing concepts of health and wellbeing. As the authors state, the durability of the model, its simplicity and its widespread application in health policy mean that it can be used as a way for healthcare and support services to deliver culturally appropriate and more

²¹ Careerforce provides qualifications and supports for the health, mental health, aged care, disability, social services, youth work, cleaning and pest management sectors (Careerforce, 2017).

holistically-effective care for Māori and non-Māori alike. Durie (2001) states that Māori are not a homogeneous group and therefore promotes the use of the model within all cultures as it can be adapted to all levels of identity. Also, Te Whare Tapa Whā, as a holistic model, can be effectively used as an organising tool within qualitative descriptive research which analyses its data using thematic analysis, as it can categorise themes according to their relationship with each other, without privileging one over the other. Accordingly, Te Whare Tapa Whā model will be used in the next chapter as a framework through which to present the data.

As well as its links with a strengths-based model, there were several other reasons to use Te Whare Tapa Whā model of health in this research. Firstly, the themes which resulted from the data matched those of the four walls of te whare. Using the model to subsequently present the data had benefits for myself as the writer and also for the reader to follow the themes through to their presentation as a whare. Secondly, Durie's (1994) model can be seen to have an association with outcome-focussed services and support systems which aim to achieve the aspirations, goals and priorities identified by service users as opposed to those identified by service deliverers (Glendinning et al., 2008; Kingi & Durie, 2000); an aim which this research also encourages. Durie's (1994) holistic model of health puts the individual at the centre – as an expert with knowledge about their own hauora (overall health and wellbeing). This empowerment was also reflected in the demands during the rights movement of disabled people in the late 1960s and the 1970s of “no participation without representation” (Finkelstein, 1985, quoted in Barnes and Mercer, 1997, p. 6) as discussed in Chapter 2 and the (still ongoing) “nothing about us without us” disability rights movement since the 1990s (Charlton, 2000, p.3). Finally, Te Whare Tapa Whā model of health is rooted here in Aotearoa/New Zealand, it is linked to the country and to the people²² and, as a framework that emphasises a holistic view of health, it has become embedded in Aotearoa/New Zealand's health policy.

During the analysis process, I examined the data in which several participants described effective forms of support or intervention that had worked well for them and their mental health including employment, adult education, media influences and having pets. These holistic forms of psychosocial support or intervention fitted into several of the four

²² With my Māori colleagues, I discussed the appropriateness of myself (as a non-Māori) using Te Whare Tapa Whā. I am thankful for their input and for their approval to use the model in my thesis, with their blessing.

dimensions. For example, some participants reported employment as being helpful because it led to them meeting friends, thus improving their social life and social wellbeing, whilst others reported that employment had worked well for them because it had meant that earning money led to an improvement of their previous depression, of feeling consumed by debt. Although Te Whare Tapa Whā is already a holistic model of health, these interventions and types of support systems which fitted into several of the four dimensions are displayed in this research as tukutuku panels for the purposes of presentation and because they signify factors that have equal weight across several of the dimensions within Te Whare Tapa Whā.

Tukutuku can be found inside traditional Māori whare (meeting houses) in the form of woven panels or carvings which tell a story of the history of the iwi (tribe) or hapū who belong to a particular whare. These tukutuku (woven panels or carvings, pictured in figure 4.3) overlap each of the four walls connecting each dimension and are often spread over two different walls. As a metaphor in this research, this represents how psychosocial interventions/support systems (such as employment) have been an effective intervention for some participants as a way to improve their social wellbeing (Taha Whānau) and for others, employment was key to improving their mental wellbeing (Taha Hinengaro). Therefore, employment (along with other, psychosocial interventions/support systems), will be presented as tukutuku in the following chapter.

Figure 4.3

*Pictures of tukutuku*²³



²³ Pictures taken from inside Tūtahi Tonu- the Marae located within the Epsom Campus of the University of Auckland.

Summary

The themes which resulted from the thematic analysis process were developed by focussing on the data through the lens of the four themes of Mason Durie's (1994) Te Whare Tapa Whā model of health as well as through an additional, interwoven theme of psychosocial interventions. Therefore, Durie's model will be used as a way to present the findings of the research in the following chapter with the additional theme presented by tukutuku. A strengths-based approach guided the research and will shape the next chapter in order to present *what works* for service users – their own unique constructions regarding suicide prevention interventions, treatments and services.

Chapter 5

Findings: Presenting te whare

5.1 Introduction

Chapter five presents the findings of the research, the data which resulted from the interviews with twenty participants (four men and sixteen women) between December 2017 and April 2018 within the North Island of Aotearoa/New Zealand. Vignettes²⁴ from the participants which relate to the themes, research question and literature are included in this chapter and the narratives within them form the basis for the major findings of the research. Participants were invited to choose an (optional) pseudonym under which they would be quoted.

Following the presentation of the data through Te Whare Tapa Whā model and the metaphor of tukutuku, participants' responses to questions about best practice will be presented - what it looks like for them and what else they recommend that best practice should include.

The findings show participants' constructions of their own unique perceptions of *what works* regarding suicide prevention interventions, treatments and services. By employing a constructionist, qualitative descriptive methodology, this chapter demonstrates how meanings (the findings of the research) have emerged as knowledge from the data. Therefore this chapter has been guided by a strengths-based approach to find out and promote *what works*. It is hoped that the findings advocate for service users to be seen as experts; a view which also shaped the aims of the research. As strengths-based practice encourages, it is crucial to find out what works for service users and then promote those strengths in order to better support people. It is important to note, however, that the findings of this research can only represent the twenty participants interviewed and, whilst relevant connections could potentially be made outside of this participant-group, the data does not provide evidence of what works in terms of mental health wellness and recovery for any other individual within Aotearoa/New Zealand or abroad.

In Chapter six, the findings presented in this chapter will be discussed in more detail. The potential implications of the findings will be discussed in the following chapter as well as recommendations for the future. The inclusion of participants' key messages will aid that discussion.

²⁴ As this research aims to promote service user's voices, it is important to state that participants' words have been quoted as they were originally said, without any corrections to grammar.

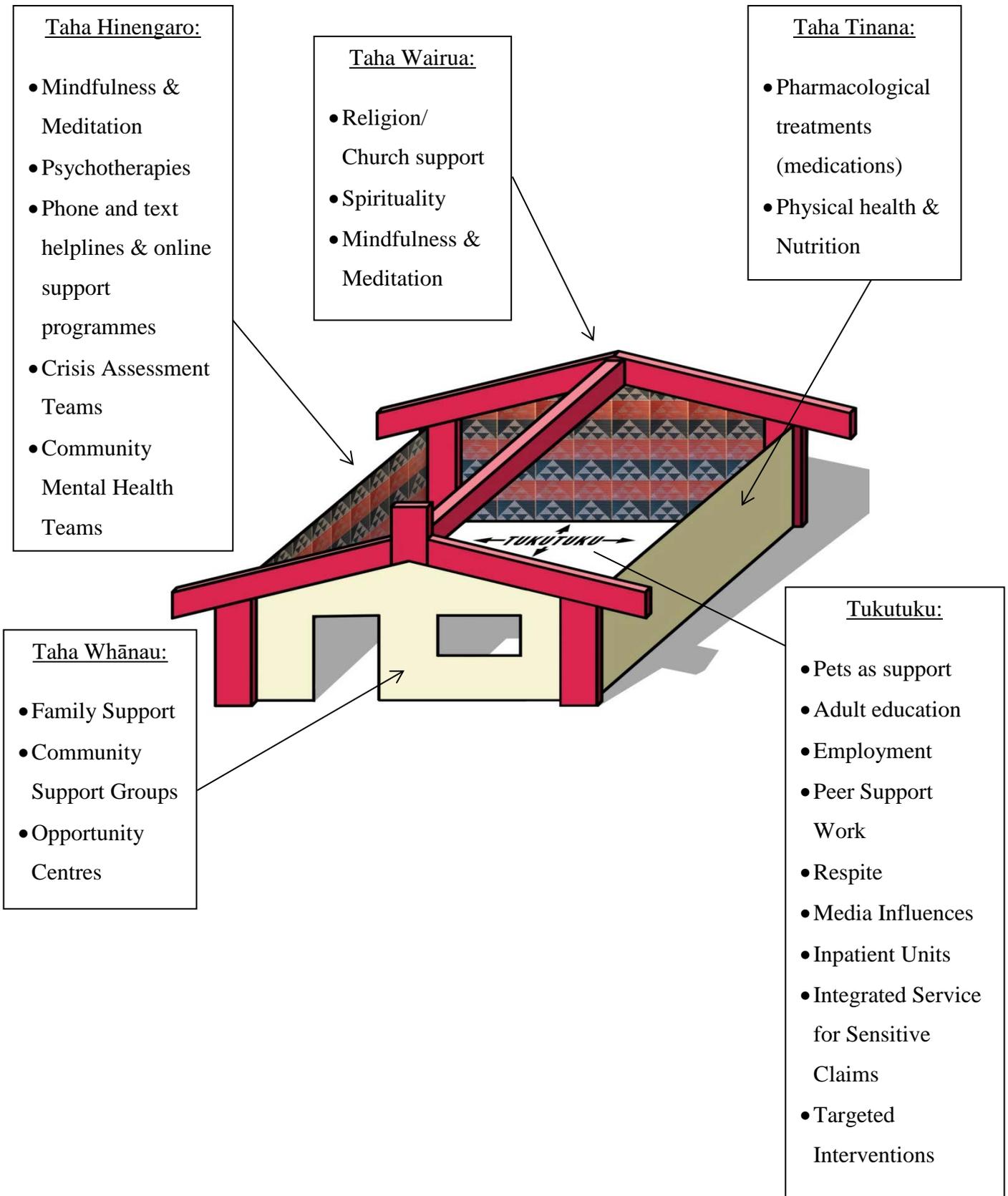
5.2 Presenting the data

Aided by the data analysis software programme NVIVO, the process of thematic analysis was carried out according to Braun and Clarke's (2006) six-stage model as discussed in the previous chapter. The last of the six stages, the production of a report, is presented in this chapter. From the data, themes began to emerge relating to how particular practices had contributed to participants' wellness. Through my interpretation of the data, the resulting themes were developed through the lens of the four themes reflective of the four dimensions of Mason Durie's (1994) model of health. The model therefore has been used as a framework for data presentation and each of the following four sections begin with a graphic illustrating the findings which will be presented in that theme. The vertical text represents the wall of the whare (house) as a theme and the horizontal text represents the data included within that wall.

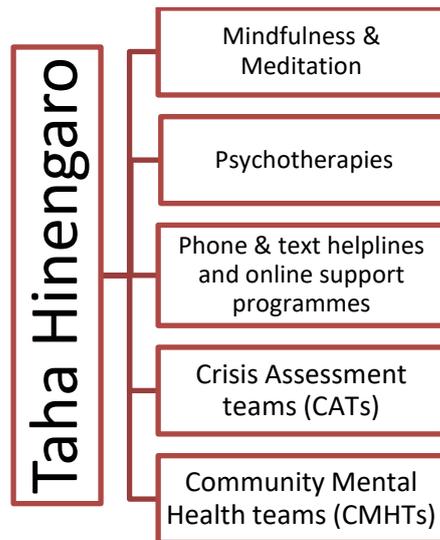
The four walls/dimensions are as follows: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Whānau (Family Health & Social Wellbeing), Taha Tinana (Physical Health & Wellbeing) and Taha Wairua (Spiritual Health & Wellbeing) (Durie, 1994). A presentation of tukutuku (as described previously) follows the four walls and will represent the overlapping connections provided by psychosocial interventions/ support systems as effective interventions for some participants. A visual representation of the data presented in this chapter can be seen in figure 5.1 and the contents of each dimension are listed in the labels:

Figure 5.1

Te Whare Tapa Whā with tukutuku: A framework for data presentation



5.3 Taha Hinengaro (mental health and emotional wellbeing)



Mindfulness and meditation

Durie (1998) refers to this dimension as the expression of thoughts and feelings through an inseparability of mind and body. Certainly, several participants reported mindfulness and meditation as practices which supported their mental health and wellbeing in a way which helped them to regulate their emotions during times of distress. One participant, for example, when discussing how mindfulness classes provided by their community mental health service had benefited them, stated “they helped me take a little bit more control over my mind and my brain” (Bob), whilst others reported that incorporating mindfulness and meditation as a routine in their daily life, for example colouring-in pictures mindfully, is effective for them:

So when I do the colouring-in, that helps and controls my mind because I have to do it really nice, I’m a bit of a perfectionist. So I’m concentrating not going over the lines and it actually takes away all the horrible thoughts. (Carol)

Several participants stated that learning about mindfulness and meditation led them on to discovering other practices which they felt simultaneously improved their mental health and emotional wellbeing including yoga, iPad applications to support better sleep, Buddhism, sensory modulation and a gratitude practice. According to Emmons and Stern (2013), gratitude practice involves a daily reflection on one’s day and focussing on positive things which have happened. After several weeks of daily reflection, one’s neural pathways are

redirected towards focussing on more and more positive things. Advocating for an increased use of gratitude practice, Tamara reported a rise in her self-awareness, compassion and emotional resilience: “after about two and a half weeks my whole perspective on the world changed...I was in awe of how my life had just changed so dramatically and was consistently good”.

Durie (1998) describes Taha Hinengaro as an inseparability between mind and body. Delia’s experiences of mindfulness and meditation indeed led her to realising this connection and the need for her mind and her body to be in more of a balance:

What it taught me was to try and detach myself from my thoughts because when you are unwell you believe everything that is going on in your head and slowly I started to learn it was the chemicals that was creating all these thoughts and actually I don’t need to take everything going on in my head seriously.

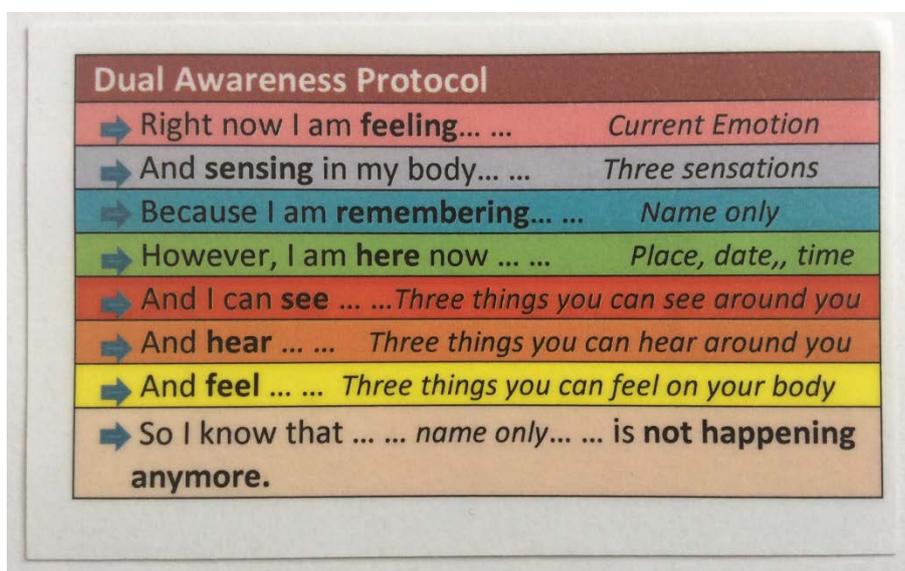
Psychotherapies

As well as mindfulness, Delia stated that psychotherapies provided to her by a psychologist were invaluable to her mental wellbeing. Cognitive behavioural therapy, for example, led Delia from feeling like a victim of her own thoughts to feeling in control of her emotions and to having an ability to challenge her own thinking. Each of the twenty participants stated that some form of psychotherapy, facilitated by a counsellor, therapist, psychologist or psychiatrist, was one of the main components in their recovery following a suicide attempt and/or is one of the main treatments which continues to support their mental health wellness, with many using the techniques from these therapies as ‘a way of life’.

Several participants reported their ability to use therapeutic strategies, taught to them by a counsellor or therapist, in their daily lives. A ‘value card sort’ and also a ‘dual awareness protocol card’ (pictured in figure 5.2, as used by Annie), for example, were samples of therapeutic exercises which participants carried with them as accessible ‘tools in their toolbox’. As grounding techniques in order to elicit ‘change talk’ or ‘change thoughts’; these were highly effective ways for participants to deescalate their suicidal crises.

Figure 5.2

A dual awareness protocol card, made and used by Annie



Claire.B had accessed acceptance and commitment therapy (ACT) for one year as well as two three-month courses and then worked for six months as a peer facilitator of an ACT group. As a psychotherapy, ACT worked better for Claire.B than others she had tried as it helped her to think about her wellness in an interpersonal context and showed her how staying well was important for others as well as for herself:

It has helped me to think about how I cannot just stay well for me but stay well for others and how I treat myself and how I look after myself has impacts on my relationships and has impacts on, say, if I am co-facilitating a therapy group and I’m saying this is what works for me then I need to be actually doing that in order to say this is what works for me.

Other participants advocated for the use of dialectical behaviour therapy (DBT) following their own positive experiences of the treatment. Anita, for example, believes that psychotherapies such as DBT should be taught in secondary schools in order to try and better support the future adult mental health population:

I think it is skills that especially teenagers going through all those emotions could really benefit, from backgrounding that emotional regulation, learning to cope and identify your emotions and what to do to deal with them... I think it would be invaluable. (Anita)

Art therapy is a form of psychotherapy which can be used to reduce suicidal ideation and distressing, traumatic thoughts. Annie described her experience of art therapy as a mixture of sensory modulation and an expression of thoughts and feelings through artistic materials as a way to talk about deeply traumatic events without having to verbally discuss them. The therapist supported Annie to ‘translate’ her creations in a safe space which, for Annie, was highly effective as a form of therapy as it meant that she didn’t need to re-tell a traumatic story: “looking back now, what I’ve learned in the last years, you are constantly re-traumatising yourself by retelling the horrific events that occurred, so you are constantly staying in that heightened sense of fear” (Annie).

Phone and text helplines and online support programmes

One quarter of the participants stated that they had used phone and text helplines, including those provided by Lifeline, Warmline and Youthline, as well as the 1737 phone and text service launched by the Ministry of Health in June 2017. For some participants, these services provided the initial step towards accessing counselling, while others used the service whenever they felt anxious or overwhelmed.

I called up Lifeline, the 0800 number; actually it was two years ago now, just when I had a job interview for my job. I was stressed out afterwards. It was just a really weird experience, I’d never had a job interview across from a desk, I’d never had that before and I was leaving the place and I felt like the world was crashing down around me because of the stress and fear. So I called Lifeline and I talked to them for a bit and they said “oh we do one-to-one counselling” and they put me onto a counsellor and Work and Income paid for 10 sessions for that. (Bob)

It was a helpline that, you know, ultimately helped me when I became aware that my suicide attempt wasn’t happening as quickly as I wanted to, I wasn’t getting the end result,

and I don't know, something just clicked in me and I actually at that point called the helpline that I had been given and had in my phone and that was the start of getting assistance. So they certainly have a place. (Delia)

I do talk to Lifeline. I got this amazing counsellor on Friday and she dodged a bullet for me because I was planning to do something on Friday and she talked me out of it, you know, because she listened, she heard. (Frances)

None of the participants reported using online support programmes. A potential reason for this, as well as a suggestion from a participant on the availability of online therapies, will be discussed in the next chapter.

Crisis assessment teams

The making of phone calls to crisis assessment teams (CATs) for support and often for immediate help was a common experience for half of the participants. Each DHB has its own mental health crisis assessment team which service users can contact in times of crisis. Of the twelve individuals who had used the service, two participants (including Carol) reported only positive experiences: "They were good...I think it was when the crisis team got involved then they would say go to respite because I said "please don't put me into hospital". However, four of the twelve participants who had accessed a CAT described only negative experiences:

It's like they didn't listen. For the people that are supposed to be there for, you know, for the people that are supposed to be there, for the first responders, and if somebody is saying to them "look I'm not safe" then you would think that they would come out and check on somebody or they would keep you on the phone for a little bit longer and just give you some skills or talk you through it, you know, bring you around to reground you rather than getting off feeling like you just hadn't been listened to and weren't worth anything. To me it actually put me in more danger of doing something than not and I still don't understand that. (Anita)

To me the crisis team are no good, they came out and they told me when I was in a real state just to start vacuuming and stuff... we rang crisis and they said just get her to clean out some of the cupboards. This is at 3 in the morning and vacuum the house and stuff like that and my parents were like "what the hell?" (Amy)

And six individuals received varying levels of helpfulness “depending on who answered the phone” (Frances):

But then I’ve had other experiences where I’ve been like trapped at Uni and I’ve been hysterical and I called the crisis team... and just repeating back what I had said to them was so, so validating and so helpful. (Claire.B)

When I was suicidal way back in 1993 there was a male nurse from the crisis team and he would phone me and see how I was ...he was amazing and for probably about two or three weeks he called me every night and came passed or every day like night or day, he was really amazing. (Annie)

Community mental health teams

Similar to CATs, each DHB also provides a community mental health team (CMHT). CMHTs are often involved from the early stages of an individual’s support programme and can provide community support workers, key workers, psychiatrists, social workers, employment consultants and occupational therapists, among others, with the aim to empower service users on their recovery journey. Half of the twenty participants discussed the way in which CMHTs contributed to their wellness. From initial meetings to ongoing support, the variety of services provided through CMHTs played a significant role for many participants:

I just picked up the phone and called the community mental health services and started seeing a psychiatrist there. They saw me really quick. They helped me a lot. I’ve been helped by the community mental health services before and always their response is really fast. (Bob)

I do know that the things that I have seen that work are when they have those family meetings in mental health and they pull in different areas. Your key worker, your psychiatrist, your family and you have those big huis [meetings] and you meet with everyone. I think that is a really good idea because we are all on the same page here and for me personally, when I had those, when I was in hospital, even though I was fucked in the head I thought to myself: I fill this room with people that give a shit. There are 13 people in this room and everyone is here for me. So even though I was unwell I thought to myself well I have got people supporting me. (Carlos)

So it was actually the main help which was the community support worker for me... I actually wasn’t going out, I wasn’t seeing anyone, I had stopped seeing all my friends and

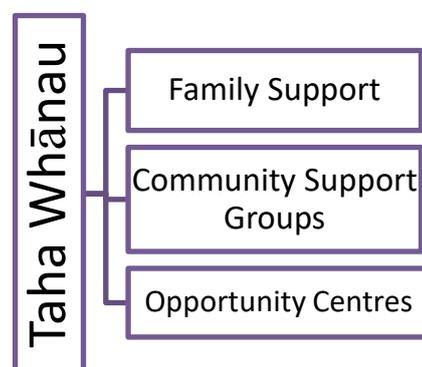
everything. So it was that community support worker who was really, really helpful. She got me to go out and now I go to the colouring-in myself and they actually helped me get a part time job...she kind of helped me do my CV. You see that was so quick I didn't have too much time to panic and with her encouragement and she was looking over my CV so that gave me kind of probably "oh maybe it is possible to get a job", you know. (Carol)

So looking at my social worker now she has been helping me see a budget advisor and stuff because I was like \$3,000 in debt...So she got me to see a budget advisor...and yeah I got out of debt because of her. (Rose)

She [social worker] was awesome and because of that, that made my recovery start faster, she would take me out for lunch and we sit and talk about work and life. I did have cancer treatment as well in this time so this changed our relationship. She was really caring towards me. She went to the hospital with me for radiation and we would go and have coffee before. (Annie)

The findings which relate to Taha Hinengaro include mindfulness and meditation practices; how varied and effective psychotherapies can be; the difficulties faced by some of the participants who accessed a crisis assessment team and the benefits of the numerous services provided by community mental health teams. These findings, as well as participants' suggestions for online therapies, will be discussed in the following chapter.

