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Supporting the bereavement needs of Pacific communities in Aotearoa New Zealand following a suicide

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Abstract

On average, at least 60 people are directly impacted by a suicide death (i.e. family, friends, colleagues, school peers). As a result, in most cases, there is a lack of support for the suicide bereaved, mental health issues are intensified, there is increased suicide risk, a strain upon family relationships, there are poor coping skills, and for some, financial difficulties. What is also less known is the culturally relevant support needs of Pacific individuals, families and communities bereaved by suicide in Aotearoa New Zealand.

An 18-month mixed methods project was designed to include an online survey, focus groups and fono (a commonly used term by some Pacific groups to refer to a 'meeting'). This was undertaken among Pacific communities as well as service providers who worked with Pacific peoples bereaved by suicide. The results of the Pacific community survey are presented.

The Pacific community survey drew a total of 173 unique responses, 153 conducted online and 20 via hard copy. This study is the first of its kind, both in Aotearoa, New Zealand and abroad, that specifically addresses the suicide postvention needs of Pacific communities.

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

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Introduction

Suicide is a significant global health issue with approximately 800,000 suicide deaths per year (Aguirre & Slater, 2010). This is further

exacerbated in that between 48 million and 500 million people each year experience suicide bereavement worldwide (Pitman, Osborn, King, & Erlangsen, 2014). It is estimated that in the USA, seven percent of the general population are exposed to suicide bereavement (Crosby & Sacks, 2002). Pitman and colleagues (2014) estimate that at least 60 people on average, are directly impacted by a suicide death (i.e. family, friends, colleagues, school peers). *Suicide postvention*, or as is commonly known, supporting and caring for the suicide bereaved, is an area we know very little about and yet is a crucial component to effective suicide prevention. Coined by American suicidologist Edwin Shneidman in the 1970s, suicide postvention is considered to be suicide prevention for the next generation by enabling the suicide bereaved to live longer, more productive and less stressful lives (Shneidman, 1972). Effective suicide postvention warrants that the suicide bereaved—family members, friends, and all those indirectly affected by a suicide—receive the optimum support and help required (Andriessen & Krysinska, 2011).

Typically, public health perspectives regarding suicide are dominated by preventative measures, yet the argument remains, that to see any momentum in the reduction of suicides, there must be a commitment at all levels, not only a limited view of prevention and intervention, but also increasing the visibility of suicide postvention (Goodwin-Smith, Hicks, Hawke, Alver, & Raftery, 2013; Tiatia-Seath, 2016).

There are various views of the notion that suicide bereavement is different from bereavement of any other means of death (Jordan & McIntosh, 2011). Some believe that those bereaved by suicide experience poorer bereavement outcomes than groups who have lost through other forms of death (Andriessen & Krysinska, 2011; Wilson & Clark, 2005). For instance, the suicide bereaved make up a significant proportion of the population with an increased risk for suicide that is between two to ten times greater when compared to the general population (Andriessen & Krysinska, 2011; Runeson & Åsberg, 2003). The suicide bereaved may also experience elevated stress levels, guilt, shame, depression, social alienation, increased stigma, and poor mental health (Aguirre & Slater, 2010; Goodwin-Smith et al., 2013; Shneidman, 1972; Wilson & Clark, 2005). There is also, in many cases, a lack of support for the suicide bereaved after the death where family relationships become strained, and there are poor coping skills, and financial challenges (Wilson & Clark, 2005). The complexities surrounding the grieving process for a population at higher risk of suicide and mental health issues, compared to the general population, are testimony to the importance of suicide postvention support in addressing grief, facilitating the healing process, and improving mental health. In addition, it is also a significant contribution to the management of suicide contagion (Goodwin-Smith et al., 2013; Wilson & Clark, 2005).

Addressing the needs of the suicide bereaved and their experiences is considered the first step in designing effective postvention services (Andriessen & Krysinska, 2011). An investigation by Brent and colleagues (2009) found that young people who had lost a parent to suicide were predisposed to higher risks of depression, particularly in the second year after the death, in comparison to young people whose parents died by sudden natural causes (Brent, Melhem, Donohoe, & Walker, 2009). Furthermore, the population of the *forgotten bereaved* or siblings of the suicide decedent (the deceased person) needs close attention. Usually the focus is given to their parents. Evidence demonstrates that siblings often grieve alone as they do not want to add to the burden of grief experienced by their parents (Dyregr & Dyregrov, 2005; Tiatia-Seath, 2015). It is found that, younger siblings experience more difficulties following a suicide death when compared to their older siblings and their parents, primarily as older siblings have established their own family support mechanisms (Dyregrov & Dyregrov, 2005).

The workplace is also an environment most often neglected in this area. An awareness amongst employers and fellow employees of the impact of suicide bereavement on occupational functioning and being able to make adjustments to promote workplace mental wellbeing and health is a beneficial step to providing effective postvention support (Runeson & Åsberg, 2003).

