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Original Article

Supporting the Bereavement Needs of Pacific Communities in New Zealand following a Suicide: A Survey of Service Providers

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***Abstract*:** On average, a suicide death (i.e. family, friends, colleagues, school peers) directly impacts a minimum of 60 people. In the majority of cases, the suicide bereaved lack support, and mental health challenges intensify. As a result, the risk of suicide increases, as does the strain upon family relationships. These issues are often exacerbated by a lack of coping skills, and for some, financial difficulties. What is less known in New Zealand is the availability of culturally-driven and relevant services particularly for Pacific individuals, families and communities bereaved by suicide. The study's aim was to examine the experiences of support workers in service agencies providing resources and support for Pacific peoples bereaved by suicide with a view to informing the development of Pacific-focussed postvention strategies. A mixed methods project was undertaken which included an online survey, focus groups and fono (a commonly used term by some Pacific groups to refer to a 'meeting'); both Pacific communities and service providers who worked with Pacific peoples bereaved by suicide participated in the overall project. This paper presents the results of the Pacific provider online survey component of the project, which drew a total of 70 unique responses. Overall, provider respondents were no more aware of postvention resources available than community respondents. The majority of provider respondents (61.4%) were unaware of group discussions (or fono) as a resource. Over a quarter of provider respondents (25.9%) were dissatisfied with resources available, while almost a quarter (23%) felt the materials had limited or no effectiveness. These findings indicate that suicide postvention support could be improved by training service providers to be more informed of resources and particularly of fono as a culturally appropriate resource, and with much room for improvement in the range and quality of suicide postvention resources. Provider respondents also felt that health professionals, churches, and community leaders were best placed to lead suicide postvention initiatives. This project is the first of its kind, as it specifically addresses suicide postvention services for Pacific communities, and highlights the insights that can be gained by privileging a culturally focussed approach.

Keywords: *Suicide postvention, Pacific peoples' health, wellbeing, suicide prevention, bereavement, mental health, New Zealand*

Suicide is a significant global health issue (WHO, 2014). Not only do approximately 800,000 suicide deaths occur each year (Aguirre & Slater, 2010), but between 48 million and 500 million people annually, experience suicide bereavement worldwide (Pitman, Osborn, King, & Erlangsen, 2014).

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According to estimates, suicide bereavement affects approximately seven percent of the general population in the USA (Crosby & Sacks, 2002). Moreover, Pitman and colleagues (2014) add, that on average, a suicide death (i.e. family, friends, colleagues, school peers) directly affects a minimum of 60 people. 'Suicide postvention', commonly referred to as supporting and caring for the suicide bereaved, is less known, yet is a growing area of research and crucial to effective suicide prevention. Coined by American suicidologist Edwin

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Shneidman in the 1970s, suicide postvention is considered a form of suicide prevention for the following generation, and enables the suicide bereaved to live longer, more productive and less stressful lives (Shneidman, 1972). Effective suicide postvention necessitates optimal support and help available to the suicide bereaved—family members, friends, and all those indirectly impacted by a suicide (Andriessen & Krysinska, 2011).

Public health perspectives typically regard suicide as something to be prevented, and yet, the argument remains, to generate momentum and effectively reduce suicide rates, a commitment at all levels and increasing the visibility of suicide postvention is needed to broaden the scope of preventative measures and interventions (Goodwin-Smith, Hicks, Hawke, Alver, & Raftery, 2013; Tiatia-Seath, 2016).

The notion that suicide bereavement is somehow different from bereavement of any other means of death is widely discussed (Jordan & McIntosh, 2011). Some believe that groups who have lost through other forms of death, experience far better bereavement outcomes than those bereaved by suicide (Andriessen & Krysinska, 2011; Wilson & Clark, 2005). For example, a significant proportion of the population with increased risk of suicide comprise the suicide bereaved, who are at between two to ten times at greater risk when compared to the general population (Andriessen & Krysinska, 2011; Runeson & Åsberg, 2003). The suicide bereaved may also suffer from higher levels of stress, guilt, shame, depression, social alienation, increased stigma, and poor mental health in general (Aguirre & Slater, 2010; Goodwin-Smith et al., 2013; Shneidman, 1972; Wilson & Clark, 2005).