5.4 Taha Whānau (family health and social wellbeing)



Family Support

As well as one's extended family health, Taha Whānau includes wider social systems and a sense of belonging, sharing and caring (Durie, 1998). Taha Whānau represents relational links with culture and identity beyond the nuclear family concept. Three of the twenty participants in this study felt that their whānau had played a vital part in their wellness and provided an ongoing source of support unmatched by service providers.

Friends, family support, it sounds cliché but actually having people that will listen to what you are going through. Even though they may not understand it... but sometimes it is just enough to get you through if someone just gives a shit...So friends and family are a massive thing because when a health professional walks out of your life the day to day grind is usually with your friends and family. (Carlos)

And my friends are very important to me and communicating like honestly and timely about how I'm going and not holding it all inside but finding appropriate times to say look I'm struggling is really, really important to me. And my family is quite important to me in my wellness although they do kind of worry about me and I feel a pressure to show them I'm okay even though I'm not. They are still important to me; they are still a reason to keep going. (Claire.B)

Whenever I have the thought of "oh my god I don't want to be here" and it's like I look at what is going on that is giving me this feeling. So I look at that and I write that down and then I write down what options have I got, what are my options and then I'm really lucky now because I've got an amazing husband...[so]what really worked was the support of my husband and my sons. (Annie)

Community support groups

The importance of wider social systems outside immediate family units was also evident from several of the participants' responses. Five participants described the crucial role which community support groups played in their recovery following suicidal ideation and/or attempt. These groups ranged from Narcotics Anonymous and Alcoholics Anonymous support groups to community arts centres offering classes, as well as community gardens and city farms which have been designed to be inclusive, welcoming volunteers with mental

health challenges to work within them. Bob described the far-reaching effects of the support groups he had accessed because of his narcotics and alcohol addictions:

In the early days, having a group of people who were trying to live with the same problems as me definitely helped to save my life. The special thing about it is that there are no paid staff, it's all mutual support, and it's free so no hidden agenda. And actually the volunteer work I ended up doing with NA led me to my career today as an addiction counsellor.

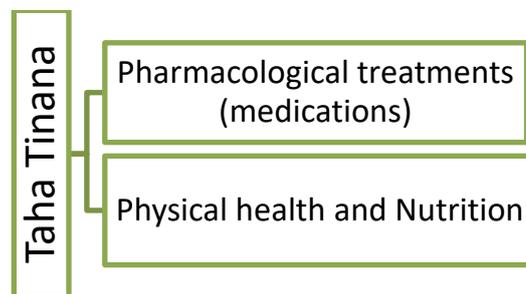
Opportunity centres

In Aotearoa/New Zealand, opportunity centres provide support with employment and recovery to people with mental health conditions. For Ghost and Frances, opportunity centres had provided 'a lifeline' to the outside world, helping them to feel connected to peers, educators and health practitioners within a safe environment so that they could learn household skills and employment skills whilst being active members of their own community: "I reckon having places that me as a mental health consumer can go to and like be treated non-judgementally like here ... because if this place wasn't here I literally would be six feet under." (Ghost)

However, both participants expressed their disappointment with the lack of availability and funding associated with such opportunity centres. Frances' local opportunity centre had been closed down several years ago and Ghost was critical of the amount of funding provided to her local centre: "They only get allocated \$150 a week for food to feed 20 plus members per day, five days a week". At the time of writing, it is unclear how the Labour Government's 2018 budget for DHBs will be spent with regards to mental health services including opportunity centres. However, for Ghost, opportunity centres have been a vital source of support since her suicide attempt and they continue to strengthen her Taha Whānau during her struggles with her mental health which she describes through a powerful analogy:

It's like you are suffocating and drowning while being submerged in quick sand inside a dark abyss - that is the best way I can think of to describe mental health. And you are in a constant battle with your mind 24/7.

5.5 Taha Tinana (physical health and wellbeing)



The third component of the holistic framework through which the data analysis is presented is Taha Tinana (Physical Health & Wellbeing). Having good physical health is only one dimension as a set of indicators; however, it is extremely important to our overall hauora (health and wellbeing). There exists an extensive amount of research which argues that improved physical health has a beneficial effect on the improvement of our mental wellbeing and vice versa (Seeman, Dubin & Seeman, 2003; Aukst-Margeti & Margeti, 2005; Lyons & Chamberlain, 2006), arguing that focusing on one's physical health alone is futile unless our wellbeing is addressed holistically. Although pharmacological treatments (medications) have clear implications for our mental health, I have chosen to present these treatments within the wall of Taha Tinana as medications affect our bodies physically and because their origin lies in a medical model of physical diagnoses and prescription.

Pharmacological treatments (medications)

All twenty of the participants had used medications relating to their mental health at some point in their lives, with many still doing so. Specific serotonin reuptake inhibitors (SSRIs) were very common, with many participants describing their use of antidepressant SSRI medications such as citalopram, fluoxetine and paroxetine. Antipsychotic medications including quetiapine, clozapine, olanzapine and risperidone were also used by a majority of the participants. Some participants reported using lamotrigine to control epileptic seizures, sodium valproate was used to treat bipolar disorder and others participants had previously been prescribed stelazine for anxiety.

Nine of the twenty participants reported positive effects from their medication, including Anita: “I’m happy with that because honestly it keeps me stable and I need to be stable.” For some participants, like Carlos, medication has a positive effect on their physical health in different ways:

I don’t sleep without it. Olanzapine actually makes me normal-ish. Without olanzapine I don’t sleep, I will sleep five hours or four hours a day. It also keeps me regular with my food as well or I wouldn’t eat. I smoke cigarettes and if I am off olanzapine I would just smoke and I won’t eat.

For Carlos, medication helps him to focus on a problem more clearly; he went on to describe his positive experience using medication with a powerful analogy:

I think what schizophrenia is, is like having very sensitive skin but olanzapine is like putting sunscreen on just to kind of take the edge off things. It doesn’t necessarily stop what I feel, but it doesn’t hurt as much.

Five of the participants believed that they felt the medication was having a positive effect on their mental health and wellbeing but the side effects (including a numbing of emotions, weight gain and/or memory loss) were a very negative part of the compromise. Six participants stated that they did not like the medication they were taking either because of the side effects or because they felt like it was not having a positive effect. Of these six, one participant reported becoming so addicted to diazepam that she needed to attend a drug rehabilitation programme whilst others felt that their medication was controlling them and forcing them to behave in ways which society would like them to: “I feel quite like blasé about it because in many ways I often feel I just take this stuff just so that they won’t think I’m being stubborn or something. I take it to please them.” (Ralph)

Physical health and nutrition

Out of twenty participants, nine felt that keeping physically healthy was essential to staying well, mentally. As echoed by Durie (1994), our physical health is connected to our whānau, spirit and mind. Addressing our mental wellbeing whilst ignoring our physical wellness, and vice versa, is almost futile according to Lopresti, Hood and Drummond (2013). Even with the most sophisticated systems, attempts to address one dimension and not the others are often incapable of producing any truly meaningful or adequate results. Through the promotion of Te Whare Tapa Whā however, Durie (1998) states that these issues must be

addressed altogether and that a holistic approach to public health is essential. This was reflected by many participants who felt let down by their GPs' or psychiatrists' prescribing of medications rather than suggesting referrals to a social worker, dietician or employment advisor, for example.

They gave me medications to take and I thought "great, this will work and everything will be fine now" but then I'd go back to my mildew apartment, my diabetes and my asthma, my debt, my unemployment and arguments with my girlfriend. No job meant I couldn't afford to eat healthy and a damp apartment would flare up my asthma. Everything would fall apart again but it would just be numbed a bit by my meds but it would all still get so bad that I'd still attempt suicide. (Michael)

Bike riding was incredibly important for Carol's recovery and ongoing wellness as it led to many unanticipated positive outcomes:

I started going every day and that made such a difference because then it helped with my physical as well as my mental because I was having a lot of pain with my autoimmune and my spondylitis, so that probably contributed to my depression as well. So my hip started getting stronger from the exercise. I started sleeping better; I noticed my mood was improving. So I found that really, really did help and it was in the estuary and it was beautiful and ... I said these affirmations like I am just really thankful, gratitude, look at this beautiful water, you know, I was going out.

So that kind of helped because it got me out of the house, it took me a while to do it, but once I got out it is not as hard and I wasn't talking to anyone so I made an effort because they can't see you under your helmet, all day you feel safe. I would say "hi" going by and they would say "hi" and you can see some of them even smile. So that got me being part of society; so that really, really helped me a lot.

For both Taimi and Tamara, who reported that medication seemed to have no positive effects on their mental health, including their suicidal thoughts, seeking out alternative tools which were not medication, was key. These alternatives included diet, exercise and the diagnoses of physical root causes of mental distress such as autoimmune diseases. Identifying physical root causes of mental health distress was not an anticipated finding of this research but it was essential to some participants' recovery. Taimi, for example, described the way in which identifying the autoimmune conditions she had and then addressing her diet and nutritional intake made an enormous difference to her mental health. Health screening at an early stage when people start to present with mental health distress is something which is lacking in

Aotearoa/New Zealand, according to Taimi, but is something which could address issues early on:

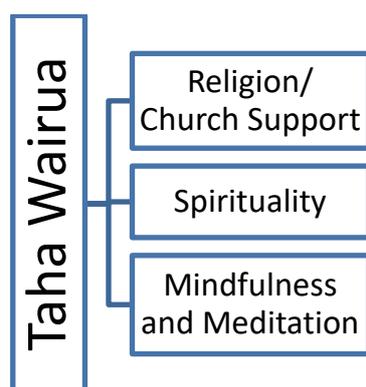
If people present anywhere with mental distress symptoms we should be checking their thyroid, checking for coeliac and checking for vitamin B12 deficiency which is the highest correlation, the most common reason why people have depression and it is not picked up.

None of these things costs particularly much money but we test for metabolic screenings and diabetes and blood sugar and it makes a difference to people’s wellbeing, but we are not doing kind of across-the-board tests on people. A lot of that stuff is picked up really late or never.

So it could be a quick blood test to see whether your inflammatory markers are up and it is not too hard to have a diet that reduces that inflammation and it is going to make an effect on your mental wellbeing.

To try to better support and inform people in Aotearoa/New Zealand about this risk, Taimi would like to see nutritionists employed in DHB health and medical centres “not only in order to get their nutrition back on track, but for consumers to understand themselves that what they are putting in their bodies is contributing or not to their mental wellbeing” (Taimi).

5.6 Taha Wairua (spiritual health and wellbeing)



The fourth theme of the data, Taha Wairua, includes unseen and unspoken energies, faith and spiritual awareness (Durie, 1998). To try and present participants’ responses fairly, contemplative practices such as mindfulness and meditation also features in this dimension

(as well as in Taha Hinengaro - Mental Health & Emotional Wellbeing) because for some participants, mindfulness and meditation held spiritual connections and some participated in regular meditation because of their faith e.g. Buddhism. As Durie (1994) explains, Taha Wairua represents an individual's search for meaning and purpose in life, the values and beliefs that determine the way individuals live, their personal identity and self-awareness. For some individuals and communities, Taha Wairua is linked to a particular religion whilst for others, it is not.

Religion/church support

A sense of meaning and purpose, a feeling of belonging to a group or community and also a source of guidance around life-changes are the ways in which some participants described the role of Taha Wairua in regards to their mental health wellness and recovery following a suicide attempt. Indeed for Amy, whose faith and venture to attend Bible College gave her a feeling of relaxation and inner peace, belief in God had radical effects on her life:

Since I started to believe in God and the faith, I didn't need to prove myself, I didn't need to, yeah I just had a peace in me that I hadn't felt before. I guess that finally there was a reason for being here on this earth, it wasn't just we are here, we get old, we suffer and we die there was something beyond and that gave me hope as well.

During her interview, Amy described her experience of a breakdown and severe psychotic episodes; she tried many treatments including medication but nothing seemed to help. Through her journey, Amy attended a Christian healing centre where she found religion and supportive people. It was these interventions which led to a turning point in Amy's mental health recovery journey and her faith is a continuing support: "I had a lot of prayer support...and my faith has since been what has been keeping me well."

Spirituality

Michael's (relatively recent) experience of Buddhism and the meditations which are a part of it provided "a completely different way to focus on reality". As Michael explained, one of Buddhism's several key messages teaches its followers that all life is suffering, pain and misery and that this suffering is caused by selfish craving and personal desire but that this craving can be overcome. Michael related this to negative experiences in his life and the mental un-wellness which he had experienced as a result: "So instead of connecting to some sort of pleasure, it [Buddhism] teaches us to disconnect from the things that hurt us and

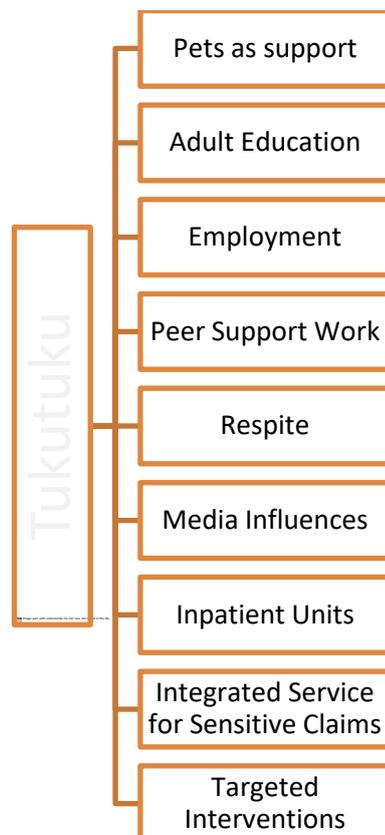
allowing ourselves to be happy.” Similar to Taimi’s advocating for alternative types of therapy to be available, Michael too was critical of the lack of information provided to him by his GP following his suicide attempt and during his recovery journey:

After all the mental illness problems that I’ve been through that was something that was never suggested ... no one ever said if you were tempted by suicide have you thought about alternative forms of healing rather than just taking medication and talking to your doctor?

Mindfulness and meditation

The spirituality gained from regular meditation and the practice of mindfulness provided Michael (and also Paula) with a spiritual connection - an intervention which decreased their suicidal ideation and distressing thoughts. This was different to the experiences of meditation and mindfulness reported by other participants previously about how the practices had affected their mental and emotional wellbeing.

5.7 Tukutuku



For the purpose of data-presentation in this research, tukutuku (woven panels or carvings which overlap the four walls/dimensions inside a whare) is a theme which represents the other remaining factors reported by participants when they were asked ‘what worked?’ Tukutuku panels connect the walls of an already-holistic model of health and show how psychosocial interventions, treatments and/or support systems can affect our mental, physical, spiritual and family health and social wellbeing as interwoven additions within our overall hauora (health and wellbeing).

Pets as support

Fourteen of the twenty participants interviewed reported an element of tukutuku presented in the graphic above. Mary, for example, stated that her pet dog played a large part in her recovery as walking her dog meant that she “had to get out of bed that day”; she interacted with other people and got some exercise. Also, the routine of walking her dog appealed to Mary as a routine-oriented person.

Adult education

Returning to adult education by enrolling in university meant that Bob began to participate in society again and felt productive. After “trying to get well for about a year”, Bob attributes his time at University as one of the main things that kept him on the path to wellness:

Social participation, whatever, just being a part of society and being productive, yeah I would never of thought that enrolling in university would actually be that beneficial for me, but going there meant I met people, meant I socialised, meant I talked to people and I made friends, I got a job, it gave me something to do. So I started to believe in myself.

I got affirmations back from the tutors. I found out I was good at reading and writing whereas I left school at 13 and the teachers told me that I was stupid and I’m never going to university and they used to put me in remedial classes or made me sit out in the hallway. They’d just punish me all the time and they made fun of my reading and writing abilities and I just went to hell with their tests and wrote fake answers in the tests to take the piss because I thought I was dumb. They told me I was dumb they made me feel like I was dumb and then going to university opened up my whole world thinking “far out, you don’t actually have to finish school to go to university and I can read and write” and actually I got As.

Employment

Of the 14 participants, whose responses are presented by tukutuku, seven stated that either finding or returning to employment has been pivotal in their recovery following a suicide attempt and/or in maintaining their mental wellness. For example, for Carol, regaining confidence after unemployment as well as interacting with other people has proven vital for her social anxiety:

So having that job it gets me up because I used to sleep in. I have to get up every morning ... get up, get all ready and go to work and I come back and I think I have done such a good day's work. It has really made a big difference. So having employment really, really did, you know, it gave me purpose and meaning in life because my kids had all left home, I used to be busy when the boys were here and now they've all kind of grown up and I'm thinking what else left is there?

So I think having that job even though I'm finding it easy now, I love it and you know what it is, I don't have to be close to them, but I am able to talk to people out there. So that social anxiety I don't have to get close to them but I can talk to them and ask how they are and it is a bit different than having close friends. So I think that helped a lot.

Delia's occupational therapist supported her to find employment that worked for her. For Delia this meant part-time hours doing a variety of different jobs with each having a support element to them. These varied employment roles, which helped Delia's social isolation, meant that she could help others, an activity that she enjoyed. Also, the part-time hours meant that she did not feel overwhelmed or exhausted.

Actually I want to help other people and through a lot of ways that shifts the focus off me. And a big part of being unwell is you become so introspective and you just become so obsessed with yourself and your thinking that this work is about focusing on other people which isn't just about helping other people it is about helping me as well to not have all the focus on myself because that is not a healthy state.

Other participants, such as Claire.B, described the supportive relationships which they developed at work and how these had been essential to their recovery. Whereas Carlos, for example, found that working in a creative environment led him to inspiring opportunities:

It is amazing; I never would have seen it. If you told me five years ago I would be doing this job, the job just grew and I took every opportunity and met people along the way. I've met some really cool people.

Carlos' experience of employment as a psychosocial tool for mental health recovery and wellness was echoed by Bob's inspirational journey:

So I work in addiction treatment and the benefits I get from that is even more rewarding than university really because I get to actually help people and it takes me out of myself for the day and it feels really good to be part of a group of people helping others and getting to watch people change their lives like I did.

Peer support work

Peer support work was hugely beneficial for several of the participants who had both received and provided peer support. Being engaged in the peer support workforce, for example, shifted Willa's thinking from identifying as "being messed up" to recognising her own struggles "within the package of humanity, and particularly humanity that has high sensitivity and has experienced trauma" by observing, supporting and being supported by other people whom she deeply respected.

Delia reflected on her experience of peer support as a "wonderful service" and Taimi described the forming of a relationship with a peer support worker as a consumer's first step towards realising that they have choices in their lives. For example, some peer support services offer consumers biographies of potential peer support workers to choose from. It became clear after speaking to many of the participants that peer support work can be invaluable to a person's recovery following a suicide attempt and that "walking along with someone who has been in your shoes" (Paula) can often provide wellness-support which is as effective, if not, more effective than that provided by clinicians. For participants like Pearl, however, the potential for peer support work has not yet been realised: "I think peer roles are not prioritised to the point where I think they are really valued."

Respite

Paula's powerful analogy of "walking along with someone who has been in your shoes" is also reflected in her experience of peer-support-led respite services. Claire.B also shared her experience of respite and especially the relatability between peers: "I find it helpful because

the staff there make no assumptions about what is going on for you. They don't know your diagnosis and they say "we are here to listen"."

Six of the twenty participants interviewed felt that respite services had been vitally important to them, both in times of emergency and during their ongoing wellness. The number of allocated respite days varied between the six participants. Carol described her experience of respite as a "relaxed and calming environment" and Rose declared the service had saved her life.

Media influences

A substantial amount of research exists which discusses a link between media reporting on suicidal behaviours and actual suicidal ideation and/or attempt (Sisask & Varnik, 2012; Hawton & Williams, 2001; Stack, 2002). In Aotearoa/New Zealand however, there exists a growing movement within the media to discuss mental health, in a safe way, in an attempt to make the subject less taboo. For example, Sir John Kirwan is an Aotearoa/New Zealander and a former member of the All Blacks rugby team. By discussing his own experience of depression, he has become a pivotal voice in mental health. The 'John Kirwan effect' (New Zealand Herald, 2017) certainly had a positive impact on three participants, in particular Michael who described how sharing feelings of anxiety and depression with friends and family had felt impossible for a male farmer living in rural Aotearoa/New Zealand. However, John Kirwan's television and radio appearances empowered Michael to share his "case of the JKs" with his family and his GP, leading him to receive effective mental health service provision. Similarly, for Claire.B, Delia and Ghost, John Kirwan's relatability in the media was a positive way to discuss mental health:

Yeah I think that is slowly starting to improve and not feeling like it is a taboo subject and the guilt and the shame, you know, starting to normalise it and the more you see in the media that helps normalise those conversations the better. (Delia)

In the same subject area however, Claire.B stated how the portrayal of mental health (and in particular suicide) could have negative impacts, for example in television programmes:

...like '13 Reasons Why'²⁵ was a disgusting production, I so disagree with it and the evidence shows there was a notable increase in the Google search 'how to commit suicide' as a result. They separated all other factors and they pinned it to that. I think that

²⁵ '13 Reasons Why' is a fictional, American web-television series. It provides the narrative of a teenage girl as she describes the thirteen reasons that led to her suicide.

was just disgusting. Like it just had so many myths about why people commit suicide and really promoted it as a solution to suffering.

Inpatient units

Of the nine participants who had accessed an inpatient unit, four reported their experiences as positive and effective while five likened their experiences to being in prison, where they felt trapped and frightened. All five of these participants shared disturbing stories of being locked in a padded cell and several stated that they had presented themselves as being mentally healthier than they were actually feeling, simply as an attempt to be discharged:

I had to try and present better than I was to try and convince them I was better, that was my only way out of that place and it didn't work the first time. But in some meeting it got through and I got out, but the thing was I wasn't well. There was no hope still, but at least I was out of that prison. It was locked down when I was in there too at one point which really scared me. I started to develop a new delusion I was going to prison. (Amy)

At the opposite end of the scale however, the four participants who had positive experiences in inpatient units felt that their stay had been crucial to their recovery as a way to receive the treatment they felt they needed: "I felt relieved because I knew how serious it was and I knew they would help me get the right treatment... I felt that I had been given a second chance." (Rose)

Annie was nostalgic about her experience of an inpatient unit and the sense of safety and community she felt whilst being there: "I loved going there because I didn't have to pretend, didn't have to pretend that everything was fine in my world, you know, I didn't have to pretend at all."

An integrated service for sensitive claims

In Aotearoa/New Zealand, residents and visitors are covered by the Accident Compensation Corporation (ACC) which is responsible for administering the country's universal accidental injury scheme. Cover provided by ACC helps to pay for the costs of recovery whether individuals are unemployed, working or retired. ACC also provides an integrated service for sensitive claims (ISSC - previously known as ACC Sensitive Claims) which provides therapy to individuals who have experienced sexual abuse. Of the twenty participants interviewed, five reported that they had accessed (or tried to access) therapy as part of an ISSC claim.

From a successful claim, participants were able to receive therapy from counsellors, art therapists, psychologists, psychiatrists and social workers.

Two of the five individuals were positive about their experience of using ISSC, including Carlos whose ISSC-provided (and subsidised) counsellor supported him so effectively for three and half years:

He was a straight talker, he was awesome and he really dug in there like we really went through some really hard sessions and we found a lot of crap in amongst it all. It was like a wound that you covered that you had to peel the covering off again and let it heal in the sun. It was very difficult.

We just went further and further and further down and he just made me feel as if I was all right that I'd been through shit and I had done some stupid shit and I had become unwell and done the drugs, but I actually wasn't bad.

One thing I find really cool about counsellors is that you can go in drop your shit and leave and I was able to do that and he was able to filter it out... There is nothing to hide, it is probably the only time in your life where you can truly say what you want without having to filter. You can say whatever, whenever, however and that is what I loved about it is that I could say anything.

He never made me feel like an idiot. He would listen, he would disagree with somethings and he would explain them but he never made me feel like a dick and that was enough.

Unfortunately, three participants' experiences of ISSC were not as positive as Carlos'. In fact, the journey of accessing (or almost accessing) ISSC for Tamara and Delia was so challenging that the experience subsequently contributed to their trauma. After an initial assessment and then six weeks of counselling, Delia was told that she was not in fact eligible for any therapy because of a minor detail in the dates of her abuse, so after "opening Pandora's box", Delia was "left high and dry". Annie was critical of the limits of ISSC's support provision: "why is it only sexual abuse can get funded counselling? Why isn't it that it is any trauma?"

Each of the five participants who had accessed ISSC stated that they had only found out about the service after many years following their abuse with some commenting that they had "never heard of" the service until a friend had suggested it to them. Understandably this was frustrating after many years of paying for therapy and not previously being informed of ISSC by a GP, for example.

She [therapist] was private and I would love to still see her but I can't afford to and I've only just found out about ACC sensitive claims which I have never known about and that is quite crazy ... I have only just found out about it now having a lifetime of stuff that is related to that. (Tamara)

Tamara's experience of ISSC has been extremely distressing: from the initial assessment (an anxious process in itself) and an intrusive system of information-gathering, to not offering the treatment she wanted:

That is really traumatic stuff to talk about...and then they would move it again and go "oh no, we can't do it then"...so I'm concerned about it, it's in my future, I've got anxiety about it for another two months.

But the [psychiatric assessment] questions are so traumatising that they actually send you on a spiral backwards before they help you.

Network therapy is a really good therapy for sexual assault or misconduct or abuse but ACC sensitive claims are like "no, no that is not really us, we don't see that"...so their assessors are not educated in the latest therapies either.

Targeted interventions

Although focused on a particular group of individuals, targeted interventions in fact provided a clear example of tukutuku as a mental health support system which overlapped into many different areas of participants' lives such as culture and identity, family health, physical wellness and community inclusion. For example, Michael attributed much of his recovery following his suicide attempt to the counselling sessions he received from the not-for-profit organisation *Man Alive*. Michael's sessions were run by men and were targeted towards men wishing to live a life without violence.

In that group it is sort of like rehab. They pull you apart and they show you who you are and then they give you a way of being a better person...I did that one for about six months, once a week. It changed my life, it definitely changed my life. So I use those tools all the time. (Michael)

Michael went on to describe the variety of positive, psychosocial effects which the Man Alive service had on his life. As a targeted intervention, the counsellors provided him with tools to recognise his triggers and manage his anger but this subsequently led Michael to feel able to find (and keep) employment and to establish a relationship with his partner. Through

the service, Michael also met peers with similar experiences who then became his friends, these friends then invited Michael to join their band (music being a passion of his) and he encouraged them to practice meditation. His peers (who, like Michael, were also recovering from drug and alcohol addiction) were supportive of Michael's recovery as opposed to the people Michael said he previously spent time with who were "bad influences". Following the counselling service provided by Man Alive, Michael stated that he truly felt safe and supported on the path to wellness - highlighting one service's ability to act as tukutuku within Te Whare Tapa Whā.

Through a Māori-focussed mental health service, Rose felt supported in a culturally appropriate way by staff who understood her whakapapa²⁶: "It feels like a whānau there, not just, you know, like a bunch of strangers or something. It feels like your family, that is really important...it was good, it saved my life actually." Paula also accessed a targeted intervention - a DHB-provided mental health service for Pacific Islanders which offers cultural-clinical care. Paula had accessed the service since she was young and she stated that her cultural identity was the most important thing to her and equally as part of her support provision: "They are my tagata [people], they take me counselling, they take me to visit my friends and family".

5.8 Best practice recommendations

During their interview, participants were asked for their recommendations regarding best practice based on their knowledge and experience. Their responses to the question "what does best practice look like for you?" included ideas of what best practice should involve as well as detailed examples and opinions of the practice(s) which had been effective for them and what needed to change (if anything). According to Ferguson (2008), there is no clear definition (and can never be) of what best practice in social work *is* as it is a product of its time and place. Therefore, it was important to find out participants' views of best practice because, as a social construction itself (Witkin, 2011), best practice must be informed by individuals with significant and relevant experience in order to address questions of what is 'best'?

Relevant to the social constructionist theoretical perspective of this doctoral research is the way in which best practice social work embraces the inclusion of service users' perspectives. Input from service users is now seen as vital; this is quite different to 30 years ago when the

²⁶ Refers to a persons' identity; reciting one's whakapapa places them in a wider context and links them to lands, ancestors and tribes.

definition of what was ‘best’ was decided upon by academics, social workers and policy makers (Ferguson, 2008). As this research set out to do, service users’ experiences and knowledge must be voiced (and heard) if the aforementioned ‘experts’ are to develop interventions, practices and ways of working that really are *best practice*. Participants’ definitions of what best practice looks like for them, what it is and isn’t and what else it should be are presented below:

It is actually compassion, it is just acknowledging the other person feels this way and asks you to help them in any way that you can and understand where they are at and give them time and patience to try and help them on their journey. (Tamara)

It looks like a fine balance between giving the person being treated the power in the relationship but at the same time relying on the expertise of the practitioner. So basically they should be holding hands and walking in the same direction and taking turns to lead. (Bob)

Four of the twenty participants stated that working with practitioners who have lived experience of mental health struggles themselves was extremely important:

I think someone with a lived experience is invaluable in my experience, just that relatability, yeah gosh it is everything actually...making those connections, because again it is that lived experience that is more invaluable for me to have a conversation with someone who has suffered from depression, is actually much more valuable than talking to someone clinical that actually hasn’t. (Delia)

Each of the twenty participants discussed how being caring and showing respect were among the most important principles for practitioners to have. The need to connect with service users, build a rapport with them and see them as human were mentioned by all the participants including Willa who described how these values were what made for an effective relationship with her DBT therapist:

I felt [they] got me and liked me, I don’t think that you can underestimate how much of a difference that makes when you are having to bring your distress and your shitty part of yourself to someone... this is a complex part of the human experience and what people need more than anything is to be taken seriously and to be met as a person and to be given respect. (Willa)

Similarly, best practice experienced by several participants had involved service providers taking time and showing interest in them as individuals. This included examples of sticking to appointments, following through on tasks and calling when promised.

I know like myself and other consumers as well like if you say you are going to call at a certain time on a certain day, you have to keep to that because if you change that it sends us into a panic and anxiety type mode. (Ghost)

The power held by practitioners and service providers generally was mentioned by over half of the participants. This was interesting for many reasons including the way in which participants reported their desire to feel empowered (and the apparent aim of their service provider to empower them), whilst also being reminded that it was in fact the provider who continued to hold the most power. The difficulties for service providers to empower individuals whilst holding on to their own 'provider-power' will be discussed in more detail in the following chapter. Pearl suggested however, that best practice should involve a sharing of power between provider and consumer in order to effectively co-design guidelines of best practice for that individual. Similarly, co-designing a treatment/care plan was what Claire.B thought of as being an important part of best practice. Reflective of a strengths-based approach, Claire.B's points highlight the importance of a service provider offering different treatment options to an individual, finding out which one(s) worked best for them and then promoting those services.

Best practice is collaborative and not coercive. I've experienced coercive treatment like inpatient mental health, outpatient community treatment and I still experience a degree of coercion around medication like "we will withdraw therapy if you don't take your medication" and I found that frustrating and disempowering.

So when care is collaborative I'm encouraged to recognise the benefits of medication and make decisions for myself.

Best practice is varied and it is tailored to the needs of the individual. So if I'm saying that ACT works for me then let's have ACT. If I'm saying DBT works for me then let's do DBT. But on the other hand it is also keeping your options open and offering a range of things and saying (based on how you present): "we think this could be helpful for you even if you are doubtful around it we want you to give it a try". (Claire.B)

A need for honesty and openness from service providers was suggested by 12 participants as an integral part of best practice. This included clear, truthful communication, informing

service users of all their options and the ability for those who provide support to be tolerant of risk.

[Best practice looks like] really open and honest dialogue as to how we can make things better. Really strong and equal lived experience voices at the table. A horizontal structure in terms of a multidisciplinary team of people working so there is no hierarchy. The consumer or the person with lived experience themselves knowing everything that is going on and making all the choices themselves...no secrets, no surprises, them being at every single meeting and every single table, no private meetings without having access to a CORT [Community of Refuge Trust] worker, consumer advisor, an advocate with them when they feel uncomfortable. (Taimi)

I think they offer such a narrow service and they are very focused on clinical diagnosis and medication, but for me I know there is another whole world of stuff out there that I'm slowly introducing them to, but it is hard work. (Claire. A)

Well to me it goes back to actually listening to the person and creating an environment, anywhere, where it's clear that what you disclose is not going to be used against you I guess in a non-judgemental compassionate way that person gives you time because I didn't disclose everything. If there was an environment where I could tell that these people were listening and someone understood something about it then I would have disclosed more. (Amy)

Best practice involves consistency across clinicians like if one clinician has a certain tolerance of risk then that should be passed on and if I know what works for me and have developed a plan with say my psychologist then they write it in the notes for the crisis team to see and so they suggest some things. (Claire.B)

Claire.B went on to discuss the importance of risk-tolerance when she discussed the peer-led respite service she accessed:

What has been most powerful for me are the staff that don't panic when I say I want to end my life. They don't say "oh I need to pass that on". They just listen and they sit with me through it and they ask questions that make me reflect on what is going on and help me to gain a different perspective and what is also helpful is when they say "I acknowledge that you have this perspective and my perspective is different and is there a way that we can kind of bring these two together or can you acknowledge there does exist another perspective on what is going on for you".

When reflecting on the best practice which they had received, and how else practice could become 'best', several participants felt that being non-judgemental, professional, patient, compassionate and empathetic were skills which every service provider must have. Carol's experience in a psychiatric hospital led her to believe that some staff in Aotearoa/New Zealand were lacking these skills and that this had contributed to her mental un-wellness:

When I went in 10 years ago I was paralysed, I couldn't even get out of bed and so I just stayed in bed day in, day out for quite a while and I remember one of the nurses, the psychiatric nurse, coming in, she pulled the covers off me and she said "don't be so lazy, get up"...[So] psychiatric nurses need to be trained in competencies that include non-judgement, patience and understanding. (Carol)

Unfortunately, half of the participants reported negative experiences, including Michael who recalled his experience with a key worker when explaining to me what best practice should *not* look like:

I had my key worker and his work buddy, I woke up and they were in my room and I was like "what the hell are you guys doing in here?" and they were like "oh your parents let us in" and they were like "you have to come with us to come and take medication" and I was like "well actually no I don't need to because I'm in recovery at the moment, I feel fine, I haven't used any medication for a few weeks and I'm not having any problems".

They were like "no you have to come with us right now, we think you are unwell" and a mate of mine turned up and he is like "Michael, the surf is cranking do you want to come to the beach?" and I was like "yeah" and these two they looked at each other and looked at me like "oh my god you are going to go to the beach and go surfing instead of come with us and get a jab?" And I'm like "yeah" and they are like "you are making a big mistake" and I was like "you guys are stupid, seriously you can't see that going to the beach for a day of surfing is going to be better for my mental health than taking a drug that I don't really want that gives me all these side effects".

And they thought I was nuts and I had a really bad time with that key worker. I wrote a letter to the Ministry of Health saying "look, me and this guy aren't working, just give me somebody else" and the reply I got was "no, you are going to keep working with this person" and it was just like fuck this so I moved out of the area so that I would be in a different zone. (Michael)

Other skills which participants stated were vital for best practice were for staff to be trauma-informed and to be ‘holders-of-hope’ rather than talking about service users having a mental health condition for life.

They must be trauma-informed so that they are not just thinking they are dealing with one person on one day at one time and with one problem. That they are realising that that person comes with a whole lot of history, a whole lot of trauma often and a whole lot of their own belief system and their own values...it is about a whole appreciation for the complexities of how people are packaged. (Claire.A)

Best practice makes assumptions around wellness and assumes everyone can achieve a degree of wellness and that no case is hopeless and yeah just holds hope in mind and if necessary holds hope for that person and with that person as they journey through. (Claire.B)

Often they will talk about you having a condition for life and needing medication for life and when they give young people those messages there is no hope there. So I think they need to understand that some people do recover and some people do move on with their lives after using mental health services and it is not a life sentence. (Claire.A)

I do remember somebody in the mental health unit saying this, you know, that “you just need to know that someone has got your back and although you are feeling quite hopeless right now Delia, we will hold onto that hope for you and it is here for you and we’ve got your back”. (Delia)

Summary

This chapter has presented the findings of the research (the data) as five main themes: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Whānau (Family Health & Social Wellbeing), Taha Tinana (Physical Health & Wellbeing), Taha Wairua (Spiritual Health & Wellbeing) and tukutuku (overlapping psychosocial interventions). Participants’ knowledge and experiences of what works were presented under these five themes which resulted from the thematic analysis process (Braun & Clarke, 2006) and, as Durie’s (1994) Te Whare Tapa Whā model of health reminds us, they represent the importance of holistic health care and support provision.

Discussions of what makes best practice ‘best’ were also explored with participants in the hope of offering socially-constructed knowledge as suggestions for what service providers can do to improve their practice. Data presented in each of the five themes shows how vital

the input of the service user is when trying to find out more information about effective suicide prevention interventions, treatments and services. Although the findings in this chapter can only represent the twenty participants interviewed, the data does highlight the benefits of using a strengths-based approach to social work in order to find out and then promote *what works*.

This research had no hypothesis to prove or disprove, rather, theory emerged from the data with many of the findings being unanticipated by myself. The themes presented hope to better inform suicidology research, suicide prevention policy formation and related Ministry of Health legislation by sharing the invaluable knowledge and experiences of the individuals who have directly accessed mental health services aimed towards suicide prevention and intervention in Aotearoa/New Zealand. Mental health consumers are the experts in their own care and it is important to remember that whatever the level of vulnerability that person has, they still have the right to express their views and to have these views listened to and acted on regarding their health and social care service provision (Steel, 2005).

The information put forward from the participants and the resulting themes have the potential to influence the Ministry of Health's inquiry into mental health and addiction which will in turn inform the next national suicide prevention strategy. The themes of the data will be discussed in more detail in the next chapter and this will include making links with the literature examined in Chapter 2. Also, participants' key messages and a discussion of the implications of the data and the resulting recommendations will be presented next.

Chapter 6

Peeling away the layers of an onion: A discussion of the findings

6.1 Introduction

From the twenty participants interviewed, a wealth of data was gained about what worked and what works regarding their experiences of treatments, services and other interventions that they have accessed because of their suicidal attempt and/or ideation. In depth questions and discussions about what works for the participants were answered with powerful stories of recovery and self-determination. Annie likened our in-depth discussion to peeling away the many layers of an onion; doing so made her eyes water with tears, but she reported feeling cathartic after reflecting on her experiences as she felt that talking about taboo subjects is essential, although it may be difficult to do.

After using the thematic analysis process as guided by Braun and Clarke's (2006) six-stage model, five main themes resulted from the data. The themes were named and presented using Durie's (1994) Te Whare Tapa Whā model of health because of its compatibility with holistic, strengths-based focussed perceptions of mental health. The fifth theme of overlapping psychosocial interventions/support systems was presented using tukutuku (woven panels or carvings inside a whare (meeting house)) as an addition to Durie's model.

In the previous chapter, quotes from the twenty participants' lengthy transcripts provided valuable insights, in their own words, into their socially constructed and unique perceptions of *what works* regarding suicide intervention treatments and services. Participants' thoughts and recommendations regarding best practice were also included as additional data in the previous chapter which aimed to provide answers to the question of what is 'best'? There were a wide range of responses to the question of "what does best practice look like for you?" and many participants also gave vital information regarding what else best practice should include, providing new ideas of what else could work in the future with regards to suicide intervention treatments and services and the overall goal of reducing suicide rates.

Moving on from the presentation of the data, this chapter will include a detailed examination and discussion of the findings presented in the previous chapter. Participants' responses will be expanded upon and linked to the literature presented in Chapter 2, before discussing the implications of the findings. Key messages from the participants will be included in this chapter as vital input to support my own discussion.

By continuing to honour the four main components of Te Whare Tapa Whā model, the themes in this chapter will be arranged in order to aid the presentation of, and movement through, the discussion. The themes used within the previous chapter can be grouped into four interrelated areas, these being people, body, mind and spirit. These areas were categorised by the participants' shared elements found within their experiences. Organising the discussion holistically also honours the individuality of recovery and the unique pathways for the participants. As presented in the previous chapter, tukutuku is an additional theme which represents the other remaining factors reported by participants; interwoven factors which connect the walls of an already-holistic model of health. Examples of these psychosocial interventions, treatments and/or support systems which participants had said worked for them in their recovery will be explored in detail in this chapter. Finally, the outcomes of the research have implications on multiple levels, including for future interventions, treatments and services, education, resources and for further research. These outcomes, and their implications, will be discussed in detail and will include recommendations for policy and for the improvement of practice to become better, if not 'best'.

6.2 People

The services and support systems considered within this section have a common factor: people are at their centre. These people-centred points of support range from formal crisis and professional mental health teams through to service user and family/whānau provided care. The support provided by crisis assessment teams, community mental health teams, community support groups, opportunity centres and family/whānau members either worked well or did not because of the people providing that support. The discussion in this section is presented using a continuum from professional care systems, through community inclusion and self-help to family/whānau support.

Implications that can be drawn from the related data presented in the previous chapter include the need for caring and respectful, person-centred support. The interventions in this section worked best when the service provider was interested in the individual and was informed regarding that person's history, state of wellness and the importance of their family members. Some participants did not have positive experiences with the other people involved in their care and this led them to discussions of how those people may improve their practice. Other participants stated the sense of belonging and social inclusion provided by family/whānau members and by community support groups and opportunity centres was a

source of crucial support which differed greatly to the medical-focused treatment provided by practitioners.

Crisis assessment teams

Despite the supportive ethos of mental health services, the accounts of some of the participants in this research related to crisis assessment teams (CATs) demonstrated a serious lack of care and support. Four participants described concerning experiences which left them feeling frustrated, isolated, and for Anita, with an increased risk of attempting suicide:

I don't have any respect whatsoever for the CAT team. I think they are pointless, I don't understand the point of actually having them in place...They didn't want to listen to my family, my support network or anything. They are not interested in anything they have to say...To me it actually put me in more danger of doing something than not and I still don't understand that. (Anita)

By ignoring the input of her family and friends, Anita believed that the CAT exacerbated her trauma and increased her suicidal intentions. According to Anita, the CAT were reminding her that only *she* was able to understand how she was feeling at that time, not her family. Quite simply, this wasn't the case for Anita who, whilst experiencing a crisis, depends on her family for guidance and care as they know her extremely well and can support her to regain control over her emotions in times of distress. The implication of not listening to Anita's requests to have her family involved in her care (and listened to) is that Anita and her family feel unable to call the CAT for help in the future. This may put more pressure on her family in the future to provide the care and support (such as respite) which the CAT could have helped Anita to access if they had listened to her initial requests for collaborative care.

Although this does not provide a justification for Anita's treatment, crisis assessment teams are under a significant amount of pressure as an increased demand for their services has come at the same time as a shortage of funding and a shortage of beds in emergency departments and mental health respite units (McAllen, 2016; Flahive, 2018). However, there were strong regional variations in participants' experiences and the positive support provided by CATs must not be overlooked. Two participants reported only positive experiences, with Carol stating how her CAT had led to her accessing other services: "I think it was when the crisis team got involved then they would say go to respite because I said "please don't put me into hospital"."

A key message regarding crisis assessment teams and how they might improve their practice

in the future came from Claire.B, who wanted to emphasise the fact, more than anything, that the thing which had saved her life so far had been timely responses from mental health teams, including the crisis assessment team. As presented in the previous chapter, Claire.B's own experiences with the CAT have been a mixture of positive and negative but she felt strongly about the CAT's need to improve their practice through training and education, especially as they are the first response for many people in distress.

I think there is probably a high chance that I will die by suicide in my lifetime just because every time I have a suicidal crisis it gets worse and worse and it gets harder and harder to reach out, but the thing that has saved me up until now has been that eventually I have just called and said I need help, I need help right now. (Claire.B)

When I asked how she thought the act of reaching out could be made easier for her and for others, Claire.B stated that she thought better training for CAT staff was essential.

I think if people can establish good experiences with the crisis team ...like really validating and applauding when someone reaches out, like for example in a suicidal crisis it is so hard to reach out, it is so hard to say I need help like help me because I have been so caught up in what is going on for me like really recognising this is a big step that you reached out. And holding hope for a person's recovery is really important and recognising the progress a person makes over time.

This section illustrates the importance of having immediate but informed and compassionate service provision for people when they are in crisis. Anita was not against the idea of a crisis assessment team *per se* (she recognised the need for their support), but her experience highlights the importance of service providers also listening to the individual's family/whānau. Her experience shows how negative experiences with services like a CAT can lead to an increase in individuals' suicidal thoughts and can heighten the risk of attempt.

The implication of both Anita's and Claire.B's experiences is that with further training and education, service providers such as CATs can improve their care and support provision. This resonates with Gordon, Stevenson and Cutcliffe's (2014) research that highlighted the role of mental health services when hindering or facilitating service users' sense of value and self-worth. The researchers found that interactions that were experienced as invalidating, controlling, coercive and stigmatising further alienated service users, discouraged them from accessing support services and increased their sense of unworthiness and aloneness. These feelings have further implications for service users potentially internalising their own invalidating environment in a process of "self-invalidation" ("the tendency to invalidate or

fail to recognize one's own emotional responses, thoughts, beliefs and behaviours...may include intense shame or self-hate" (Linehan, 1993, p. 10)). As a way to address this, Benson, Boden and Owens (2014) state that establishing a caring and honest relationship between service providers and service users is an essential necessity for effective therapeutic outcomes. From this doctoral research, participants' own reflections on this essential necessity reflect Benson, Boden and Owens' findings and are discussed in more detail further on with regards to best practice recommendations.