In many cases, the suicide bereaved lack adequate support following the death where family relationships become strained, and families lack the skills to cope, and/or face financial difficulties (Wilson & Clark, 2005). The grieving process involves additional layers of complexity for the suicide bereaved who are at higher risk of suicide and mental health issues, compared to the general population. It is clearly evident of the importance of suicide postvention support in addressing grief, facilitating the healing process, and providing better mental health and wellbeing outcomes for those impacted by a suicide. To this end, suicide postvention makes a significant contribution to the management of suicide contagion (Goodwin-Smith et al., 2013; Wilson & Clark, 2005).

The first step in designing effective postvention services is to address the needs of the suicide bereaved based on their experiences (Andriessen & Krysinska, 2011). In a study by Brent and colleagues (2009), it was found that, when compared to young people whose parents died by sudden natural causes, those young people who had lost a parent to suicide were often predisposed to higher risks of depression, particularly in the second year after the death (Brent, Melhem, Donohoe, & Walker, 2009). Another group demanding close attention are the 'forgotten bereaved' or siblings of the suicide decedent, who are often 'invisible' as the focus tends to be directed to their parents. Evidence demonstrates that siblings often grieve alone, to avoid adding to the burden of their grieving parents (Dyregr & Dyregrov, 2005; Tiatia-Seath, 2015). Furthermore, since parents and older siblings have tended to establish their own family support mechanisms, it is the younger siblings that experience more difficulties following a suicide death than their parents or older siblings (Dyregrov & Dyregrov, 2005).

The impact of suicide bereavement in the workplace is another often neglected area of concern. A beneficial step to providing effective postvention support is to raise awareness amongst employers and fellow employees of the impact that suicide bereavement has on people's ability to function in their roles. Another strategy is to signal to employers the importance of promoting workplace mental health and wellbeing more generally (Runeson & Åsberg, 2003).

The suicide bereaved are at a higher risk of complicated grief (Shear et al., 2011). They need timely and relevant care informed by a deep understanding of the grieving and healing processes (Andriessen & Krysinska, 2011). Due to a common misconception that there is a specified timeframe and methodical process in grieving (Peters, Cunningham, Murphy, & Jackson, 2016), for most suicide bereaved, they do not receive such care in reality.

It is widely accepted that, irrespective of culture, commonalities exist in the psychological experiences for the suicide bereaved (Kaslow, Samples, Rhodes, & Gantt, 2011). Yet, the fact that grieving takes place in various forms across cultures, and that diverse social attitudes toward suicide persist, the need for culturally relevant and appropriate postvention support, services and resources has never been greater (Kaslow et al., 2011). Clearly there is a need for broader worldviews and more effective responses to the support needs of the suicide bereaved.

Andriessen's (2014) review of suicide bereavement and postvention related material in core international suicidology journals since the 1970s, revealed that these particular topics either did not

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feature or were Western-dominated. Accordingly, Andriessen then argued that under-investigated populations, such as those bereaved after elderly suicide, should become the focus of future research (Andriessen, 2014).

At present, the study of Pacific worldviews around suicide bereavement is hugely lacking. Promoting such investigations will provide a significant contribution to the field, and better inform dominant mainstream thinking by introducing Pacific epistemologies and frameworks, and thus, improving effective suicide prevention planning and action plans.
The aim of this study was to examine the experiences of support workers in service agencies who resource and support Pacific peoples bereaved by suicide; with a view to providing lived-experience-informed development of Pacific-focussed postvention strategies. In particular, what was their awareness of, satisfaction with, and assessment of postvention resources available.