In relation to these findings, it is worth noting that since 2016, Te Pou (2016) has offered a free online self-assessment tool - *Real Skills* - which is available to organisations in the health and disability sectors. The tool provides easy ways for organisations and their workforce to assess their knowledge and skills regarding working with people who are experiencing mental health and addiction needs and provides them with plans for targeted workforce developments.

Gordon, Stevenson and Cutcliffe's (2014) research into service users' sense of value and self-worth also holds links with Michael's negative experiences with his support provider. And so, the implications that can be drawn from some participants' experiences with CATs, and the need for these service providers to be less invalidating, controlling and coercive, can also be extended to all professional intervention when there are judgements being made about people's safety and wellbeing. These findings suggest the need for an alternative treatment package of interventions aimed at support during crisis which could in turn lead to a reduction in inpatient stays. Nugter, Engelsbel, Bahler, Keet and van Veldhuizen (2015), suggest that Flexible Assertive Community Treatment (FACT) could provide such a package. A FACT team shifts between different levels of support depending on the service user's needs. Therefore, service users do not have to be transferred to a different team when their level of needs changes. The authors recommend the adoption of FACT as a treatment which ensures a continuity of care and that the level of care is finely attuned to the needs of the service user (Nugter, Engelsbel, Bahler, Keet & van Veldhuizen, 2015).

Community mental health teams

The participants, who discussed their community mental health teams (CMHTs) as something which had been helpful to them and their wellness, described the range of services provided via multi-disciplinary teams as "a massive part" of their recovery. From effective family/whānau meetings (hui-a-whānau) to confidence-building, support to do exercise,

giving advice for getting back into employment or being a daily/weekly visitor to people who otherwise felt isolated; the feedback from participants presented in the previous chapter was very positive.

When discussing how CMHTs can continue to work well (or how they can improve), Taimi stated that validation is the most important skill which CMHT staff can possess – echoing Claire.B’s similar point earlier regarding CATs. Recognising someone’s feelings, acknowledging them as important and in some cases repeating back what they have said are ways in which service providers can validate a person’s feelings of distress. Mills et al. (2009) claim that validation is an essential skill for anyone supporting an individual experiencing distress including suicidal crisis.

When asked for her messages regarding how suicide prevention and intervention services could potentially be improved in Aotearoa/New Zealand, Mary suggested how CMHTs (including mental health support workers and qualified therapists) should be available within local GP surgeries/ local GP medical centres as opposed to GPs referring a person to a CMHT located elsewhere.

This is my bug bear, so you go into the GPs office, they say if you are sneezing put a mask on, if you are having trouble breathing let us know...so then my idea is if you are feeling psychotic or if you are having a breakdown or if you are feeling really depressed, ask us too.

So instead of the person getting worse, it would then be “oh we have got somebody on staff here that can have a chat to you, or you can come back later if you want to”... just make it freely available. It maybe wouldn’t put people off then because they don’t want to be referred for mental health and it would also be like if somebody is unwell, whether they are unwell with their knee or their thyroid or head, it is all unwell, it should be treated equally, but it is not in our health system.

And then you would have a queue going out the door and people saying “oh no we can’t afford it”, but you know, can you afford not to as well? I know I worked out the tax that the community lost when I wasn’t working and it was like a horrendous amount of money and yeah you lose a lot. If somebody kills themselves that is an immediate loss of contribution to society.” (Mary)

CMHTs have a key role to play in the future of suicide prevention and intervention in Aotearoa/New Zealand. However, the number of people accessing, or wanting to access help

from CMHTs is difficult to measure. According to The Office of the Health and Disability Commissioner (2018), the number of people accessing community mental health team services is no longer collected by the Ministry of Health, following the devolution of funding to DHBs in 2013/14.

The range of services provided by multi-disciplinary teams under community mental health services were beneficial for the participants in this research; however, the findings can also be seen to recommend that these services go further. Overall, the findings suggest that participants would like to see mental health services become more humanised and more embedded in everyday services. As Mary's point implies, by embedding community mental health services into general health services (within local GP surgeries/ medical centres), mental health services could become much easier for many individuals to access. The implication of this is that more funding would be needed for primary care providers to offer services aimed towards mental health wellness. Unfortunately however, as a result of the devolution of funding to DHBs, it is not currently possible to conduct a clear measurement of the use of community mental health services or an evaluation of their provision; further research into this area is therefore recommended.

Community support groups

Highlighting the importance of community inclusion and social wellbeing, five participants described the ways in which a support group in their community had played a large part in their wellness. The extract from Bob's interview presented in the previous chapter is an interesting example of how one part of his recovery went on to support other dimensions in his health. He wanted to emphasise how attending Narcotics Anonymous and Alcoholics Anonymous meetings "massively contributed" to his wellness by helping him to feel mutually supported by his peers leading to voluntary work and then later to a career as an addiction counsellor. Other participants who often felt isolated because of their social anxieties described the joy they felt when accessing creative arts classes provided by their local community centre. When discussing the photography and writing he created during the sessions at his local community centre, Ralph stated that supporting service users to express themselves can also benefit others: "I do kind of believe personally that a lot of people with mental health they have a lot of creative wealth that they can share with people".

Opportunity centres

Opportunity centres were “a crucial lifeline” for Ghost and Frances. If we imagine the centres as a whare then it is easier to see why. By connecting them to friends, their community, health practitioners and employers, opportunity centres are currently providing people-focussed support to Ghost and had previously done so for Frances. However, their praise for opportunity centres was also met with frustration at the low number of centres themselves and at the lack of spaces within existing centres. Frances’ local opportunity centre had been closed down several years ago leaving her “without a purpose” whereas Ghost’s local lifeline wasn’t going to be available to her for much longer as she grew older: “once you are over 60 you are no longer classed as a member. You can come as a visitor but then you are going to be like “where do I go to from here?”” Related to these concerns is the recent interest shown by Aotearoa/New Zealand’s media in the United Kingdom’s future anti-loneliness strategy. The Government of the United Kingdom has implemented a plan which will allow Doctors to recommend and write prescriptions for group activities such as cooking classes, walking groups and art clubs, instead of medication, by 2023 (New Zealand Herald, 2018). Understandably, this is of interest to Aotearoa/New Zealand as ‘social prescribing’ could have a positive impact on the lives of people (including Frances and Ghost) making their social inclusion more accessible.

An implication of losing her lifeline was that Frances was now more dependant than before on her CMHT as she would contact them more often and she felt more distressed between visits from her key worker. The closure of her local opportunity centre and the subsequent loss of her connection to the outside world had left Frances feeling isolated from her friends and her community. As a related result, Frances would regularly phone Lifeline for extended periods of time because she yearned for someone to talk to. Frances stated that she knew that this was not part of Lifeline’s remit but she felt that she had no other option. It is interesting therefore, to wonder whether callers like Frances were contributing to the helpline’s limited availability and how many of the phone calls received by Lifeline (2016) every five minutes could be from other people in a situation similar to her. If the Government were to provide an opportunity centre again for Frances then this would likely have significant and positive effects on the efficacy of helplines such as Lifeline.

Family support

For the three participants who stated that family/whānau had played a vital role in their wellness, family support was an ongoing source of care unmatched by health practitioners or other service providers. As researched by Barrero (2008), the family (immediate and extended) can play an important part in the promotion of good mental health and in the prevention of suicide.

The Strategy to Prevent Suicide in New Zealand: Draft for public consultation (Ministry of Health, 2017), recognises the need for suicide prevention and intervention efforts to become “closer to home” by “providing support in communities and to whānau, addressing people’s needs and providing services that are culturally appropriate” (Ministry of Health, 2017, p.26). To do this, the draft strategy aims to continue to deliver a cross-government initiative (jointly implemented by the Ministry of Health, Te Puni Kōkiri and the Ministry of Social Development) in order to “better support whānau to develop their own ways to prevent suicidal behaviour” (Ministry of Health, 2017, p.27). However, for some families, it may not be clear *how* to develop their own ways to prevent suicidal behaviour. The draft strategy (Ministry of Health, 2017) does list some ways in which family/whānau members can help to prevent suicidal behaviours including:

- “Whānau and families encouraging each other to participate in programmes and activities that can improve their wellbeing (e.g. physical activity)” (p.12)
- “Providing individuals and whānau with information about how to helpfully talk to someone who they are worried might be thinking about suicide.” (p.15)
- “Supporting individuals and whānau to talk about suicide and preventing suicidal behaviour in a responsible way” (p.15)
- “Individuals, whānau and communities contributing to developing and implementing district health board suicide prevention action plans” (p.17).

These suggestions seem a little vague and a recommendation therefore would be for the Ministry of Health to provide clear and specific examples of *how exactly* individuals and whānau will be supported to talk about suicide in a responsible way and *where to access* the programmes which may improve their wellbeing. The final bullet point above is of particular interest as it states that individuals, whānau and communities will be able to contribute to DHB suicide prevention action plans. Hopefully, the current mental health and addiction

inquiry will be able to ascertain how individuals, whānau and communities would like to be involved with this contribution.

6.3 Body

This theme reflects the third component of Durie's (1994) model presented in the last chapter: Taha Tinana. Supporting and maintaining our physical health and wellbeing is vital to our overall hauora and several participants reported that effective medications, regular exercise and healthy diet and nutrition were the key ways for them to do this. These findings related to physical health and nutrition as interventions for suicidal ideation or as treatment during a person's recovery journey were unanticipated results and were not revealed by the literature review. The conclusions which can be drawn from these findings, as well as their subsequent potential to influence change, will be put forward further on with input from participants themselves.

Pharmacological treatments (medications)

Within this theme, medications were a key finding as something which worked for participants. All twenty of the participants had used medications relating to their mental health at some point in their lives, with many still doing so. Participants' descriptions of the effects of these medications were varied: nine individuals described their experience of medication as positive, five participants felt the effect was positive but the side effects were a significant problem, six participants stated that they did not like taking medication because of the side effects and because they did not feel as though it had a positive effect including one participant who felt that they had to take it to please others.

The benefits of taking medication for people experiencing suicidal ideation can be substantial: anxiety and severe distress can be greatly reduced; people can focus more positively on situations and several participants reported being able to regulate their emotions more easily because their medication had reduced their intrusive and controlling thoughts. Research by Fawcett and Busch (2014) states that pharmacologic treatments are an important part of suicide prevention and this was echoed by almost half of the participants I interviewed. However, medication does not work well for everyone, as highlighted by Tamara and Taimi's pursuit for other health interventions, and likewise by Michael's search for alternative forms of healing. Carlos (who found that medication worked well for him personally) was critical of the lack of information available to service users regarding

medications and of their possible side effects. He also felt that medications were too quickly prescribed to people before other interventions had been explored:

Everyone within suicide gets told that this is how we deal with it, this is suicide and that is how we'll give you medication or we'll give you mood stabilisers or give you anti-depressants, but not everyone gets asked why... I never once got asked why, why do you want to kill yourself?... It is almost like you get like a generic suicide pill, you got suicidal thoughts, here is your suicide pill. It is not specific about financial, it is not specific about relationships. (Carlos)

In contrast, research carried out by Hammad, Laughren and Racoosin, (2006) states that medications which are prescribed to address feelings of major depression and suicidal ideation can in fact increase the risk factors for suicide which include behavioural variables (feelings of helplessness, hopelessness, worthlessness and severe depression); impulsivity; psychosis and severe anxiety disorders. It could be argued however, that medications which are aimed at broader mental health challenges could potentially (indirectly) prevent suicide and therefore may be effective when prescribed alongside other interventions such as psychological treatment and/or psychosocial support. Within this study, it is difficult to know how much of an effect medications had on the other types of treatments and support services which participants reported as helpful. What this suggests is that recovery and mental wellness are not supported by medication alone, rather, that medication can support the interdependency provided by services. Medication may help some individuals to decrease levels of anxiety and depression so that they can return to employment which in turn increases their sense of self-worth and their social wellbeing. For others, medication seemed to have no positive effect and those participants instead attributed their recovery to a change in their lifestyle. A conclusion which can be drawn from these findings is that medication may be prescribed too early and too often to individuals experiencing mental distress. This conclusion is supported by the feedback from service users and bereaved family/whānau members who have taken part in the public meetings conducted as part of the Government's current Inquiry into Mental Health and Addiction (Ministry of Health, 2018a). The inquiry panel has held over 200 public meetings in order to hear from service users and bereaved family/whānau among others. Feedback from these meetings has been reported in the media and has included criticisms of "a system that reacts to the sick instead of stopping people getting that way" as well as "resentment at a perceived over-reliance on medication" (Reed, 2018).

It was generally accepted by participants of this doctoral research that while medication played an important role in their wellness, it was not likely to be the main answer to their difficulties. In other words, other changes needed to take place and medication was one way to support these changes to happen. As the strengths-based approach acknowledges (Pattoni, 2012), the individual must be at the centre of these changes, not necessarily as the only person responsible for making them happen, but as the driving force behind deciding what needs to change and how.

Physical health and nutrition

When participants were asked ‘what worked?’ physical exercise was one of the things which had (and continued to have) a huge impact. For some, attending community exercise classes improved their social wellbeing, for others, training for future competitions or matches gave them a goal to focus on, distracting them from negative and intrusive thoughts. There is a plethora of research which examines and advocates for the benefits of exercise as a way to release endorphins in our brains which reduce our perception of pain and also trigger a positive feeling in the body. Exercise also increases concentrations of norepinephrine, a chemical that can moderate the brain's response to stress (Penedo & Dahn, 2005; Puluska & Schwenk, 2000; Stanescu & Vasile, 2014).

According to the Mental Health Foundation (Aotearoa/New Zealand) (2018a), regular exercise can have a profoundly positive impact on depression and anxiety by relieving stress, helping us to sleep better and improving our overall mood. These benefits were reported by the nine participants who discussed physical health as something which was beneficial to their mental health. A particularly telling example of the positive effect of improved physical health came from Carol’s experience of bike riding presented in the previous chapter. By improving her physical health (Taha Tinana), Carol’s exercising also increased her mental and emotional wellbeing (Taha Hinengaro) as well as her social wellbeing (Taha Whānau); highlighting the benefits of addressing our overall health and wellbeing (hauora) holistically.

The draft Strategy to Prevent Suicide (Ministry of Health, 2017) acknowledges poor physical health as a risk factor for suicidal behaviours. Outlined in the draft strategy as a potential area for action was the improvement of people’s physical activity by enabling “individuals, whānau, families and friends to encourage each other to participate in programmes and activities that can improve their wellbeing” (Ministry of Health, 2017, p.13). Linked to this are Taimi’s recommendations for service providers to support people to improve their diet

and exercise as well as making it easier for people to have physical root causes of mental distress diagnosed. The need for easier and earlier diagnoses of autoimmune diseases which are linked to mental distress, for example, was a key implication which resulted from speaking to Taimi, who stated that health screening when people start to present with mental health distress, is something which is absent but vital in Aotearoa/New Zealand.

Research carried out by Benros, Waltoft and Nordentoft, (2013) found that out of 92,000 Danish people with a diagnosed mood disorder (such as depression, severe anxiety or bipolar disorder), 36,000 had suffered a severe infection or the development of an autoimmune disease (such as type 1 diabetes, celiac disease or lupus) at some point before being diagnosed with the mood disorder. The authors concluded that an inflammation in the brain caused by an autoimmune disease increased the risk of developing a mood disorder by 45% and that such disorders also led to suicidal behaviours.

The findings from the participants in this thesis suggest that regular exercise can have an extremely positive affect for individuals experiencing depression and suicidal ideation. Exercise can improve mood and sleep, increase our community inclusion and may be an alternative to medication. Taimi's recommendation for earlier health screening as a way to potentially identify and treat autoimmune diseases is supported by Benros, Waltoft and Nordentoft's (2013) research. Increasing GPs' resources, funding and the allocated time set for appointments²⁷ could support this recommendation to happen when individuals first present with feelings of mental distress (and then by continuing this health screening throughout recovery). Diagnosing and treating an autoimmune disease (which can cause brain inflammation and potentially a mood disorder) with diet, exercise and/or medication focussed on treating the disease could dramatically affect an individual's chances of later developing a mood disorder. Taimi's suggestion, as well as the other participants' positive experiences of exercise, reinforce the importance of the links between mind and body and highlight the importance of holistic health and treatment.

6.4 Mind

The interventions and treatments presented within this theme each had a profoundly positive effect on the participants' ways of thinking. These included the way in which phone and text helplines are able to provide support without the (socially anxious) individual having to

²⁷ Typically, GP appointment times are set for 15 minute time slots, although some practices might have quick 'acute' clinics that are for one problem only and may be shorter (The Royal New Zealand College of General Practitioners, 2018)

physically go and visit a practitioner. Psychotherapies had been accessed by all twenty of the participants and were beneficial for all of them in varying ways with some participants finding a particular talking therapy to be effective only after trying several others first. The range of psychotherapies which were discussed by the participants is a strength of the study's data and it is hoped that this research highlights the benefits of practitioners offering a wide range of therapies to service users.

As stated by Claire.B in the previous chapter, effective practice works best when individuals are informed about all the treatment options available to them, are supported to try these options and then are able to continue accessing those which work *or* are able to change to explore others which might work better. Related to the call from participants for service providers to offer a wider selection of treatment choices outside of medical-model options, is the positive effect which many participants reported after using mindfulness and meditation practices. In the previous chapter, mindfulness and meditation practices were presented within two different themes: Taha Hinengaro (Mental Health and Emotional Wellbeing) and Taha Wairua (Spiritual Health and Wellbeing). However, in this chapter the findings which relate to mindfulness and meditation will be combined and discussed under one sub-heading.

Phone and text helplines and online support programmes

Five participants had used phone and text helplines such as those provided by Lifeline, Warmline and Youthline as well as the 1737 phone and text service launched by the Ministry of Health in June 2017. Experiences were largely positive, with participants reporting how essential helplines were to them as a way of being listened to and taken seriously, whilst not having to physically go and see a practitioner face-to-face, which for some individuals was an overwhelmingly negative experience. Several participants praised this type of mobile support as they could access immediate help wherever and whenever they needed it. However, an implication of this availability is that it has led to services being over-stretched and unable to answer many calls/texts. Whilst helplines clearly have a place in Aotearoa/New Zealand's mental health support services, several participants also reported difficulty when trying to get through to helplines or when trying to receive a response to a text message or a call-back request. This has previously been evident from the organisations' own research (Lifeline, 2016; Youthline, 2015) which continues to reflect current, desperate calls for funding to these charities to be increased (Davidson, 2018). Due to funding shortages, these helplines are missing one in four phone calls. This comes at a time when more people than ever are calling Lifeline with the helpline now receiving an average of six

calls a day from people in severe distress - double the amount it received three years ago (Davidson, 2018).

None of the participants reported using online support programmes. According to Kauer, Mangan and Sanci (2014), this could be a reflection of the ages of participants, all of whom were aged over 18 years, following the guidance from the HDEC ethics process, which advised that people aged less than 18 years would be too vulnerable to take part. One participant (Carol) did state that she would find online dialectical behavioural therapy sessions for adults to be useful and suggested the use of conference calling as a way for individuals who may struggle with social anxiety to 'attend'. Certainly, this appears to already be available in the United States of America (<https://emotionallysensitive.com/>) but at the time of writing did not appear to be provided in Aotearoa/New Zealand. This is, perhaps, an area for further research. Online cognitive behavioural therapy (CBT) however *is* offered in Aotearoa/New Zealand (<http://.beatingtheblues.co.nz>) where eight weekly online treatment sessions of CBT are provided as part of treatment through one's GP. Also, SPARX provides free, online cognitive behavioural therapy to young people providing them with the key skills needed to help combat depression and anxiety (<http://sparx.org.nz>).

Psychotherapies

Each of the twenty participants described psychotherapy as one of the main components in their recovery following a suicide attempt and/or as one of the main treatments which continues to support their mental wellness. Psychotherapy helps an individual to understand themselves better by exploring how their early life experiences and personality affect their current thoughts, relationships, feelings and behaviours and provides tools with which to address these feelings.

A strength of the data presented in the previous chapter is the variety of psychotherapies which were described as being beneficial for each of the twenty participants. Participants reported positive results from accessing psychological treatments including ACT, CBT and DBT. These psychotherapies were extremely valuable to the participants as a way to understand the meaning of their experiences, thoughts and behaviours and to make changes to become more satisfied in their life (Te Pou, 2009a).

According to Flaxman, Blackledge and Bond (2010), acceptance and commitment therapy (ACT) is a mindfulness-based cognitive behavioural therapy which focuses on forgiveness, values, compassion, acceptance and living in the present moment. ACT worked well for

Claire.B because the practitioner used the therapy to target Claire's avoidance of, and unwillingness to accept, negative emotions, thoughts and feelings, by teaching her effective strategies to acknowledge her emotions and to encourage forgiveness and acceptance. Claire.B's experience of acceptance and commitment therapy (ACT) demonstrates the importance of mutual support between family/whānau members and peers. As a form of psychotherapy, ACT not only supported Claire.B to address negative feelings following a traumatic experience but it also helped her to become more committed to staying well for herself and for others. According to Heydari et al. (2018), ACT is seldom used for severe depression and suicidal ideation and instead is more aimed towards individuals' experiencing low-level depression and anxiety. However, Orsillo and Batten (2005) report that ACT can also be used in trauma interventions. Claire.B's responses therefore show how using a trauma-focussed therapy, as a way to dismantle negative thoughts or feelings (Ruiz, 2010), blended with the wish to support one's peers, can decrease suicidal thoughts and aid recovery following an attempt.

Cognitive behavioural therapy (CBT) is a psychological treatment approach used for a variety of mental health conditions, particularly anxiety and depression. CBT practitioners view thoughts (cognitions) as playing a pivotal role in an individual's feelings and behaviours. A CBT practitioner works to help clients identify and modify their cognitions and beliefs (Binks et al., 2006). Delia's CBT practitioner supported her to identify her cognitions of feeling like a victim and then modify those thoughts and feelings positively. For Delia and the other participants who had accessed CBT, use of the therapy implied an ability to feel in control of their own emotions and led them to challenge their own thinking.

Another psychotherapy discussed in the literature and accessed by participants is dialectical behaviour therapy (DBT). DBT is specifically designed to treat individuals displaying suicidal and self-harm behaviour (Linehan, 1993). Created by Dr Marsha Linehan, the therapy combines cognitive behavioural ideas with those drawn from Buddhist practices within an overall philosophy of dialectics. DBT involves weekly group skills training in managing emotions, individual therapy sessions for the service user and ongoing team consultation for the therapists.