Method
The research design for this study builds on previous work completed for the South Australian Suicide Postvention Project (Wilson & Clark, 2005). It uses a concurrent mixed methods approach including the collection of data through a survey, focus groups and fono - a widely used term by some Pacific groups to mean meetings. The study was conducted over a period of 18 months (October 2014-April 2016), funded by Te Rā o Te Waka Hourua Research Fund (http://wakahourua.co.nz/research-projects).
Ethics approval was received from the New Zealand Southern Health and Disability Ethics Committee, and informed consent was obtained from all participants.

The overall research project – of which the study presented in this paper was a component - was undertaken in two phases: Phase One consisted of (1) an online survey with quantitative and qualitative questionnaire items largely based on findings from a literature review, and (2) consultation with suicide postvention experts, key stakeholders, and focus groups; Phase Two involved open community and service provider fono (meetings).

This paper focuses on quantitative findings, supplemented by relevant qualitative results, from the Pacific provider online survey questionnaire responses from Phase One of the overall project.

Data collection
The provider online survey used a structured questionnaire consisting of close-ended (quantitative) and open-ended (qualitative) items. The target population was those who offer support to Pacific peoples bereaved by suicide: Pacific service providers – e.g. health professionals, social workers, nurses, spiritual leaders. A purposive sample was recruited through service provider networks. A final sample size of 50-100 participants was set to ensure adequate coverage and to enable sub-group analyses. As the location and size of the target population of service providers was unknown, it was not possible to designate a sampling frame or implement a sampling regime for this pioneering study. The study used an online questionnaire with Pacific language translations made available, although none were requested. For service providers, quantitative questions were asked about their socio-demographic characteristics, their awareness of types of services offered and resources available, and their satisfaction with, and assessment of general resources available. Finally, one or two options were asked of participants to identify Pacific-led organisations or professions they considered should be leading Pacific initiatives in supporting the suicide bereaved. Free-text responses permitted respondents to make further comments regarding the following qualitative items: the type of guidelines to support those bereaved by suicide; the type of support their service usually provides to support the suicide bereaved; the type of suicide postvention provided for youth; the support (if any) in place in one's organisation if a staff member or client has taken their life; satisfaction, awareness and effectiveness of suicide postvention resources; challenges faced in relation to supporting Pacific communities bereaved by suicide; what should be included in Pacific guidelines to help support those who have lost someone to suicide; and what will work.

Analysis
The online survey was administered through Survey Monkey (www.surveymonkey.com). The collected quantitative data were then transferred to Microsoft Excel before being analysed using IBM SPSS Statistics 22. Free-text responses (qualitative data) were entered into NVivo 10 and linked to the SPSS analysis data set.

We then produced descriptive tables of quantitative variables relating to Pacific service providers (without any statistical testing).
For each substantive variable, the numbers of respondents and the percentages in various

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categories are shown. Note, that tables include valid responses (i.e. missing data are excluded) such that, total numbers – and associated percentages - may differ from table to table. For the multiple response questions, numbers indicate how many people gave each a response. A narrative approach deemed appropriate for Pacific suicide research was employed for the analysis of all the qualitative data gathered from service providers.

Results

The service provider survey drew a total of 70 online responses. Participation was not limited to Pacific respondents or those from an organisation. It was primarily targeted to those working with suicide bereaved Pacific individuals, families and communities. The demographic characteristics of respondents are shown in Table 1. The majority of respondents were female (78.3%) and of Samoan (44.3%), followed by Tongan (12.9%) and Tokelauan (10.0%) descent. Over half of the respondents were NZ-born (57.1%) and resided in Auckland (61.4%), followed by Wellington (18.6%), and Waikato (8.6%).