As discussed previously, DBT has been shown to have some efficacy, especially in reducing suicidal ideation and suicidal behaviours (as well as other extreme behaviours) (Koons et al., 2001; Turner, 2000; Van den Bosch, Koeter, Stijnen, Verheul, & Van de Brink, 2005 and Verheul et al., 2003). Swenson (2000) suggests that part of the appeal of DBT is the way in which the therapy rests on a number of assumptions, including the view that the service user

is doing their best, (while dialectically still needing to do better), and while the therapy and/or therapist can fail, the service user cannot (Linehan, 1993). These positive implications of the DBT approach were reflected in Anita's discussions regarding her experience of the therapy. A recommendation which arises from Anita's data is for aspects of DBT, such as skills training, to be provided to young people in secondary schools in order to try and better support the future adult mental health population. The research into the efficacy of DBT as a treatment for suicidal ideation (as discussed in the literature review) supports the findings of this thesis which endorse the use of DBT as an effective intervention for suicidal behaviours (Koons et al., 2001; Turner, 2000; Van den Bosch, Koeter, Stijnen, Verheul, & Van de Brink, 2005 and Verheul et al., 2003). Currently in Aotearoa/New Zealand DBT is offered by some district health boards for their mental health service users. Most individuals will be referred to DBT by their mental health service provider. Access to DBT requires an assessment by a mental health professional and it is recommended that the therapy is continued over a significant period of time, often for a year or more (Te Pou, 2010).

A particularly telling example of the benefits of psychotherapy was Annie's experience of art therapy that supported her to explore and 'talk' about deeply traumatic events. Art therapy as a form of psychotherapy was an unanticipated finding of the research. As opposed to being used as a mainstream suicide prevention intervention, art therapy is a well-established modality for individuals with low levels of anxiety (Stuckey & Nobel, 2010). However, as a rehabilitation tool for trauma recovery, art therapy has only become available and recognised by both ACC²⁸ and Work and Income²⁹ (WINZ) in the past four years (Mackintosh, 2017).

Malchiodi (2012) defines arts therapy as the use of creative arts (art, music, movement and other art forms) as a form of therapy to support individuals to communicate traumatic memories, to repair and to recover. Art therapy assists an individual's capacity to self-regulate their emotions and to modulate their reactions to traumatic experiences (Malchiodi, 2012). The profession continues to develop in Aotearoa/New Zealand and opportunities for arts therapists (which were previously limited) are now increasing with high demand (Mackintosh, 2017). For Annie, art therapy has been a crucial part of her recovery and its positive effects led her to ask questions about the availability of (funded or subsidised) psychotherapy (not only arts therapy) in Aotearoa/New Zealand:

²⁸ Residents and visitors in Aotearoa/New Zealand are covered by the Accident Compensation Corporation (ACC) that is responsible for administering the country's universal accidental injury scheme.

²⁹ Provided by the Ministry of Social Development, the department for Work and Income provides employment services and financial assistance throughout Aotearoa/New Zealand. Also referred to as WINZ (Work and Income New Zealand).

You can get counselling or you can get six psychology sessions through some doctors and that can be extended or there are other counselling that you can get for free or not expensive or you can get counselling paid for by WINZ, but you have to know that. It is not advertised, you know, unless you know it and you can pass it on. Why on earth isn't it advertised?

Whilst this commentary stemmed only from one participant, it underlines the holistic nature of what people find useful, as creative expression is both a form of communication similar to other externalisation processes (Langlotz, 2015), as well as an exploration of the initial stage of a recovery process through which to practice stress tolerance (Stuckey & Nobel, 2010). With regards to suicide prevention, Donaldson, Spirito and Overholser (2003) state that psychotherapies in general can help an individual to gain a level of control, learning how to cope effectively with negative mood states, stressful life events and pessimistic expectations. This was the experience of each of the twenty participants with several using the techniques taught to them by a counsellor, therapist, psychologist or psychiatrist as 'a way of life'. Whilst some researchers claim that more research needs to be done into the efficacy of psychotherapy for suicide prevention (Brown & Jager-Hyman, 2014), findings from the twenty participants in this thesis highlight the benefits of psychotherapy as a tool for suicide prevention. The ability for psychotherapies to be flexible and person-centred has been crucial for the participants involved. The research advocates therefore for psychotherapies to be made available and funded through ACC as interventions for suicidality as opposed to currently only being offered as a form of trauma recovery therapy following sexual abuse.

Mindfulness and meditation

Mindfulness and meditation practices work for different participants in different ways. For example, in a similar way to Annie's use of art therapy, Carol uses mindful colouring-in-pictures to occupy her hands and body in order to focus her emotions as it "takes away all the horrible thoughts". Tamara's practising of mindfulness and meditation however led her to a daily gratitude practice. Michael and Paula discussed their uses of mindfulness and meditation as a form of spirituality. Both participants described the practices as an intervention which decreased their suicidal ideation and distressing thoughts. According to the Mental Health Foundation (2018c), mindfulness is an approach to focussing our attention that is characterised by openness, acceptance and an enhanced ability to respond to the present moment. Paying attention to a particular thought, feeling, physical sensation, other

person or thing focuses our mind. By being mindful, we gain a clearer understanding of how our thoughts and emotions influence our health and life overall.

Related to the data from Michael and Paula, research carried out by Barnhofer et al. (2007) found that the action or practice of meditating can provide cognitive-based treatment for preventing relapse to suicidal depression. Interestingly, the ‘mindfulness and meditation movement’ has led to meditation and mindfulness practices increasingly being used in workplaces, health services and in schools. In fact, mindfulness is being promoted in schools around Aotearoa/New Zealand as a youth suicide prevention method (Clements, 2017). More than two hundred schools are facilitating the *Pause, Breathe, Smile* (PBS) mindfulness programme. PBS is an evidence-based programme aligned to the Aotearoa/New Zealand curriculum, supported by the Mental Health Foundation and now delivered by The Mindfulness Education Group (Devcich, Rix, Bernay & Graham, 2017).

The positive effects that some of the participants experienced from using mindfulness and meditation practices reflect accurately what Durie (1998) defines as *Taha Hinengaro*: the expression of thoughts and feelings through an inseparability of mind and body. In times of distress, several participants used mindfulness and meditation to regulate their emotions and others used the practices as part of their daily routine to help them to feel focussed and less anxious. Practising mindfulness and meditation led Tamara towards her own personal research into a gratitude practice. After trying several different medications and accessing other forms of psychotherapy, Tamara wanted to find out what else might be effective for her mental wellness. Through a friend, she discovered a gratitude practice linked with an interactive mindfulness practice. A daily reflection and a focus on the positive things which have happened, teamed with daily meditation, have been more effective for Tamara than cognitive behavioural therapy, dialectical behaviour therapy and acceptance and commitment therapy.

A study by Marchand (2012) discusses the success of using mindfulness and meditation for depression, anxiety and suicidal ideation. According to the author, clinicians need to become more familiar with mindfulness practices in order to be able to offer consumers treatment options from a more extensive and current choice of interventions. Both Carol’s and Bob’s community mental health teams suggested and provided them with mindfulness sessions which they each found to be effective ways to focus, take control of their emotions and as a way to “take away all the horrible thoughts” (Carol). Other participants including Tamara and Michael stated that mindfulness practices had not been suggested to them by their community mental health service, or by their GPs. They both thought that this was lacking

from the list of potential interventions that GPs could offer. These findings imply that those mindfulness and meditation sessions offered by some service providers are well received by the service users who access them. This suggests a recommendation therefore, for other service providers (including other CMHTs, GPs or community centres) to do the same. The fact that these practices affected participants in several different ways and resulted in positive changes within different dimensions of their health and wellbeing illustrates the potential for mindfulness and meditation to provide effective, non-medical and affordable therapeutic treatment to many people in many different ways.

6.5 Spirit

This theme is broad in its scope and includes those faiths, spiritual beliefs, systems of support and places which offered a sense of purpose and connection and which acknowledged health and wellbeing improvements as being more than physical adjustments or medical treatments. Participants experienced spirituality in different ways with some explaining how their Christian faith had been vital to their recovery whilst others reported the ways in which Buddhism provided them with a new way to focus on reality following the trauma of a suicide attempt. Two participants discussed the ways in which local opportunity centres provided them with a sense of purpose and a feeling of being connected to their local community. Rather than addressing spirituality, opportunity centres are discussed in this section because they positively affected participants' spirits, as in, their internal, socially-constructed understanding of what and who else they belong to.

Spirituality

Similar to Amy's experience was Michael's discovery of how effective spirituality could be as a suicide intervention and as a continuing source of mental health support. Michael also advocated for spirituality to be "taken more seriously by doctors" as an available form of mental health support. Comparable with the findings from the Waitemata Clinical Research and Resource Centre team (Agnew et al., 2004, p.41), Michael's key message was that his spirituality played a large part in his recovery following a suicide attempt and in his ongoing wellness journey. Therefore, he would have liked to have had some information provided to him by his GP regarding spiritualism and alternative forms of healing. As a strengths-based approach also promotes, Michael thinks that this is something which must improve in the future for other consumers of mental health services.

As these findings suggest, spirituality and religious beliefs can provide powerful support for people following a suicide attempt or suicidal ideation and/or during their ongoing wellness journey. Related to this is Mason Durie's (1985) response to a piece of research undertaken from 1978-1980 by the Māori Women's Welfare League which uncovered the issues and barriers Māori were experiencing in health. The research found that the primary barriers were the lack of spiritual recognition and perceived racism. In response, Durie developed Te Whare Tapa Whā as a holistic model of health which included and promoted spiritual health (Taha Wairua) as having equal importance to physical health, mental and emotional health and family health and social wellbeing. Durie's model encouraged clinicians to see Taha Wairua as essential in Māori health and to support it within their service delivery. As evidenced by Amy and Michael's experiences, if Taha Wairua is part of our own personal whare, it must be recognised and supported in our healthcare in order to support our overall hauora. This could be achieved if more service providers were to recognise alternative models of health including those described in Chapter 2 such as Te Whare Tapa Whā model (Durie, 1994) or the Fonofale model (Pulotu-Endemann, 2001). If the recognition of these models was strengthened further, and more assessments and interventions that reflect this approach were developed, then more healthcare providers would be able to actively include and promote spirituality in their service provision. More specifically, as Michael recommends, before prescribing medication, GPs could support this by suggesting referrals to spiritual community support workers or caregivers (Selwyn Foundation, 2015) and these could be provided by CMHTs.

Religion/church support

Religion and church support were discussed by several of the participants as important parts of their Taha Wairua (Spiritual Health & Wellbeing). After trying many treatments including medication for the severe psychotic episodes she experienced following a breakdown, Amy stated that only her newfound belief in God was the intervention which contributed to her continuing wellness. Echoing Amy's experiences is research carried out by the Clinical Research and Resource Centre team at Waitemata DHB in Auckland, into Pacific models of mental health service delivery in Aotearoa/New Zealand. The team found that church support networks provide Pasifika people with "a range of support mechanisms to assist mentally unwell family members to 'get well'" (Agnew et al., 2004, p.41). From speaking with Pasifika consumers of mental health services and their families, the team described the significant and inextricable links between culture, religion, spirituality and identity which exist within different models of health beliefs (including the Fonofale model; the Faafaletui

model and the Te Vaka model, among others). Each of these models, in a similar way to Te Whare Tapa Whā, highlights how important religion and spirituality are for many people in Aotearoa/New Zealand in terms of their overall health and wellbeing. According to Tiatia-Seath (2015), churches and other places of worship have a large part to play within the support of people's mental health wellness and more specifically suicide prevention. As the data from Amy's interview reminds us, places of worship, faith groups and the connections which these bring can be powerful support systems for people during mental health distress as well as providers of ongoing wellness support.

6.6 Tukutuku

As a metaphor for presentation purposes in this research, tukutuku shows how additional, overlapping psychosocial interventions, treatments and/or support systems can affect our overall hauora (health and wellbeing). Presenting these areas separately to the four dimensions in the previous chapter worked well because the psychosocial interventions, treatments and/or support systems reported by participants related to one or more of the four dimensions of Te Whare Tapa Whā; for example, they did not easily 'fit' into one dimension, or they overlapped into several. Presenting them therefore, as examples of interwoven interventions, demonstrates them as unique but also as holistic. These further forms of support which work for participants also serve to illustrate how recovery is not an exclusively individual journey but rather one that connects the four different domains of people, body, mind and spirit.

Pets as support

Mary's pet played a large part in her recovery due to her bond with her dog, the need to "get out of bed that day" to walk it, the exercise she subsequently did and the social interactions she had with people when she walked her dog. This is a strong example of tukutuku as simply by having a pet, Mary's physical health, social wellbeing and subsequently her mental health all improved. Animals have been associated with positive effects on service users' wellbeing in a variety of health care settings (Barba, 1995). Related research by Barker and Dawson (1998) found that animal-assisted therapy was associated with the reduction of anxiety levels for patients in hospitals who had a variety of psychiatric diagnoses. In Aotearoa/New Zealand, for people living with particular mental health disorders who do not have their own pet, mental health assistance dogs are available (<http://ppadt.org.nz>).

Adult education

Bob's experience of returning to adult education was another example of tukutuku. As he stated: the social participation, the positive affirmations he received and the subsequent career he began as a result of gaining his degree were all factors which contributed to his wellness as a result of returning to University. As Bob's statement in the previous chapter shows, it is crucial to view our health holistically, and by supporting one wall the other walls in our Whare will be strengthened. As an intervention for suicide, entering into or returning to adult education was not an expected finding of this research. The overwhelming effect which it had on Bob's recovery however was another key message he wanted to share. How then, can it be made easier for more adults (if they wish) to return to education? In December 2017, the current Government announced its new policy to fund the first year of tuition fees for students within post-school education or training (Collins, 2017). This fees-free first-year incentive aims to lessen the financial burden felt by students and allow for more people to enter (or return to) higher education. Similarly, if the Government were to increase the number of occupational therapists available, then this could provide another way to support people to find (and keep) meaningful occupation; the importance of which was supported earlier on by Delia's experiences.

Employment

Similar to Bob's experience of returning to education, seven participants stated that either finding or returning to employment had been pivotal in their recovery following a suicide attempt and/or in maintaining their mental wellness. Being at work helped both Delia and Carol's respective mental health as well as their social wellbeing as social interactions with their colleagues decreased their isolation and social anxieties and increased their confidence. Claire.B and Carlos' experiences reveal how supportive environments at work can be crucial to our mental wellness.

For each of the participants whose data was presented in this section however, supportive working environments would not have been as effective without the positive support of their colleagues. The successes experienced by the participants who felt that finding or returning to employment had been crucial to their recovery were possible because their employers and colleagues showed understanding, care and compassion. However, according to Lennan and Wyllie (2005), this is not a common experience. All twenty-five of the organisations involved in their research throughout Aotearoa/New Zealand expressed concerns about

employing people with experience of mental health challenges. Employers were concerned about the person's safety, were worried that the person would not 'fit' into the organisation's culture and feared that they would not be productive employees. Colleagues were also apprehensive about how the person would behave (Lennan & Wyllie, 2005). The authors of the research recommended that employers should be provided with information and strategies so that they were better equipped to support staff who became unwell due to a mental illness. The findings also suggested that outside de-stigmatisation organisations must focus on the need to reduce employers' fears of the unknown regarding mental illness.

Organisations such as Te Pou, Like Minds Like Mine, the Mental Health Foundation, Changing Minds and Mind and Body aim to provide employers with relevant training and education in order to reduce mental health stigma and discrimination in their workplace. As part of their de-stigmatisation efforts, the Mental Health Foundation (2016a) published *Working Well: A workplace guide to mental health*. The guide, which promotes the use of Te Whare Tapa Whā model as a holistic approach to health and wellbeing, was designed "as a resource for employers who want to proactively understand, measure and increase mental wellbeing in their workplaces" (Mental Health Foundation, 2016a, p.1).

Peer support work

As detailed in the literature review, the organisation Te Pou (2012) was cautious regarding the efficacy of peer support programmes within suicide prevention, stating that there was an insufficient body of evidence to support any claims of success. However, since 2012, peer support services have continued to grow and peer support workers are now being provided by DHBs and NGOs throughout Aotearoa/New Zealand. Following this growth, in 2017, the Mental Health Commission produced a report which examined the power of peer support services. The report stated how effective the increased peer support workforce had been, how the recovery-focussed strengths-based model of peer support work had been central to its success *and* how the increase in the workforce had been driven by consumers' demands. According to the report, peer support services in Aotearoa/New Zealand are based on the accumulated knowledge of people with lived experience and there is wide support of the workforce from service users, consumer leaders and advocates who all request to develop peer support services further (Mental Health Commission, 2017).

Data from this doctoral study, presented in the previous chapter, reveals how important peer support work is for participants as a service which is as effective, if not more effective than that provided by clinicians. Receiving support through this service from individuals with

similar experiences helped the participants to feel a sense of equality and mutual respect which was crucial to their acceptance of the support provided by people “who can talk the talk and walk the walk” (Delia). Participants’ experiences of peer support work reflect the requests presented in the Mental Health Commission’s (2017) report to develop peer support services further in order to expand the “wonderful service” (Delia).

Similarly, participants’ positive evaluations of peer support work as an effective service echo the conclusions made from Te Pou’s (2017b) assessment of a particular peer support service in 2017. Te Pou stated that overall “the mutuality of peer to peer relationships and the explanatory journey of recovery transforms people’s lives” (Te Pou, 2017b, p.42). The report went on to discuss the significant amount of evidence which reveals the positive and substantial shift in the perception of the peer support model and the ways in which clinical pathways of shared learning have been “improved and further developed since 2011” (Te Pou, 2017b, p.41).

Respite

With a strengths-based approach in mind, respite was a key service which worked well for the six participants who had accessed it. This research therefore recommends that this vital service should be promoted and made more widely available. Some participants reported that they did not know that respite was potentially available to them until their CMHT informed them or they were told by a friend. Willa’s key message was that places which offer respite services should increase and the number of respite days allotted to a person must also rise so that the crucial service can be effective for more individuals.

The whole idea of it is that you have an allowance and you get to choose when you are at the most distressed within these three months or within the month you choose when it’s most needed...I would have a lot more respite places to have options. (Willa)

Carol was thankful for her respite allocation as an alternative to staying at hospital:

I said “please don’t put me into hospital” and I think then because I knew it was doing so much damage to be in hospital that when I went into respite and I didn’t have to stay in long, one night, two nights and I came back kind of different, yeah definitely different and a lot better.

Through a referral from a clinician, respite stays can be provided by DHB or NGO services, they may be peer-led or cultural specific and the number of allocated respite days varies

depending on the referral. For people living with mental health challenges, respite can be an effective transition from hospital, a planned break away from home and/or as a way of preventing further distress and possible admission to hospital (as evidence by Carol's experience). These findings suggest that respite services are vitally important to all of the six participants who access them, both in times of emergency and during their ongoing wellness. As Willa recommends, an increased number of places offering respite and an increased number of allotted respite days, teamed with better promotion of the service itself could lead to more individuals accessing an effective service. A wider implication of this could be a decrease in pressure on emergency departments and inpatient units in hospitals which are already stretched from increased demand with 170,000 people now using mental health and addiction services – an increase of 71% since the previous decade (Prime Minister's Media Release, January, 2018).

Media influences

Media appearances from celebrities such as John Kirwan and Mike King³⁰, who discuss their own experiences of mental health challenges, had a positive effect on participants' feelings towards their own mental health, helping to make the topic less taboo. This was shown by Michael's declaration of his "case of the JKs" to his family and friends following John Kirwan's presence in the media which meant that Michael felt able to reach out for help without having to use words which felt unmentionable to him.

Claire.B felt that television programmes such as '13 Reasons Why'³¹ were harmful, not only because the programme perpetuated myths around suicide but also because it "promoted it as a solution to suffering". However, she advocated for more messages from 'everyday people' rather than celebrities to show that mental health challenges are a reality for people from all walks of life regardless of celebrity status, age, culture, gender or employment role: "maybe not just notable people in the community, not just Mike King...but like just everyday people speaking out."

Although suicide rates in Aotearoa/New Zealand continue to increase (Chief Coroner's Office, 2018), the effects of John Kirwan's message have certainly been positive for the participants interviewed in this study. Mike King stated that New Zealand's mental health

³⁰ Mike King is an Aotearoa/New Zealand comedian and television personality who often discusses his own experience of mental illness and addiction in the media.

³¹ '13 Reasons Why' is a fictional, American web-television series. It provides the narrative of a teenage girl as she describes the thirteen reasons that led to her suicide.

services weren't ready for 'the John Kirwan effect', however, because of the increased number of people presenting to mental health services who in return are faced with long waiting lists and a limited availability of services (Shadwell, 2017).

The national campaigns and increasing media influences as described in the literature review had a positive effect for some participants whilst others felt that certain portrayals of mental health had created a suicide contagion. These campaigns have certainly raised awareness of mental health conditions and brought mental health discrimination to the attention of the Aotearoa/New Zealand public. A positive result of this has been the changing attitudes towards those with mental illness (Wyllie, Cameron & Howearth, 2008) that has in turn led to increased employment opportunities and financial gains for New Zealand's economy through increased hours worked by those with mental illness (Vaithianathan & Pram, 2010).

Before 2016, media guidelines explicitly prevented journalists from reporting attempted or completed suicides (Parliamentary Counsel Office, 2016). Changes included in the 2016 Amendment Act however, which are part of this wider societal change, have meant that more open acknowledgments of mental health challenges and wellbeing can happen. However, this increased awareness has led to a growth in service use and a significant amount of pressure on mental health services and resources. As highlighted by Mike King (Shadwell, 2017), the implication of the success of these campaigns is that services must be better funded, resourced and prepared in order to be able to provide the services that are increasingly needed.

Inpatient units

Participants' experiences of, and attitudes towards inpatient units were mixed. Of the nine participants who had accessed an inpatient unit, four individuals shared positive experiences whilst five, including Carol, described prison-like settings and disturbing treatment:

The mental health system did a lot of damage to me like when they put you in lockup; I felt that I was in prison. I felt like you are being a bad girl, you are going to be punished because I was suicidal they actually lock you up... actually I don't think the lock up helps anybody. I mean if you are violent then they have to protect others I can understand that, but I'm always as placid and mild as a mouse. To put you in lockup I think is just criminal, I felt like a prisoner. (Carol)

Taimi's first experience of mental health services in Aotearoa/New Zealand was so negative that it forced her towards drastic changes. She used the distressing events described below as inspiration later on in her life through her work within mental health advocacy:

When I came to New Zealand I was chucked behind a barb wired fence in a padded room and coerced into therapies that I didn't want and I was scared shitless...For me having that experience as opposed to what I experienced in Australia made me hurry up and change how I was living my life so I didn't ever have to go back and experience that again...it was terrifying...but it was probably a good thing because it changed my life because I experienced something really negative that I didn't ever want anyone to go through again and that is how I got into this business. (Taimi)

Experiences of 'lock up' and of seclusion in a padded cell as described by Carol and Taimi are not uncommon in Aotearoa/New Zealand. In fact, a report by Te Pou (2017a) revealed the variation of seclusion rates in different DHBs throughout Aotearoa/New Zealand during 2015. The findings of the report state that the rate of seclusion across Aotearoa/New Zealand's mental health inpatient services in 2015 was nearly 8% of admissions (out of 10,727 inpatient admissions). The Office of the Director of Mental Health Annual Report 2015 (Ministry of Health, 2016a) found a slightly higher figure in which 10% of people (out of 7,545 people) were estimated to be secluded. The report praised the efforts of seclusion reduction strategies that had led to a steady reduction since 2009, when 19% of people who accessed mental health inpatient services had experienced seclusion (Ministry of Health, 2010).

Although the report described the positive changes regarding seclusion rates within mental health services, it also stated that improvements still need to be made, particularly as "seclusion is a practice that negatively impacts on the individual freedom and recovery of people in New Zealand" (Te Pou, 2017a, p.7). Te Pou continue to strive for the elimination of seclusion and advocate for a zero-rate of seclusion in the future (Te Pou, 2017a). The aim for a zero-rate of seclusion to be used in Aotearoa/New Zealand's mental health inpatient units is supported by research that concludes that seclusion is a major source of distress for most people involved and the experience often accentuates previous traumatic experiences (Happell & Harrow, 2010; Taylor et al., 2009). The research links to Claire.A's key message regarding best practice in the previous chapter where she stated that mental health support staff must be trauma informed not only in order to provide a better standard of care but also so as not to add to a person's existing trauma by using distress-causing treatments.

Adding to the demand for a zero-rate of seclusion was the concern expressed by the United Nations Committee Against Torture regarding Aotearoa/New Zealand's use of seclusion within prisons and mental health facilities for punishment and discipline (United Nations, 2015). Later, The Human Rights Commission in Aotearoa/New Zealand produced a report that outlined a number of serious concerns about the country's seclusion practices. Although this later report did not condemn the use of seclusion nor advocate for a zero-rate, it did conclude that: "the use of seclusion, segregation and all forms of restraints should be significantly reduced, and reserved for the most extreme of cases, and then used only for a very short time (The Human Rights Commission, 2017, p.14)

Related to this doctoral research are the recommendations from The Human Rights Commission's report (2017), echoed by Te Pou's (2017a) report, that state that sensory modulation and art therapy are two possibilities that must be explored as alternatives to seclusion rooms within mental health inpatient units. The two documents describe sensory modulation as a workplace based reduction tool that can provide a "key prevention framework for reducing the use of seclusion and restraint in mental health services" (Te Pou, 2017a, p.7). Earlier research by Sutton and Nicholson (2011), carried out with staff and service users within mental health inpatient units within four DHBs in the North Island of Aotearoa/New Zealand, reported sensory modulation interventions as being effective in modulating distress and promoting calm.

Sensory modulation is an approach involving learning to understand and use our senses (including sight, sound, smell, touch, and taste) in a way to feel calmer and relieve distress (Champagne, 2008). Serious concerns regarding the use of seclusion rooms (and restraint) within Aotearoa/New Zealand's mental health services have led to a focus towards sensory modulation interventions as an alternative to seclusion and restraint. During her interview, Carol described the benefits she experienced when using sensory modulation as calming tools to use whenever she felt anxious but particularly when she thought about previous traumatic events, including the seclusion room she experienced within hospital.

I also did a sensory modulation course and I found that really helpful. So it is actually getting things like toys and I got a whole big box of stuff and if you are feeling stressed or anything because I had a lot of anxiety going out. So before you actually have all these little nice things that they showed us on the course. So I collected them all and if I'm feeling really stressed I go and use these...squeezy balls and smelling things and I put a bit of coffee because I like the smell of coffee. So I find that actually calms because I was

getting really stressed and my heart was racing and I noticed that really calmed down the anxiety. (Carol)

Both Carol's experience and Annie's use of sensory modulation through art therapy mirror the findings from Sutton and Nicholson's (2011) research. The data from these two participants in particular further promotes the use of creative therapies as an alternative to seclusion (and restraint) within Aotearoa/New Zealand's mental health inpatient units and mental health services generally.

Amongst the stories of distressing treatment, the positive experiences that were shared acknowledged caring staff members and a sense of belonging to an inclusive care environment. Staying in an inpatient unit was crucial for Rose who praised the staff who supported her and who was grateful to be in the best place to "get the right treatment." Annie felt that effective and inclusive inpatient units had previously been beneficial for her wellbeing and she was critical of the current lack of availability of such services. She described the shortage of places offering inpatient stays (the unit she discussed nostalgically in the previous chapter was closed down several years ago); the strain on resources; the high demand for mental health services generally and the scarcity of beds (stays) in Aotearoa/New Zealand's mental health services.

In July 2018, the Ministry of Health published a document that summarised the use of mental health and addictions services provided in Aotearoa/New Zealand during the year 2015-2016 (Ministry of Health, 2018b). The findings of the document revealed that 13,000 people required a bed (for at least one night) in a mental health inpatient unit during that year (by 'required', the demand for a bed had come from the person themselves, a GP or the crisis team). However, in 2015-2016 there were just 590 beds for people in mental health crisis in Aotearoa/New Zealand meaning that there were more than twice as many patients needing beds as there were spaces available to accommodate them. During the same year, there was double the amount of people who were being seen for crisis assessments as there were beds for one night available (Ministry of Health, 2018b).

In 2017, research carried out by the Office of the Auditor General found that the need for mental health services is far exceeding the growth in resources. For example, clients seen by Mental Health and Addiction Services during the years from 2008/09 - 2015/16 increased by 50% while funding for those services grew by just 16.5% during the same time (Office of the Auditor General, 2017). As the earlier quote from Mike King stated, Aotearoa/New

Zealand's mental health services did not appear to be ready for 'the John Kirwan effect'. As the demand for mental health services grows, and the current inquiry into mental health and addiction is still ongoing, perhaps the previous recommendation of increasing the number of respite places and the number of stays could help to address this need for services? And perhaps alternative sources of support can be promoted instead of mainstream mental health services? As the findings of this research illustrate, there exists a variety of interventions that can work outside of the medical model of recovery (Hamilton, 1967).

An integrated service for sensitive claims

Since December 2014 - when the ISSC provision (previously ACC sensitive claims) was introduced - claims have increased dramatically. The service provider states that this increase is due to improvements to both the services provided and their accessibility (ACC, 2017). For two participants in this study, ISSC has delivered what it aims to provide: "streamlined, holistic, individually tailored pre-cover support, assessment, and treatment services for clients (and their family/whānau) who have experienced sexual abuse or assault" (ACC, 2017, p.81). However, for three participants, the service has failed them greatly, providing disturbing experiences that added to their trauma and in some instances, increased their suicidal ideation.

Targeted interventions

For Paula, the importance of having support provided by other Pasifika people was clear. However, while many District Health Boards do provide mental health services targeted towards Pasifika people, more research is still needed into the quality of care for Pasifika mental health service users and regarding the efficacy of these services (Le Va, 2017). The demands for better, more culturally-sensitive mental health services for Pasifika people are not recent (Tiatia, 2008; Te Pou, 2008), however, the pressure is certainly increasing, particularly since Pasifika people (as well as Māori) are reported to have the highest rates of anxiety and depression of people in Aotearoa/New Zealand. Pasifika people are diagnosed far less than people of other ethnicities (Lee, Duck & Sibley, 2017) *and* Pasifika males are among the most at risk of suicide within Aotearoa/New Zealand (Tiatia-Seath, Lay-Yee & von Randow, 2017).

Pasifika communities are the most under-diagnosed and least engaged with the country's health system (Lee et al., 2017). While Pasifika and Māori communities both tend to have high levels of mental distress, "Pacific peoples exhibit lower rates of actual diagnosis and

mental health service use than Māori" (p. 10). Lee et al. (2017) found language barriers and significant cultural divides were amongst the main reasons for limited engagement: "Perhaps due to the lack of cultural competence among doctors, many Pacific peoples report experiences of low-quality service in primary healthcare" (Lee et al., 2017, p. 17). An implication of these barriers means, that not only are Pasifika people less likely to access mental health services, but it is also difficult to ask Pasifika people directly, what could actually work to improve their health outcomes? Ten years ago Tiatia's (2008) research aimed to find answers to this question. Her research reported that, in order to increase levels of engagement among Pasifika people and to improve the quality of services that they experience, health services must focus on issues of cultural competency.

As a way to address this, Tiatia (2008) recommends the promotion of Pacific models of care within healthcare services (such as the Fonofale model; the Faafaletui model and the Te Vaka model, as discussed in Chapter 2). In a way similar to Te Whare Tapa Whā model of health, these models advocate the importance of spirituality as an essential component of Pacific people's health (Pulotu-Endemann, 2001). Represented by the roof of the fale (house), culture includes values and beliefs acting as a shelter for the family for life. These values and beliefs can include beliefs in traditional healing methods as well as western methods (Pulotu-Endemann, 2001). This implies therefore, that if current, general health services were to provide traditional healing methods alongside western methods, then Pacific peoples may be more likely to access health services. Interestingly, this has links with Mary's earlier recommendation for community mental health services to be embedded into general health services (within local GP surgeries/medical centres). As well as the promotion of Pacific models of care, Tiatia (2008) reports that increasing the capacity of the Pacific health and disability workforce has the potential to positively affect the numbers (and experiences of) Pasifika people accessing mental health services (and health services generally). This thesis therefore recommends a growth in the services provided *by Pasifika people, for Pasifika people* that could increase cultural competency and improve health outcomes for Pasifika people - as evidenced by the importance for Paula to be supported by her tagata.

6.7 Implications and recommendations

Throughout this chapter, the findings of this research have been examined in detail and the conclusions that can be drawn from those findings have also been discussed. The wide-ranging variety of effective interventions, treatments, services and support systems that

participants have said are helpful, as well as those that need to be improved, presents as an advantage of the research. These findings subsequently have significant implications for:

- health practitioners' practice (in terms of recommendations for best practice)
- policy (as the research aims to inform the Ministry of Health's current and ongoing mental health and addiction inquiry)
- further research
- future interventions and treatments.

This section will also put forward recommendations suggested by myself and by the participants regarding the promotion of current and effective interventions, treatments and services that coincidentally includes implications for the education of such support provisions and their potential. Recommendations for service providers to view health and wellbeing more holistically have featured throughout this thesis as well as the demand to include more service users as experts within research into what works regarding suicide prevention interventions, treatments and services. The implications of these demands for further research therefore, are outlined in this chapter. In the following chapter, these suggestions for further research will be explored in more detail as part of my concluding comments.

Best practice recommendations

As well as questions of ‘what works?’ participants were also asked for their thoughts on best practice and these were presented in the previous chapter. The findings from questions regarding what makes best practice ‘best’ and what it should look like suggest that best practice should include:

- Clinicians (and all staff) taking the individual seriously, taking the time to show interest and validating their emotions and experiences.
- Staff must be caring and show respect and compassion – seeing the individual as human is essential.
- Looking outside of the diagnostic box, being aware of the individual’s complexities, including past traumas.
- Seeing strengths and promoting them (reflective of a strengths-based approach).
- Sharing the power through collaborative (and not coercive) treatments such as the co-design of treatment plans.
- Showing honesty and openness.
- Staff being ‘holders of hope’ rather than diagnosing individuals with a ‘condition for life’.
- Non-judgemental, professional and consistent care, for example by providing timely responses and keeping to promises.
- Suggesting other therapies/interventions outside of the medical model such as art therapies, sensory modulation and psychosocial interventions.
- Exploring other possible physical factors such as physical root causes of mental distress and how these may impact on an individual’s mental health.
- More of a holistic focus on health, reflective of Te Whare Tapa Whā model of health; best practice must support an individual’s overall health and wellbeing.
- Family/whānau members being listened to in times of crisis.
- Finally, staff having lived experience is valuable (though not stated as essential by all participants).

The above points provide a summary of the data presented in the previous chapter regarding service users’ knowledge and opinions of best practice. These findings demonstrate how theories and understandings of practice can be developed from the everyday experiences of service users and how gathering people’s narratives to make sense of best practice can help to build a unifying representation of how practice can be improved and become ‘best’ for a

particular time and place (Ferguson, 2008). Participants' constructions of best practice listed above align with current knowledge; establishing a caring and honest relationship is acknowledged as highly important for therapeutic outcome (Lambert & Barley, 2001), and recommendations for a strengths-based approach are common (Pulla, 2014). Similarly, the principle of collaborative working and allowing for the individuality of that person appears in the Aotearoa New Zealand Association of Social Workers' practice standard publication (ANZASW, 2014). Furthermore, treating service users with respect and being open minded and non-judgemental are skills that are listed as essential, basic indicators for staff working in the field of mental health (Ministry of Health, 2008d). Finally, these recommendations can also be used by service providers as a way to check whether their practice aligns with what service users are saying they want it to include.

Outcomes of the research

Although the aforementioned guiding documents (ANZASW, 2014; Ministry of Health, 2008d) inform staff of what their practice standards should involve, the guidance is not reflective of participants' experiences as service users. For example, in the previous chapter, participants discussed how important it is for them to be listened to and to have their feelings validated by practitioners. This importance featured in several participants' discussions of what best practice should look like but also featured in their criticisms of services provided by a crisis assessment team or by a key worker, for example. These findings show similarities with research conducted by Gordon, Stevenson and Cutcliffe (2014) that described the importance for participants to feel validated and listened to by practitioners. The study highlighted the role of mental health practitioners when hindering or facilitating service users' sense of value and worthiness. The research found that when professionals worked *on* rather than *with* service users, a sense of unworthiness increased dramatically, leading the service user towards further alienation away from treatment whilst simultaneously increasing their suicidal ideation and attempt.

Coney (2004) discusses the difficulties within mental health and social care for practitioners who wish to empower those who they support whilst also holding on to their 'provider-power'. For example, mental health service providers such as psychologists, psychiatrists, and social workers are often seen as the more powerful person in their relationship with service users (Coney, 2004). These practitioners have the power to diagnose, treat and/or detain individuals at the same time as trying to empower them to become more independent. Interestingly however, Zarb (1992) describes the futile nature of trying to empower someone

other than ourselves: “empowerment is not something that can be given, but something that people must take for themselves” (Zarb, 1992, p.127). Perhaps the issue then, is not how service providers can empower service users but how those mental health services can create environments where empowerment is enabled. Peer support work, for example, is an environment in which this empowerment may be easier to achieve than others as it can bring about a feeling of equal power and, for the service user with lived experience working as a peer support worker, a feeling of being an expert who can guide others. Service users in this research also reported feeling empowered by the media influences and national campaigns discussed earlier that aim to raise awareness of mental health conditions and decrease stigmatisation. Similarly, participating in exercise, returning to employment and accessing adult education led several participants to feel empowered, as illustrated by the powerful experiences presented in the previous chapter.

This research suggests that these psychosocial areas as interventions for suicidal ideation and severe depression hold great importance and recommends that service users, service providers and researchers focus further on the interventions described as tukutuku in this thesis. Focussing efforts of funding, further research and improved practice on the potential for psychosocial interventions as a powerful tool for recovery and wellness is becoming increasingly necessary, particularly as mental health services provided within the medical model are over-stretched and under-resourced (Office of the Auditor General, 2017).

The findings of this research reflect and promote the use of models of service delivery that are flexible enough to combine personal preference and the strengths of service users, with intensive and person-centred support from service providers. For example, Flexible Assertive Community Treatment (FACT), as described in this chapter, recognises the individual and their environment. And so, this treatment enables and builds upon the positive connections between the individual and their environment, whether that be through opportunity centres, pets, cycling or employment. From a psychosocial perspective or from a social work viewpoint in particular then, overall, the participants’ testimonies highlight the benefits of holistic models of service delivery such as FACT as opposed to the more fragmented services that tend to deny holistic emphasis on personhood.

Related to the previously listed recommendations for best practice in this research are O’Gara’s (2008) reflections on his own experiences as a mental health social worker. The author discusses the dynamics of his practice alongside the ethical dilemmas that “flow from the statutory powers to protect vulnerable people” (p.229). Pertinent to Claire.B’s thoughts in the previous chapter is O’Gara’s (2008) call for practitioners to continually question all

aspects of their practice and of the best options whilst also acknowledging that the very act of having and using such powers raises profound ethical dilemmas that cannot be reduced to simple ideas of 'good' or 'bad' practice.

As shown in the previous chapter, several participants felt there was a lack of information provided by practitioners when informing them of all the treatment options available. Tamara for example, argued for an increased awareness of alternative treatments such as mindfulness and gratitude practices whereas Michael was critical of the lack of other forms of healing such as spiritualism and meditation suggested to him by his service providers. Therefore, if our knowledge of best practice is derived from research evidence and service user participants, (Marsh & Fisher, 2005) then the aforementioned list of best practice recommendations provided by participants is an essential piece of knowledge.

A strength of this research is its individuality; currently, there has not been another piece of research conducted with service users in Aotearoa/New Zealand regarding their experiences of suicide prevention treatments, services and interventions. It is hoped that this research can be used to better inform future legislation including the Ministry of Health's current (and ongoing) mental health and addiction inquiry that aims to:

...hear the voices of the community, people with lived experience of mental health and addiction problems, people affected by suicide, and people involved in preventing and responding to mental health and addiction problems, on New Zealand's current approach to mental health and addiction, and what needs to change.

(Ministry of Health, 2018a, p.3)

The inquiry will report back to the Government by the beginning of November 2018 and I hope that this doctoral research can influence the information that will be passed on regarding suicide prevention and intervention in an attempt to positively affect Aotearoa/New Zealand's suicide rates. I hope this study enables the voices of a marginalised group to be heard and their knowledge and experiences may lead to important applications to improve practices. This includes the use of a strengths-based approach to social work that was discussed in detail in Chapter 2 and throughout the thesis; the benefits of which have been evidenced by participants' experiences. Included in the strengths of this approach have been alternative therapies such as art therapy, mindfulness and meditation, gratitude practices, diet and exercise and sensory modulation. Alternative therapies have had a profound effect on the health and wellbeing of most of the participants in this study,

highlighting the importance of exploring interventions outside of the medical model. Other unanticipated findings included Taimi's own experience and subsequent recommendation of the early diagnosis of physical root causes of mental distress including autoimmune diseases that can lead to brain inflammation affecting one's mental health. Interestingly, none of the literature covered in Chapter 2 actually addressed this and it is important to question why reviews of the literature did not reveal links to physical root causes of mental distress including autoimmune diseases. Perhaps this was due to my search terms focussing on suicide prevention interventions, treatments and services, whereas existing research regarding autoimmune diseases and subsequent brain inflammation relates to mental health distress as a wider issue, rather than focussing on suicidal ideation as a potential implication. There is, however, a large amount of literature regarding the impact of mental distress on the body, for example the negative effects of stress on the body (DeLongis, Folkman & Lazarus, 1988; Lehavot & Simoni, 2011; Marshall & Cooper, 1976).

According to Cole (2018), many autoimmune diseases (such as type 1 diabetes, celiac disease or lupus) go undiagnosed for significant periods of time. Why is this? Cole's (2018) theory is that to be officially diagnosed with most autoimmune diseases, the immune system must have destroyed a large amount of tissue (in the brain or the nervous system). Subsequently, many people remain stuck between diagnoses: they are damaged by the effects of an autoimmune disease on their brain (inflammation that can cause mood disorders) but are not yet 'medically unwell enough' to be diagnosed as such. The implications of this are widespread: countless individuals may be prescribed medications to treat a mood disorder whilst their autoimmune disease remains undiagnosed and untreated. Secondly, these mood disorders (such as depression, severe anxiety or bipolar disorder) can lead to suicidal thoughts and behaviours including attempt (Benros, Waltoft & Nordentoft, 2013). And finally, if individuals continue to function with undiagnosed autoimmune diseases, symptoms of which they believe will be treated by medications for their mood disorder, then that autoimmune disease not only continues to affect their health but also continues to go undiagnosed. Upon further investigation, it appears that research into these links is a relatively recent area of study (Benros, Waltoft & Nordentoft, 2013; Cole, 2018; Brundin, Erhardt, Bryleva, Achteyes & Postolache, 2015). This also offers a potential reason as to why this research was not covered by my review of the literature. Findings from this doctoral research therefore suggest, as recommended by Taimi as a participant and supported by recent and emerging research, that the diagnoses of autoimmune diseases must be made easier and conducted earlier, preferably when people start to present to services with mental

health distress. These findings have substantial implications for health policy and practice because in Aotearoa/New Zealand, the availability of physical health screening for people experiencing mental distress appears to currently be lacking.

Experiences of mindfulness and meditation practices have featured heavily throughout the findings and discussion chapters of this thesis. Although mindfulness and meditation practices are increasingly popular in schools, this is currently only on a trial basis within two hundred Aotearoa/New Zealand schools (Clements, 2017). The use of mindfulness and meditation practices in schools is an essential part of Aotearoa/New Zealand's future of suicide prevention according to some of the participants, including Anita who felt that such practices would be invaluable to young people: "I think it is skills that especially teenagers going through all those emotions could really benefit from, backgrounding that emotional regulation, learning to cope and identify your emotions and what to deal with them."

Long-term use of mindfulness and meditation practices in schools could potentially act as a selective prevention strategy, as put forward in Chapter 2 by the World Health Organisation. As a selective prevention strategy, widespread mindfulness and meditation practices could be available to a population based on age (school children) who may not currently express suicidal behaviours but who may be at a heightened risk of psychological or behavioural risk, as Anita suggests. The findings of this research have implications for education in schools in that the data suggest how mindfulness and meditation can provide users with the tools to regulate their emotions during times of distress.

As Delia explained, using mindfulness and meditation practices led her to a realisation of the connection between her mind and body. Resourcing and promoting these practices within schools could be extremely beneficial to the future adult mental health population. An evaluation of the efficacy of the *Pause, Breathe Smile* (PBS) programme (Clements, 2017) being trialled in two hundred Aotearoa/New Zealand Schools reported that the mindfulness programme had benefited children by increasing calmness, improving empathy, kindness and respect and by enhancing emotion regulation, resilience and self-regulation (Devcich, Rix, Bernay & Graham, 2017).

These findings not only support Anita's recommendation of such practices to be used in schools but also have implications for education policies to promote mindfulness and meditation practices and for platforms like the PBS programme to continue for longer than a trial period and to be made available to all schools in Aotearoa/New Zealand. As adults, participants' experiences of using mindfulness and meditation have further implications as

they echo Marchand's (2012) suggestion that clinicians need to become more familiar with mindfulness practices in order to be able to offer consumers a more extensive choice of treatments for depression, anxiety and suicidal ideation.

National campaigns and media influences have been effective in their aims to increase awareness and discussion around mental health. However, this has in-turn led to a growth in the demand for mental health services; a growth that services did not appear to be ready for. As the demand for mental health services in Aotearoa/New Zealand increases, this research recommends that mental health services must be better funded and resourced to be able to support the increasing number of individuals requesting support. The need for the number of places offering respite to increase, as well as the number of respite days allocated for example, were key messages that resulted from the research findings.