Table 1. Demographics of respondents

Variable	Level	n	%
Region (n=70)	Auckland	43	61.4
	Wellington	13	18.6
	Waikato	6	8.6
	Christchurch	2	2.9
	Other	6	8.6
Ethnicity (n=70) [a]	Samoan	31	44.3
	Tongan	9	12.9
	Tokelauan	7	10.0
	Cook Islands	3	4.3
	Niuean	3	4.3
	Māori	3	4.3
	Fijian	2	2.9
	Tuvaluan	1	1.4
	European	16	22.9
Birth country (n=70)	New Zealand	40	57.1
	Samoa	12	17.1
	Tonga	5	7.1
	Tokelau	5	7.1
	Cook Islands	1	1.4
	Niue	1	1.4
	Fiji	1	1.4
	Other	5	7.1
Gender (n=69)	Female	54	78.3
	Male	15	21.7
Age group (n=61)	25–44	38	54.1
	45–54	19	31.1
	55+	9	14.8
	Mean age	61	43.0

a.A respondent could report more than one ethnic affiliation.

The types of agencies respondents worked for, and the type of support their service or organisation typically provided to support those bereaved by suicide, are summarised in Table 2. The most prominent service providers were in mental health (21.4%) and healthcare (17.1%), whilst the most common type of support provided related to mental health (35.1%).

Table 2. Type of service and support provided

Variable	Level	n	%
Service type (n=70)	Mental Health	15	21.4
	Healthcare	12	17.1
	Social Services	9	12.9
	Education	8	11.4
	Child and Youth Services	5	7.1
	Family Services	4	5.7
	Pacific Health	4	5.7
	Church	2	2.9
	Justice	2	2.9
	Other	9	12.9
Support type (n=57)	Mental health support	20	35.1
	One-on-one counselling	6	10.5
	Spiritual guidance	4	7.0
	Family counselling	3	5.3
	Other	22	38.6
	None	2	3.5

Respondents were aware of various forms of resources, with pamphlets and websites being the most well-known (Table 3). Around half of respondents (52.9%) were aware of 0800 numbers and bereavement support groups, but were less aware (38.6%) of group discussion or fono. Most were satisfied with current suicide postvention resources (74.1%). Of the respondents that indicated they were aware of suicide postvention resources, the majority considered current suicide postvention resources as effective (76.9%). Just over one quarter reported ‘not very’ or ‘not at all satisfied’ with the resources (25.9%). A similar number considered the resources were not very or not effective (23%).

It was considered that Pacific-led organisations or professions should be leading Pacific initiatives in supporting the suicide bereaved; participants identified health professionals (44.3%), churches (41.4%), and community leaders (35.7%) as the priority groups (Table 4).

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Table 3. Resurces for the suicide bereaved

Resource perceptions	Resource type or level [a]	n	%
Aware of the resource (n=70)	Pamphlets	46	65.7
	Websites	43	61.4
	0800 telephone support	37	52.9
	Suicide bereavement groups	37	52.9
	Group discussions	27	38.6
	DVDs	15	21.4
Satisfied with resources (n=54)	Very satisfied	5	9.3
	Satisfied	10	18.5
	Fairly satisfied	25	46.3
	Not very satisfied	12	22.2
	Not at all satisfied	2	3.7
Resources were effective (n=52)	Very effective	3	5.8
	Effective	14	26.9
	Fairly effective	23	44.2
	Not very effective	10	19.2
	Not at all effective	2	3.8

a. A respondent could report more than one type of resource.

Table 4. Preferred leadership for Pacific initiatives to support the suicide bereaved

Preferred lead to support initiatives (n=70) [a]	n	%
Health professionals	31	44.3
Churches	29	41.4
Community leaders	25	35.7
Social workers	17	24.3
Youth workers	12	17.1
Educational institutions	11	15.7
Police	7	10.0

a. A respondent could report up to two types of leader.

Discussion

There is a need for organisations who work alongside Pacific communities to have access to, and be assisted by postvention guidelines. This could address the relative dissatisfaction with materials (i.e. 25.9% were not very satisfied or dissatisfied with materials), and the sense that they were limited in their effectiveness (23% of respondents felt the materials were fairly or not very effective). It is acknowledged that national and international guidelines do exist (e.g. Clinical Advisory Services Aotearoa (2016); Australian Institute for Suicide Research and Prevention & Postvention Australia (2017); and Public Health England (2016). However, it is noteworthy that Pacific-centred postvention guidelines did not exist prior to this project, and it is hoped that this resource will be widely used and considered by those who work alongside Pacific communities.