Included within this increase in services must also be a change to how our overall health (hauora) is seen. An implication of the findings from this research is the importance of seeing health as a holistic model. Using and promoting holistic models of health such as Te Whare Tapa Whā with the addition of tukutuku - are a crucial way to support our overall health and wellbeing by supporting each dimension of our hauora. This research strongly recommends Te Whare Tapa Whā model of health to be used by all staff, clinicians and professionals in the field of mental health.

As mental health services are currently under so much pressure, alternative therapies such as creative therapies must be explored as a potential mainstream approach to suicide prevention as opposed to being viewed as a modality for individuals with low levels of anxiety (Stuckey & Nobel, 2010). Other alternative therapies evidenced by the data present an extensive variety of beneficial interventions, treatments and services that work for those people interviewed. A strength of these findings is the implications they suggest for policy and practice. For example, whilst medication was helpful for several participants, others felt that medication was prescribed too early by practitioners as opposed to suggestions of referrals to a social worker, dietician or employment advisor, for example. These findings are supported by similar criticisms voiced by other service users and bereaved family/whānau members to the mental health and addiction inquiry panel earlier this year (Reed, 2018). Therefore, recommendations for policy and practice from this research suggest that if practitioners were to recognise and decrease an over-reliance on medication, whilst simultaneously offering service users access to psychosocial support services, then many more individuals may experience more positive outcomes regarding their recovery and ongoing wellness.

The many different suggestions experienced and reported by the participants as being effective also have implications for the promotion and resourcing of these interventions, treatments and services. For example, participating in exercise, meditation and mindfulness practices and art therapy (as interventions for suicidal ideation and attempt) were not areas covered by the research discussed in the literature review. After hearing participants' powerful disclosures regarding the efficacy of these interventions, I wondered why I had not come across research into these areas when conducting my review of the literature. Certainly, research into art therapy as a tool for treating suicidal behaviours remains limited and the research that *does* exist tends to focus on the modality as a treatment of low-level anxiety (Stuckey & Nobel, 2010). An implication of this focus has been the delay in seeing art therapy as a rehabilitation tool for trauma recovery that has only become available and recognised as such by both ACC and Work and Income in the past four years (Mackintosh, 2017). The findings from this research suggest that art therapy, as a possible alternative (or possibly as a complementary alternative) to medication could also be seen as a promising mainstream treatment for suicide prevention and I recommend that further research into the potential of this field should be explored. Similarly, this research also supports the use of art therapy and sensory modulation practices as alternatives to seclusion rooms within mental health inpatient units. The successes of these alternatives have been evidenced by Sutton and Nicholson's (2011) research, advocated for by the Human Rights Commission (2017) and Te Pou (2017a) and are strongly recommended following the findings of this doctoral research.

Finally, one of the refreshing (and hopefully empowering) features of this research is the input from service users with lived experience themselves. This asset has not only provided crucial input from experts but also highlights the importance of collaborative enquiry. Service users must be included in suicide prevention research if we are to find out and then promote *what works* with the aim to better support people experiencing suicidal ideation and hopefully reduce suicide rates. The benefits of interviewing service users have been described throughout this thesis and it is hoped that future attempts to research with this group labelled as 'vulnerable' are made easier in order for effective, collaborative research to be possible.

As shown by the interview data, mental health service users want to have a say in the treatment they receive. As experts in their own care, they are also a source of invaluable knowledge into effective suicide prevention and intervention treatments and services. Not only do the findings of this thesis recommend more collaborative working in terms of research but they also encourage joint-working from health professionals with regards to

treatment, for example, sharing power in the co-design of treatment plans.

Summary

By using a qualitative descriptive methodology, much like a strengths-based model, which this study promotes, this research shows how finding out what works and then promoting it is more effective than starting with a predetermined hypothesis. This is shown by the variety of interventions, treatments and services described by the participants as opposed to the possibility of focussing on one or a few preselected interventions, treatments and/or services chosen by a hypothesis. This variety is a strength of the research. Participants' constructions are the product of this research and these products, as social-constructions of knowledge, can be used to influence suicide prevention and intervention policies; promote effective interventions; encourage further research, and inform best practice guidelines.

As discussed in this chapter (and promoted throughout the thesis), it is essential that service users are seen as experts in their own care and therefore are asked for their input into suicide prevention and intervention research. Not including service users in research has implications for developing policies that are effective and that recognise the potential of a strengths-based approach to recovery. By including service users in the research, design and evaluation of policies (and related practices), healthcare support that promotes an interdependency between services would be better informed, more effective and further promoted. As evidenced by the findings of this research, recovery is not entirely individual but rather is made more possible when our health and wellbeing are viewed holistically and when a variety of psychosocial interventions, psychological services and pharmacological treatments are not only suggested but are also made available. That is to say, that although each person's recovery journey is unique, and one that must be person-centred and guided by the individual themselves, recovery includes much more than an individual's efforts. Recovery following a suicide attempt and the continuing wellness of a person depends heavily on the different dimensions of their support – the holistic approach to their wellness - through the acknowledgment of the potential held by connected support systems, interdisciplinary services, effective treatments and personal, psychosocial interventions. It is hoped that the evidence regarding what works for service users provided in this research, as well as the list of best practice recommendations provided in this chapter, can be used by the Ministry of Health and practitioners everywhere. An overall recommendation of this research is for the extensive input from participants to be listened to and then promoted in the Government's current inquiry on mental health and addiction that has a specific focus on preventing suicide.

Each of the findings presented in the Chapter 5 have been discussed in detail within this chapter and participants' key messages have also been put forward. Recommendations and implications resulting from the research, including how to make best practice 'best' were suggested by using participants' experiences and ideas. As the themes emerged from the data (and were then developed further through the lens of Durie's model), a strengths-based approach was evident as an approach that had worked for some participants, and one that others wished for. In this chapter, the themes have been discussed in relation to previous research and current inquiries and outcomes of the research were presented. Chapter 7 will follow this discussion with my conclusions to the research with a recap on issues of transferability, usefulness and data validity. A reminder of the research questions, a summary of the main findings and several suggestions for further research will also be presented next with links to the influential literature and Aotearoa/New Zealand's current suicide prevention legislation discussed in Chapter 2.

Chapter 7

Conclusion

7.1 Summative statement

This thesis by research aimed to gain further insight into effective suicide prevention interventions in Aotearoa/New Zealand by asking service users ‘what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?’ Participants were also asked for their input into discussions of best practice - what it looks like and what else it could be. Their key messages of what else can be done to address Aotearoa/New Zealand’s concerning suicide rates were also included throughout the previous discussion chapter. Invaluable knowledge and suggestions were provided by service users as experts in the field of suicide prevention and intervention; their own experiences as data have revealed crucial socially-constructed knowledge. Through semi-structured interviews, the twenty participants were asked for their opinions of the following:

- What worked regarding the treatment/intervention they received?
- How has their experience of mental health service provision affected their wellness?
- What else helped?
- What could have been done differently?
- What are their key recommendations regarding best practice?
- What are their ideas regarding suicide prevention efforts overall and what else could work?

7.2 A holistic model of health

As presented in Chapter 5, the themes that resulted from the thematic analysis of the data were developed through the lens of the four themes of Durie’s (1994) Te Whare Tapa Whā model of health: Taha Hinengaro (Mental & Emotional Wellbeing), Taha Whānau (Family Health & Social Wellbeing), Taha Tinana (Physical Health & Wellbeing) and Taha Wairua (Spiritual Health & Wellbeing) and as an additional and interwoven dimension of tukutuku (psychosocial interventions). Te Whare Tapa Whā model of health worked well as a framework for presenting the extensive and varied interventions, treatments and services that participants discussed and its compatibility with holistic, strengths-based focussed perceptions of mental health complemented the research design.

The resulting themes of this research demonstrate the importance of viewing health and wellbeing holistically. Each of the dimensions within our overall health and wellbeing (hauora) are connected, and are further strengthened by the additional support of interwoven tukutuku. As Durie (1994) originally advocated, the model in this research also highlights the importance of Taha Wairua (Spiritual Health and Wellbeing) within our overall health and wellbeing, as evidenced by several of the participants' experiences. It is hoped that this research exhibits the benefits of using Te Whare Tapa Whā model of health. Its durability, simplicity and its widespread application in health policy mean that it can be used as a way for healthcare and support services to deliver culturally-appropriate and more holistically-effective care for Māori and non-Māori alike.

7.3 Outcomes of the research

To guide the reader through my discussion of the findings in Chapter 6, the data themes were grouped into four interrelated areas of people, body, mind and spirit. Categorised by the shared elements found within participants' experiences, the four discussion areas also honour the individuality of recovery, highlight the unique pathways for the participants and reflect the importance of a holistic model of health. The themes that were presented and discussed show what has worked for the twenty participants involved in this research. The interventions and services that have been effective for them included phone and text helplines, religion, peer support, professional care systems (CATs & CMHTs), community inclusion groups, self-help and family/whānau support. Medications were commonly used with varying levels of helpfulness whereas the wide range of psychotherapies used by participants, including DBT, CBT and ACT, were beneficial for each person, in varying ways.

The data also revealed a variety of alternative interventions that participants found effective. Many of these were unanticipated by myself, including art therapy, the diagnoses of autoimmune diseases, mindfulness and meditation practices, having pets as support, and spirituality. Further, effective psychosocial interventions that were discussed by participants included things like staying physically active, eating a healthy diet, accessing regular respite services, the effect of positive media influences, returning to employment and education, accessing targeted interventions and receiving timely responses back from experienced service providers.

Several participants discussed how some existing services, treatments and interventions could be improved. For example, some participants had had negative experiences with a crisis assessment team (CAT) and their subsequent suggestions included the need for further training and education so that service providers such as CATs can improve their care and

support provision. Following on from her own experiences, Mary recommended embedding community mental health services into general health services. As a result, mental health support workers and qualified therapists could be available within local GP surgeries/local GP medical centres as opposed to GPs referring a patient to a community mental health team located elsewhere. Taimi advocated for earlier health screening as a way to potentially identify and treat autoimmune diseases that are linked to mental distress; a recommendation I support. Ideas for future interventions were also suggested including Carol's idea for online DBT sessions via conference call. As Carol stated, this could be effective for individuals, like herself, who experienced social anxiety. All of these suggestions have a common characteristic of trying to link the individual seamlessly into support. For example, a more holistic approach would recognise the individual's support needs and the disconnections (if any) with their body/mind/relationships/spirit.

Further outcomes discussed in Chapter 6 were the thirteen points listed by participants with regards to what best practice must include. These essential standards and expectations, provided by people with lived experience, can be used to guide best practice guidelines used by the Ministry of Health and respective District Health Boards. I hope that participants' stories discussed in this thesis might encourage service providers to examine the impact they have as individuals and how they may continue to improve their practice and the services in which they are involved. The best practice recommendations listed by participants, and the stories which they resulted from, can be used by service providers as ways to check whether the practices they use align with those that service users say they need.

In an attempt to positively affect Aotearoa/New Zealand's suicide rates, this research aims to inform policy and influence the information that will be passed on to the Government regarding suicide prevention and intervention. Through various processes, including approaches to key stakeholders, conference presentations and journal articles, I aim to promote the findings of this research as well as the implications and recommendations discussed in Chapter 6. Also, within mental health forums and through strategic processes for feedback, I hope to share the key messages of the research with the Ministry of Health and the DHBs involved. Coincidentally, through the current Inquiry into Mental Health and Addiction, the Government has expressed its intentions to hear from people with lived experience of mental health challenges who have been affected by suicide to ascertain what needs to change regarding Aotearoa/New Zealand's current approach to mental health (Ministry of Health, 2018a).

7.4 Implications for policy and practice

As previously mentioned, the Ministry of Health's Strategy to Prevent Suicide in New Zealand: draft for public consultation (Ministry of Health, 2017) has been in its draft stage during the final year of my PhD. Although it seems strange to still refer to this document as a draft, at the time of writing it is still being used as such by the current Labour Government. The Government is now including the 2017 public consultation draft as part of the evidence to inform the current (and ongoing) inquiry into mental health and addiction (Ministry of Health, 2018a). The inquiry is due to report back to the Government by the beginning of November 2018. At the time of writing (October, 2018), the 2006-2016 New Zealand Suicide Prevention Strategy remains to be the guiding document used by the Ministry of Health to prevent suicide, as confirmed to me by an email from the suicide prevention committee (I. Ross, personal communication, August 31, 2018). This document was written over 12 years ago and is in urgent need of updating. The current inquiry into mental health and addiction aims to update the Government's knowledge of suicide prevention and intervention and I hope that this doctoral research can provide additional data.

As put forward in Chapter 5, this research recommends the use of a strengths-based approach within social work (and other allied disciplines) to be encouraged and promoted. Finding out what works for an individual and then supporting that to then happen, has not only been the aim of this research but is also an effective way to support an individuals' recovery and ongoing wellness. The powerful experiences shared by the participants reveal new knowledge about what works for people experiencing suicidal ideation and how support can be improved for people following a suicide attempt. In Aotearoa/New Zealand, there has not been a review of the effectiveness of suicide prevention interventions, treatments or services carried out with service users, to date. How can we know, fund, provide or improve what works for people experiencing suicidal ideation without their active input?

Many of the strategies and best practice recommendations discussed in this research could also be used to better support people living with other mental health challenges such as anxiety, mild depression or trauma recovery, for example. There are some strategies however that are specifically focused on suicidal individuals such as dialectical behavioural therapy and the services provided by a crisis assessment team. Also, participants discussed their experience of emergency respite which is specifically available for individuals in crisis experiencing suicidal ideation as well as other services including 24 hour telephone helplines (suicide crisis helpline) and emergency inpatient units. Participants' stories regarding these approaches provide reports regarding the efficacy of psychological treatments, the difficulties experienced when trying to

contact helplines and the ways in which specific suicide intervention services such as CATs are not abiding by the best practice guidelines they promote. I believe that it is vital for the Ministry of Health (and wider Government) to hear from service users regarding their experiences of existing suicide prevention efforts; according to the people who use them, are they working? If so, how? And if not, why not?

Overall, the findings suggest that participants would like to see mental health services become more humanised and more embedded in everyday services. With regards to this, and the systemic factors and social discourses which can contribute to suicide, I believe that more effective support is needed and must be provided by multi-disciplinary teams. Some of the participants who *had* experienced this were positive examples of its success (for example Carol and her community support worker), whereas others, like Michael, were examples of how people can fall through the gaps of separate disciplinary teams where the efforts are not joined up.

The importance of holistic care and support therefore was a key feature in the findings whilst also seeing the person as an individual who has socio-economic factors affecting their life. Subsequently, efforts to reduce poverty, improve education and provide better housing for people in Aotearoa/New Zealand would also make a significant difference to people at risk of suicide. Furthermore, stigma and shame surrounding mental health is very real for men in Aotearoa/New Zealand and often restricts them in being able to talk about their mental health and also in their efforts to access support. National campaigns are helping this however and the potential for national de-stigmatisation campaigns should not be overlooked as an effective way to reach people who may be at risk. A recommendation is for these campaigns to grow and increase - those that exist currently are effective, but their success, as commented on by the participants, suggests that they could go further and include more, for example, the voices of 'everyday people' with lived experience, or more men speaking up about their experiences of mental health; perhaps featuring Māori sportsmen in national campaigns could be effective? And finally, the links between undiagnosed autoimmune diseases and suicidal ideation was also a vital aspect of this research. A suggested implication of this therefore is for people to be offered blood tests when they first present to their GP with feelings of depression or suicidal ideation so as to determine whether they may have an auto-immune disease.

7.5 Future research with vulnerable participants

The unique approach of this research to include service users not only provided an invaluable source of data but also brought about an understandable amount of fear from gatekeepers. This fear led to an extensive process and subsequent lengthy delay to the start of the research as described in Chapter 3. During the ethical approval process, existing safeguards were developed with further detail and the safety of participants was crucial. However, I hope that this thesis shows how research with individuals deemed extremely vulnerable, when conducted in line with ethical standards, can be done so safely with fruitful results for researchers, participants and for the pool of knowledge of suicide research. The twenty participants who took part in this research reported a positive change in wellbeing following their interview and stated that being heard had had a cathartic affect. This outcome is comparable with previous studies conducted with ‘at-risk’ participants (Biddle et al., 2012; Coggan, Patterson & Fill, 1997; Gibson, Benson & Brand, 2012; Røn & Scourfield 2005; Smith, Cokrowicz & Poindexter, 2010; Thornton et al., 2012) that state that the risk of participants experiencing distress or re-attempting suicide because of their participation in suicide-discussion is an unsupported presumption. A particular study reported that “a tendency to overstate risks has hampered research, especially qualitative research seeking to explore the suicidal experience” (Biddle et al., 2012, p.357).

7.6 Further research

As discussed in Chapter 6, the outcomes of this research have implications for practice, policy, future interventions and treatments and for further research. Suggestions for further research that have come from participants’ themselves and also from my interpretation of the data are listed below.

- A measurement of the use of community mental health services is needed. The number of people accessing, or wanting to access help from CMHTs is difficult to measure as this data is no longer collected by the Ministry of Health, following the devolution of funding to DHBs in 2013/14 (The Office of the Health and Disability Commissioner, 2018).
- Further research that examines the efficacy of mindfulness and meditation practices in schools potentially leading to a trial of the practices for more than the current 200 schools, or to a longer trial period.

- An updated examination of the efficacy of sensory modulation (and other creative therapies) as alternatives to seclusion and restraint techniques in mental health inpatient units.
- Aotearoa/New Zealand-based research into the effects of easier and earlier diagnoses of autoimmune diseases that are linked to mental distress.
- Further research into the potential for psychosocial interventions such as pets as support, adult education, creative therapies, diet and exercise, media influences, religion and spirituality as tools for recovery.
- A study similar to this doctoral thesis carried out in the South Island of Aotearoa/New Zealand (particularly Canterbury) could reveal vital new knowledge regarding what works for service users in those areas of the country with the highest rates of suicide.
- A study that asks if there is potential for online DBT sessions for adults in Aotearoa/New Zealand, with conference calling for individuals to ‘attend’ as per Carol’s suggestion.

7.7 Limitations of the research

I hope that participants’ views have been fairly and accurately presented in this research. Efforts to protect the validity of the data have been supported by input from the participants, through the use of member checking as a form of respondent validation, in order to check the transcripts for accuracy before analysis took place (Birt, Scott, Cavers, Campbell & Walter, 2016). Guidance from the research reference group described in Chapter 3 also contributed to data-validity and the research was strengthened overall by the advice of the research reference group members. Similarly, questions of reliability that may arise from the use of thematic analysis in the research were also addressed by the involvement of participants in checking their transcripts and by the contributions of the research reference group. The limitations of this study were discussed in more detail in Chapter 3 and although this research can only represent the twenty participants who took part, the transferability and usefulness of the data for other service users and for service providers and Government alike are offered as potentially beneficial findings and recommendations. Only four DHBs responded to applications for locality approval and so the research is not representative of the entire North Island of Aotearoa/New Zealand or of the country itself. Several groups (and therefore important voices) are missing from this research; individuals from the rainbow community, people aged under 18 years and more Māori participants for example, would have contributed additional and essential knowledge of what works according to some of the most at-risk populations.

However, with those limitations in mind, it *is* hoped that this research can better inform current knowledge and future legislation regarding suicide prevention and intervention services in Aotearoa/New Zealand by providing the Government's Inquiry into Mental Health and Addiction with a current understanding of what *is* working. For example, this research can be viewed as a report which examines the efficacy of existing interventions, treatments and services and those which subsequently require further funding and resourcing. Service users have also shared which forms of treatment are less effective for them and why as well as their ideas of what else could be promoted nationally which isn't already happening. Similarly, the recommendations for best practice are suggested so that service providers can check whether their practice aligns with what service users are saying they want it to include.

7.8 Summary

Through the use of qualitative strategies of inquiry, this research positions itself underneath a constructionist epistemological umbrella. It has been guided by a strengths-based approach to find out and promote *what works*. And, by using a qualitative descriptive methodology, this research aimed to give service users 'a voice' by contributing to the existing field of suicide prevention research. As evidenced by the data presented in Chapter 5, service users are experts in their own care and their opinions must be heard if practice is to become 'best' or at least better. Little is known about what works with regards to effective suicide prevention interventions and how a strengths-based approach could help (Ball, 2010); it is this gap in knowledge that this thesis aims to fill.

Whatever the level of vulnerability a person has, they still have the right to information, the right to express their views and to have those views listened to and acted upon regarding their health and social care service provision. It is hoped that this study can influence future legislation and policy formation and ultimately, reduce the rates of suicide in Aotearoa/New Zealand and possibly elsewhere. Finally, given that one of my aims as a researcher has been to promote the voices of service users, it seems appropriate to conclude with a statement from a participant. Following her interview, Claire.B summarised her viewpoint as follows:

It can be such chaos going on inside your head, where you have no idea what is happening, you are just trying to stay afloat but you can't even raise your hand above water. When that happens, you need people to listen to you, to hear you and to be genuinely caring, to validate your feelings, to hold on to hope for you, to find out what could work for you in order to help you, and then to support you to make that happen.

Appendix A: Reference group members' invitation and information sheet



Study Title: What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/New Zealand

Ethics Committee Ref: 17/NTB/85

Locality: Various North Island areas including Waikato, Whangarei, Tauranga and Gisborne.

Lead Investigator: Behiye (Becky) Ali

Contact Phone Number:

Kia Ora, Hello,

Thank you for your expression of interest regarding being part of a reference group for my research. This letter aims to give you more information.

Information about myself

I have worked as a support worker for almost fifteen years; working with young people and adults with mental health support needs. I am passionate about advocating for individuals' rights, choices and involvement in their support and within wider areas such as the healthcare policies that affect them. I am currently enrolled in the PhD Social Work programme at The University of Auckland.

The project

My research question asks: what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?

To help answer this question I plan to conduct 10-20 interviews with people who use/have used mental health services aimed towards suicide prevention and intervention. I would like to ask them for their experiences and knowledge regarding the interventions and treatments that they have received and ask them questions around 'what works?'

Participants need to be over 18, must not have experienced any suicidal thoughts or feelings in the past six months and must be able to talk about their mental wellbeing in a healthy way.

The interventions and treatments that I am referring to can include psychological treatments (talking therapies), pharmacological treatments (medications) or psychosocial interventions (such as support groups, crisis telephone helplines, online computerised programs, church support, family/cultural support or peer support workers). I plan to conduct these interviews in the North Island between December 2017 and April 2018.

Why am I asking for your help with this research?

A research reference group can provide reflection and valued discussions during the research process. I am looking to establish a reference group to enhance the research itself, as well as my own knowledge, with your support. Ideally, this reference group would be made up of individuals who have key expertise and knowledge relating to my research. For example, I am looking to expand my knowledge regarding Māori and Pacific cultures when it comes to researching about suicide prevention and I am also keen to hear your opinions about the research questions that I plan on asking the participants.

I would like to meet with this reference group at least 3 or 4 times during my research process (from August 2017 to September 2018); particularly at the beginning for some advice and at the end for input into discussions of the findings. It is hoped that this reference group could work with me to develop my ideas and guide me through conducting my research. Following the reference group meetings, I would like to thank you for your help by offering you a \$20 Countdown gift card.

Confidentiality and records

Taking part in this reference group is completely your choice. If you do choose to be involved, please note that any reference group meetings would be audio recorded and I would ask you to sign a confidentiality and non-disclosure agreement as we would be discussing individuals' personal experiences (the de-identified data). The confidentiality agreement, audio data and transcribed records will be kept in a secure place and then destroyed after ten years. Your input into the discussions will be included in my PhD research and final thesis and your identity can be replaced with a pseudonym, if you would like.

What will happen to the research?

This research will be published as my PhD thesis and copies will be given to my University supervisors, markers of my thesis, and potentially other organisations like the Ministry of Health. There is also a potential that papers may be written and presented as a result of the research.

Taking part

If you have any questions about this research, or if you would like to take part in the reference group, then please feel free to contact me:

Becky Ali

Tel:

Email:

My supervisors Dr Barbara Staniforth and Dr Carole Adamson can also be contacted if you have any other concerns or queries:

Dr Barbara Staniforth

Tel:

Email:

Dr Carole Adamson

Tel:

Email:

If you are **not** interested in taking part in this research as a reference group member then you do not need to do anything else. Please feel free to discard this letter.

Many thanks and best wishes,

Becky Ali

University of Auckland Doctoral Candidate

Appendix B: Reference group members' confidentiality and non-disclosure agreement



Study Title: What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/New Zealand

Each reference group member must sign an agreement.

This Confidentiality and Non-disclosure Agreement (the "Agreement") is entered into by and between ("Disclosing Party") **Becky Ali** of The **University of Auckland**, and (Reference Group member) _____, of _____ (Organisation) _____ ("Receiving Party") for the purpose of preventing the unauthorised disclosure of Confidential Information as defined below. The parties agree to enter into a confidential relationship with respect to the disclosure of certain proprietary and confidential information ("Confidential Information").

1. **Definition of Confidential Information.** For purposes of this Agreement, "Confidential Information" shall include all information or material provided to and shared with the Receiving Party as data – this includes audio data, written field notes, transcriptions and all other data formats. All Confidential Information (data) is the property of the Disclosing Party. The Disclosing Party's Confidential Information is of a sensitive and personal nature. This Confidential Information will therefore not be shared by the Receiving Party (the Reference Group member) with any individual outside of the Reference Group.

2. **Exclusions from Confidential Information.** The Receiving Party's obligations under this Agreement do not extend to information that is: (a) publicly known at the time of disclosure or subsequently becomes publicly known through no fault of the Receiving Party; (b) discovered or created by the Receiving Party before disclosure by the Disclosing Party; or (c) is disclosed by the Receiving Party with Disclosing Party's prior written approval.

3. **Obligations of Receiving Party.** The Receiving Party shall read and discuss the Confidential Information in the strictest of confidence, within the Reference Group only. The

Receiving Party shall deny access to the Confidential Information to any other individuals outside of the Reference Group. The Receiving Party shall not use any of the Disclosing Party's Confidential Information in order to benefit from, publish, copy, or otherwise disclose to others, or permit the use by others for their (Receiving Party's) benefit or to the detriment of the Disclosing Party. The Receiving Party shall return to the Disclosing Party any and all transcripts, audio recordings, notes, and other written, printed, or tangible materials in its possession pertaining to Confidential Information following its use within the Reference Group.

4. **Time Periods.** The non-disclosure provisions of this Agreement shall survive the termination of this Agreement and the Receiving Party's duty to hold the Confidential Information in confidence shall remain in effect indefinitely.

5. **Relationships.** Nothing contained in this Agreement shall be deemed to constitute either party a partner, joint venturer or employee of the other party for any purpose.

6. **Severability.** If a court finds any provision of this Agreement invalid or unenforceable, the remainder of this Agreement shall be interpreted so as best to affect the intent of the parties.

7. **Integration.** This Agreement expresses the complete understanding of the parties with respect to the subject matter and supersedes all prior proposals, agreements, representations and understandings. This Agreement may not be amended except in writing signed by both parties.

8. **Waiver.** The failure to exercise any right provided in this Agreement shall not be a waiver of prior or subsequent rights.

This Agreement and each party's obligations shall be binding on the representatives of each party. Each party representative has signed this Agreement below:

Disclosing Party:

_____ (Position)

_____ (Signature)

_____ (Printed Name)

Date: _____

Receiving Party:

_____ (Position)

_____ (Signature)

_____ (Printed Name)

Date: _____

Appendix C: Framework of essential elements in qualitative interviewing³²

Elements	Considerations	Action
Preparation, planning and implementing an interview schedule	Preparation is vital. Select the correct research methodology and data collection tool/s to acquire data. Develop an interview schedule and use it flexibly as a guide to facilitate meaningful discussion.	Liaise with research supervisor or research team to decide which research methodology best addresses the study's research question, aims and objectives. Develop an interview schedule with predetermined questions focusing on the study's research question and aims.
Accessing vulnerable groups	Consider issues with gatekeepers of vulnerable groups and negotiating access to participants. Participants require sufficient information to make an informed decision to participate. Consider how participants may self-select to participate in a study.	Meet gatekeepers in person to facilitate relationship building, develop trust, allow questions to be asked and clarification to be sought. Provide detailed study information to potential participants and contact names and numbers if they wish to take part in the research. Consider utilising social media to recruit participants.
Time/location of interviews	Flexibility on the part of the researcher.	Conduct interviews at a time and location which is suitable for the participant.
Rapport and relationship building	Consider how to deal with distress and emotions. Interviews may be therapeutic for participants. Mutually trusting and positive relationships facilitate discussing sensitive topics.	Effective listening is required. Support structures may be required to deal with distress. Rapport development and a trusting relationship are key to facilitating the discussion of sensitive topics. Care is required for participant & researcher.
Therapeutic Interviewing	Know your interview questions so that your schedule is a guide, allowing free flow of conversation. Develop skills in empathetic listening and being comfortable with interview silences. Consider how you will deal with distressed participants.	Knowledge of interview questions is required for free flowing conversation between researcher and participant. Develop a distress protocol. Source a quiet, private interview location free from interruptions. Provide water and tissues to participants to promote comfort.
Concluding Interviews	Closing of relationship after data has been collected. Ensure positive closures for the participant and the researcher. Reflexivity is required to consider values, beliefs and perceptions which may influence the research process.	Debriefing with participant after interview has ended. Provide contact numbers of support services ³² as required. Meet with supervisor or research team to discuss the interview process. Bracket interviews: meet with a critical friend/supervisor/research team to challenge self-deceptions.
Ethical Considerations	Trust. Informed consent. Anonymity and Confidentiality.	Devise a risk assessment and distress protocol. Adhere to ethical research principles.

³² Adapted from Dempsey, Dowling, Larkin and Murphy, (2016, p.481)

Appendix D: Interview guide



Ethics Committee Ref: 17/NTB/85

Study Title: What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/New Zealand

Locality: Various North Island areas including Waikato, Whangarei, Tauranga and Gisborne

Lead Investigator: Becky Ali

Contact Phone Number:

These are the main questions that I will ask you during our interview:

1. What worked?

Can you paint me a picture of what contributes/has contributed to your wellness? What worked for you?

Drawing on your experience of recovery and that of other people, can you talk to me about the suicide prevention interventions and treatments available to people?

2. Best practise recommendations.

What part did the mental health services play in your wellness?

What does 'best practice' look like for you?

What are the key messages you would share with other health professionals working within mental health?

Do you think there is anything which health professionals are missing regarding suicide prevention?

Appendix E: Participant invitation and information sheet



Study Title: What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/New Zealand

Ethics Committee Ref: 17/NTB/85

Locality: Various North Island areas including Waikato, Whangarei, Tauranga and Gisborne.

Lead Investigator: Behiye (Becky) Ali

Contact Phone Number:

Kia Ora, Hello,

My name is Becky and I would like to invite you to take part in a study about suicide prevention in New Zealand - taking part is completely your choice. This information sheet gives you more details so that you can decide whether or not to take part. It explains why I am doing the study, what your participation would involve, what the benefits and risks to you might be and what would happen after the study. Before you decide, please feel free to talk about the study with other people, such as family, whānau, friends or your employer.

If you agree to take part in this study you would be asked to sign the consent form on the last page of this document and you would be given a copy of both the information sheet and the consent form to keep. This information sheet is six pages long; please make sure you have read and understood all the pages.

What is the purpose of the study?

I have worked as a support worker for almost fifteen years; working with young people and adults within the field of mental health. I am passionate about speaking up for peoples' rights, choices and involvement in their support and within other areas, including the healthcare policies that affect them.

The knowledge and experiences of the people who have used intervention services aimed at suicide prevention are rarely included in the Ministry of Health's suicide prevention strategies, actions plans and/or guidelines. By 'interventions and treatments' I mean talking therapies, medications or things like support groups, crisis telephone helplines, online computerised programs, church support or family/cultural support.

I believe that information from people such as yourself about what works and what perhaps doesn't work so well is extremely important for academics, health professionals and the Ministry of Health to know about suicide prevention in New Zealand – which has some of the highest rates of suicide in the world. Please note that this research has been approved by the Ministry of Health's Health and Disability Ethics Committee.

What will my participation in the study involve?

My research question asks: what works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?

To help answer this question I am hoping to carry out one-to-one interviews with people like yourself who have lived experience of suicidal ideation and/or attempt and whom have accessed mental health services aimed towards suicide prevention and intervention.

Participants need to be English speakers; aged over 18; must not have experienced any suicidal thoughts or feelings in the past six months and must be able to talk about their mental wellbeing in a healthy way.

I am planning for the interviews to take place between December 2017 and April 2018; I would like to agree a specific date and time that is convenient for you. I imagine the interview will last about one and half hours with a break for refreshments in the middle. These interviews will be recorded using an audio recorder. You are welcome to bring a support person with you into to the interview, if you wish. However, I would ask for their role to be supportive and not vocal.

What are the possible benefits and risks of this study?

The opinions and knowledge of the people who use/ have used suicide prevention services are rarely heard by policy-makers. Therefore, by taking part in this research, you could

potentially contribute to efforts which aim to better support people experiencing suicidal ideation.

I plan to carry out the interview in a relaxed and sensitive way. However, if you were to experience any distress then you can leave the interview at any time, you can decline to answer any question and you can request that the audio recorder be switched off. I would also ask that you make yourself aware of the support systems and services available to you through your service provider, in case you become distressed during or following the interview. Please note that if you become extremely distressed then I may need to inform your service provider.

You might also like to take note of the following numbers:

If you need emergency assistance phone 111

Lifeline 0800 543 354 (available 24 hours)

Youthline 0800 376 633 (available 24 hours)

Samaritans 0800 726 666 (available 24 hours)

Auckland Sexual Abuse helpline 09 623 1700 (available 24 hours)

Like Minds Like Mine Free phone 0800 102 107 (for information or advice on mental health matters).

Who pays for the study?

There are no costs associated with taking part in this research.

Light refreshments will be available during the interview and, following the interview discussion, I would like to thank you for taking part by offering you a \$20 Countdown gift card.

What if something goes wrong?

If you were injured in this study, which is unlikely, you would be eligible **to apply** for compensation from ACC just as you would be if you were injured in an accident at work or at home. This does not mean that your claim will automatically be accepted. You will have to lodge a claim with ACC, which may take some time to assess. If your claim is accepted, you will receive funding to assist in your recovery.

If you have private health or life insurance, you may wish to check with your insurer that taking part in this study won't affect your cover.

What are my rights and what happens if I change my mind?

Taking part in this study is completely your choice. The interview will be audio recorded and then typed up into notes by a professional transcriber who must sign a confidentiality agreement. You will be offered the notes from your interview to check for clarification.

After the interview, you can choose to withdraw from the research if you wish to. Please note that you would have a three-week window of opportunity to do this. This three-week window would start from the date of the interview **or** from when you receive your interview-notes, should you wish to receive them. If you do not return your interview-notes to me then I will assume that you are happy with what has been typed and I will then use the information you have provided in my study. Please keep a copy of this information sheet for your own records.

What happens after the study?

The consent form, audio-recording and written notes will be kept in a secure place and then destroyed after a minimum of ten years.

Your identity will be kept completely confidential and an alternative name/ pseudonym (which you can choose) will be used. Your employer/ organisation/ service provider which has sent you this invitation on my behalf will not know if you have chosen to take part in this research. I will not be sharing the research with your employer so you can be as open and honest as you like.

Our conversation from the interview will be discussed with a research reference group – a group of people who will advise me and guide the research process. This group of people will only see the de-identified data i.e. notes of the interview discussion without anyone's real names used. They must sign a confidentiality and non-disclosure agreement so they cannot share the discussion with anyone else.

The research reference group members are: Dr Matthew Shepherd (Ngāti Tama) (Clinical Psychologist & Senior Lecturer at University of Auckland); Taimi Allan (CEO at Changing Minds); Kieran Moorhead (Advocate & Researcher at Changing Minds); Sonia Pope (Tuākana Mentoring Programme, School of Psychology, University of Auckland) and Sheree Veysey (Counsellor with Mind and Body Consultants).

The research will be my PhD thesis and copies will be given to my University supervisors, markers at The University of Auckland and other universities and potentially other organisations like the Ministry of Health. You will also be offered a summary of the findings. There is also a potential that papers may be written and presented as a result of the research.

Who do I contact for more information or if I have concerns?

If you have any questions, concerns or complaints about the study at any stage, you can contact me or my supervisors at The University of Auckland:

Dr. Barbara Staniforth

Tel:

Email:

Dr. Carole Adamson

Tel:

Email:

If you want to talk to someone who isn't involved with the study, you can contact an independent health and disability advocate on:

Phone: 0800 555 050

Te Reo speakers - please call the phone number above and ask for the language-line

Fax: 0800 2 SUPPORT (0800 2787 7678)

Email: advocacy@hdc.org.nz

You can also contact the health and disability ethics committee (HDEC) that approved this study on:

Phone: 0800 4 38442

Email: hdecs@moh.govt.nz

For Māori cultural support, queries or complaints related to this research, please feel free to contact Ms Hineatua Puhatoto Parkinson (Māori and Pacific Research Committee at The University of Auckland) on:

Phone:

Email:

Taking part

If you have any questions about the study, or if you would like to register your interest to take part, then please feel free to contact me:

Becky Ali

Tel:

Email:

If you are not interested in taking part in this research then you do not need to do anything else, please feel free to discard this letter.

Many thanks and best wishes,

Becky Ali

University of Auckland Doctoral Candidate

Appendix F: Participant informed consent form



Study Title: What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa / New Zealand

I agree and understand that:

- I may give my consent to be part of the study but then withdraw this consent- I understand that I have three weeks after the interview date to request to have information I have provided removed from the study.
- The interview will be audio recorded, typed up and then kept for a minimum period of ten years.
- The interview-notes will be offered to me for clarification and I understand that if I do not return my notes within three weeks that the researcher will assume that I am happy with the contents and they can be used in the study.
- The (de-identified) interview conversation will be shared by Becky Ali with her University supervisors, a research reference group and Academics from various Universities who will mark the thesis.
- The researcher will use the (de-identified) interview conversation in her University PhD thesis and possibly in conference presentations and academic journals.
- If I share something during the interview which the researcher thinks may lead to the harm of myself or others, then the researcher may need to share this with the appropriate people including my service provider.
- I can leave the interview at any point, I can decline to answer any question and I can ask for the audio-recorder to be switched off without having to provide any reason.
- I can bring a support person with me into the interview.

- I have read and understood the Participant Information Sheet.
- I have been given contact details for several resources and helplines which offer advice and support should I become distressed and I am aware of the support systems and services available to me through my employer/ organisation/ service provider.
- I am aged over 18, I am not currently experiencing suicidal thoughts or feelings nor have I experienced these within the past six months.

I wish to receive a summary of the study results

YES

NO

Contact details (where a copy of the summary can be sent to):

or email: _____

Declaration by participant:

I agree to take part in this study.

Participant's name:

Signature: _____ Date: _____

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name:

Signature: _____ Date: _____

Appendix G: The HDEC Review process in more detail

Following the submission of my initial application in September 2016, a conference call review meeting was held via telephone with the Southern Health and Disability Ethics Committee review team in December 2016. The committee declined ethical approval for several reasons; these included a concern for selection bias as the committee believed that if prevention services *had not* worked for participants then those participants would have died already. Interestingly, this reminded me of the assumption discussed in Chapter 2 that participants are assumed to have died when we ask *why haven't service users been involved in New Zealand Government suicide prevention research to date?* Another reason for the committee's decision was a concern for the safety of participants in the (originally planned) focus groups. The committee was understandably concerned that a discussion of suicide prevention interventions may lead into discussions of suicidal ideation and past trauma which could be distressing for participants.

The 29 outstanding ethical issues which formed the committee's decision to decline were subsequently addressed with great attention to detail. An example of this was the addition of two psychologists to the research. These psychologists were appropriately qualified and experienced to support people experiencing distress and suicidal ideation. The plan was for one of the psychologists to be inside the focus group(s) with myself as the facilitator and the other psychologist to be sat outside of the focus group – both psychologists were available for participants to talk to should they have become distressed. This was one of many revisions made to the application which was resubmitted for review in May 2017. The second application included documents additional to those previously listed. These extra documents included: an invitation and information sheet, participant information sheet and consent form for the research reference group members; a confidentiality agreement for the transcriber; a consent form for each of the organisations/stakeholders involved; a participant information sheet and consent form for each of the two psychologists; an updated research protocol and updated evidence of peer review.

The second review meeting was a face-to-face meeting with the Northern HDEC held in Auckland on the 6th of June 2017. The committee acknowledged and accepted the safeguards put in place and the changes made following the initial rejection of the application. The Northern committee provisionally approved the research pending the resolve of 10 (new) concerns and a 35 day window was given in which to re-submit the application with these

changes. These 10 concerns included: changes to formatting on the documents; the creation of a site safety plan for the researcher; a more detailed emergency plan of what myself and the psychologists would do if a participant experienced extreme distress (and attempted suicide); the addition of the name and contact number for a relevant Kaumātua (an elder in Māori society) onto each of the participant information sheets and an addition to the selection criteria given to organisations/ stakeholders (who I would be asking for help with recruitment) of the following criteria: that participants were not to be invited if they were currently experiencing suicidal crisis. These changes were made and the application was resubmitted within the 35 day window on the 26th of June 2017.

Full approval was received from the HDEC in July 2017 subject to the following conditions being met before the study commenced:

Standard Conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.
2. Before the study commences at *a given* locality in New Zealand, it must be authorised by that District Health Board locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

These conditions provided the next stage of the ethical approval process. Following approval from the HDEC, locality authorisation can only be sought, and gained, from District Health Boards (DHBs) through the HDEC's Online Forms process. In order to apply for their locality authorisation, each of the four DHBs had their own ethics approval process to go through, similar to that of the HDEC's. This process involved detailed online application forms, several meetings, pōwhiri and presentations. Alongside their own ethics committee, each of the four DHBs also had Te Puna Oranga Māori (Māori Research Review Committees) inclusive of Kaumātua. Each of Te Puna Oranga Māori had an additional ethics approval process, again similar to that of the HDEC's.

Appendix H: Poster advertising for research participants

Would you like to share your opinions, knowledge and experience of suicide prevention interventions and treatments?



As part of my University research study, I would like to find out:

What works for individuals who experience suicide prevention interventions and services in Aotearoa/New Zealand?

I am looking for people who are using mental health services and who have experienced suicidal thoughts or feelings. I am **also** looking for people who have used these services previously and who now may be discharged.

The mental health services to which I am referring include interventions or treatments which are aimed towards suicide prevention. These can include talking therapies like CBT or DBT; certain medications; support groups; helplines or online computerised support or specific services targeted at Māori and Pasifika people.

I would like to ask the people who use these services for their opinions, knowledge and experience of the suicide prevention interventions or treatments which they have used, or are still using. I would like to find out what has worked best for them, or helped them the most.

Participants must be English speakers aged over 18 years who are not currently experiencing suicidal crisis. They must be able to talk about their mental wellbeing and experiences in a healthy way.

If this is you, and you would like to take part in an interview, then please feel free to contact me for further details.

Participants will be thanked for their time and input with the offer of a \$20 Countdown gift card.

Kia Ora,

My name is Becky and I am a PhD social work student at the University of Auckland. I have worked as a support worker for almost 15 years within the field of mental health.

I am passionate about speaking up for people who use mental health services to voice their opinions about their care, support or health service provision.

If you think that you would like to take part in this research, or if you have any questions or queries, please feel free to contact me:

Email:

Phone:

Appendix I: HDEC Letter of Approval



Health and Disability Ethics Committees

Ministry of Health

133 Molesworth Street

PO Box 5013

Wellington

6011

0800 4 ETHICS

hdecs@moh.govt.nz

14 July 2017

Dear Miss Ali

Re: Ethics ref:	17/NTB/85
Study title:	What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/New Zealand

I am pleased to advise that this application has been approved by the Northern B Health and Disability Ethics Committee. This decision was made through the HDEC-Full Review pathway.

Conditions of HDEC approval

HDEC approval for this study is subject to the following conditions being met prior to the commencement of the study in New Zealand. It is your responsibility, and that of the study's sponsor, to ensure that these conditions are met. No further review by the Northern B Health and Disability Ethics Committee is required.

Standard conditions:

1. Before the study commences at *any* locality in New Zealand, all relevant regulatory approvals must be obtained.
2. Before the study commences at a *given* locality in New Zealand, it must be authorised by that locality in Online Forms. Locality authorisation confirms that the locality is suitable for the safe and effective conduct of the study, and that local research governance issues have been addressed.

Non-standard conditions:

- Please change the wording of the title to match with the objective of the study.
- How would the researcher know if the ex-suicide survivor is okay and mentally safe to participate in the study?
- Please consult with Pacific mental health services about the study and how to support Pacific participants.

Non-standard conditions must be completed before commencing your study. Non-standard conditions do not need to be submitted to or reviewed by HDEC before commencing your study.

If you would like an acknowledgement of completion of your non-standard conditions letter you may submit a post approval form amendment. Please clearly identify in the amendment that the changes relate to non-standard conditions and ensure that supporting documents (if requested) are tracked/highlighted with changes.

For information on non-standard conditions please see section 128 and 129 of the Standard Operating Procedures at <http://ethics.health.govt.nz/home>.

After HDEC review

Please refer to the *Standard Operating Procedures for Health and Disability Ethics Committees* (available on www.ethics.health.govt.nz) for HDEC requirements relating to amendments and other post-approval processes.

Your next progress report is due by 13 July 2018.

Participant access to ACC

The Northern B Health and Disability Ethics Committee is satisfied that your study is not a clinical trial that is to be conducted principally for the benefit of the manufacturer or distributor of the medicine or item being trialled. Participants injured as a result of treatment received as part of your study may therefore be eligible for publicly-funded compensation through the Accident Compensation Corporation (ACC).

Please don't hesitate to contact the HDEC secretariat for further information. We wish you all the best for your study.

Yours sincerely,

Kate O'Connor

Chairperson

Northern B Health and Disability Ethics Committee

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