Mental health support was the most common type of support offered to individuals bereaved by suicide. There could be a variety of reasons for this, which may include the increasing need for mental health support or the bias of the 15 respondents (21.4% of total 70) who in fact worked in the sector. However, there are a large number of respondents (38.6%) who sought help from 'other' types of support services. This suggests that informal networks play a substantial role in postvention support. The field of suicide postvention would hugely benefit from further research in this area.

Qualitative responses indicate that the message - that suicide postvention care is a form of suicide prevention - needs to be communicated to Pacific communities more effectively and as culturally relevant and appropriate. Though respondents' awareness of the types of resources available for suicide postvention support was similar to the Pacific communities' responses (Tiatia-Seath et al, 2017), with pamphlets and websites being the most well-known, followed by 0800 numbers and bereavement support groups; discussion groups or fono were less well known.

Awareness among providers of the types of resources available was no greater than that among those receiving support. Although respondents qualitatively identified specific suicide postvention services such as Skylight and Clinical Advisory Services Aotearoa (CASA), suicide postvention providers were not, as one might have expected, more aware of resources than the people they support.

Qualitative responses indicate that maintaining and strengthening Pacific workforce development and capacity in organisations, such as Victim Support and the NZ Police, will provide optimal and appropriate support for Pacific families. Furthermore, there is a need for the recognition of the evolving diversities of Pacific communities so that they may be provided with tailored support that will be of greater value and impact. Finally, respondents deemed health professionals, church and community leaders the most appropriate to lead Pacific suicide postvention.

As this study is the first of its kind, the findings are descriptive and indicative only as our sample of respondents was purposively identified through networks in the absence of a specific sampling frame, and thus may not represent the target population of people who work for service providers of postvention support.

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Conclusion

While the majority of bereavement suicide postvention providers were more or less satisfied with postvention resources available, just over a quarter of respondents (25.9%) expressed dissatisfaction with them. Notably, almost one in four (23%), felt the materials were only effective to a certain extent, or not at all. Significantly, resources were developed before the introduction of postvention guidelines, indicating the need for such guidelines to make the materials more relevant.

Awareness was another issue to emerge from findings. Although one might expect suicide bereavement support-type providers to be more aware of the resources available, the levels of responses were the same as those of the community component of the overall project. We may conclude that the postvention providers are only as aware of resources as the community they support. This may indicate a need for more training for service providers who support the suicide bereaved, around the availability of resources. Further, whilst most providers were aware of pamphlets and websites, 0800 helplines and bereavement groups, the majority were unaware of discussion groups or fono, precisely the settings where Pacific- informed postvention support can be provided in context. This may indicate that suicide postvention support could be improved by increasing the visibility of fono in the delivery of suicide postvention support. However, it is notable that a significant proportion of suicide postvention providers (38.6% or 22 out of 57) existed as part of other, possibly informal, support networks. Further research is needed to clarify our understandings of this source of suicide postvention support.

The best approach identified for maintaining and strengthening suicide postvention support was through reinforcing the capacity of organisations such as Victim support or the NZ police. An approach that reflects the demographics underpinning this project and where most Pacific peoples are resident in Auckland and would therefore have access to these services (Statistics New Zealand, 2013). Finally, though the study was susceptible to bias, as the majority of bereavement support providers worked in healthcare or the mental health sector, it was still felt by them that health professionals, churches and community leaders were best placed to lead suicide postvention efforts.

We believe that our provider survey complements our community survey (Tiatia-Seath et al., 2017), and its findings are important in improving the provision of postvention support, for example, indicating the need for better training and raising of awareness of Pacific and culturally relevant resources. This study highlights the insights that can be gained by adopting a culturally focussed approach, in this case, canvassing Pacific provider perspectives on suicide bereavement and postvention with a view to improving service guidelines.

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