The suicide bereaved are at a higher risk of complicated grief (Shear et al., 2011). Relevant and timely care for the bereaved requires an

understanding of the grieving and healing process (Andriessen & Krysinska, 2011). Generally, there are misconceptions that there is a specified timeframe and methodical process in grieving (Peters, Cunningham, Murphy, & Jackson, 2016). Yet, in reality, this is far from being the case for most bereaved.

There is wide acceptance that commonalities exist in psychological experiences for the suicide bereaved, irrespective of culture (Kaslow, Samples, Rhodes, & Gantt, 2011). Yet, the ways in which grieving takes place vary across cultures, and the diverse social attitudes toward suicide affirm that culturally relevant and appropriate postvention support, services and resources need particular attention (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 over a 40-year time span, found that there was a lack of these particular topics published across these journals and what was available was Western-dominated. Andriessen argued that future research should focus on populations that are under-investigated like bereavement after elderly suicide (Andriessen, 2014).

Currently, there are gaps in the existing evidence base where Pacific worldviews around suicide bereavement will do much to inform dominant mainstream thought and further promotion of Pacific epistemologies and frameworks, particularly in the planning of suicide prevention.

Support

The most common and recommended form of postvention assistance is the suicide bereavement support group, which consists of a group of people with shared experiences (Henare Ehrhardt Research, 2004; Peters et al., 2016; Wilson & Marshall, 2010). Support groups provide a safe, empathetic and non-judgemental space for participants to open up about their journeys and share thoughts around coping, moving forward, and resources. They empower those that have been bereaved by suicide for some time or multiple times and assist novice members with suicide grief (Jordan, 2014). However, the stigma and shame often attached to suicide as well as, in some cases, cultural expectations tend to impede access to help for the suicide bereaved. This may also be in addition to feelings of trauma, fatigue, and a lack of confidence to ask for help (Wilson & Clark, 2005). In fact, there is evidence suggesting that those bereaved by suicide tend to engage with interventions if they are actively offered rather than seeking assistance for themselves (Cerel & Campbell, 2008). Other barriers identified include: a lack of information and awareness of services; untimely support; financial pressures; and religious prejudices (Wilson & Marshall, 2010).

Resources

Access to resources has been implicated by inadequate referral systems that fail many suicide bereaved (Campbell, 1997). The discoveries of a recent study by Thornton, Handley, Kay-Lambkin, and Baker (2017) may be of benefit for improvements in accessing suicide postvention resources online. The authors argue that services should include appropriate websites to recommend to those who prefer online engagement. In addition, although there is a wealth of online resources in relation to suicidal behaviours, someone with no prior knowledge of organisations or relevant websites would have difficulty in a general Internet search for suicide postvention support. They argue that there is a need for organisations to adapt their search optimisation strategies so that their websites can be found more easily (Thornton et al., 2017).

Training is vital for all services to increase awareness of the needs of people bereaved by suicide and of the availability of support services and resources (Peters et al., 2016). Whilst training is available to provide postvention support, there appears to be a significant gap in specific Pacific-focused suicide postvention training, thus a reliance upon mainstream frameworks may be irrelevant, inappropriate, and at worst, detrimental to Pacific contexts (Tiatia-Seath, 2017).

The term Pacific peoples in this study refers to those of Oceanic Polynesian, Melanesian and or Micronesian heritage (Tiatia-Seath, 2017). They make up 7.4 percent of the New Zealand population and are the fourth largest major ethnic

group following New Zealand European, Māori and Asian populations (Statistics New Zealand, 2013). Within ten years, the Pacific population will constitute 10 percent of the New Zealand population (Statistics New Zealand, 2013).

Aims

This New Zealand based study aimed to provide information that would better support Pacific individuals, families and communities bereaved by suicide. As such, it was important to engage Pacific communities in order to provide relevancy, appropriateness and effectiveness of current Pacific suicide postvention strategies. This evidence base would then provide a foundation for the development of Pacific suicide postvention guidelines.

The study objectives were to:

1. Engage Pacific peoples bereaved by suicide by examining their support needs for postvention.
2. Identify postvention models and strategies both nationally and abroad and how these may be applied to the development of Pacific postvention strategies.
3. Develop postvention guidelines to meet the needs of Pacific communities.
4. Advance knowledge regarding Pacific postvention and to contribute new knowledge to the fields of mental health, suicidology and public health in New Zealand.

Methods

The previous work of the South Australian Suicide Postvention Project was used as a guide to help formulate the research design for this study (Wilson & Clark, 2005). A concurrent mixed methods approach was employed, facilitated by the collection of data through the application of a survey, focus groups and *fono* (a commonly used term by some Pacific groups to mean meetings). The project was conducted over 18 months (October 2014-April 2016), funded by Te Rā o Te Waka Hourua Research Fund (http://wakahourua.co.nz/research-projects). Ethics approval for this research was granted by the New Zealand Southern Health and Disability Ethics Committee.

There were two phases to the research: Phase One comprised a survey with quantitative and qualitative questionnaire items (largely based on findings from a literature review), and consultation with suicide postvention experts, key stakeholders, and focus groups, whilst Phase Two involved open community and service provider fono. This paper discusses the quantitative findings of the Pacific community survey responses from Phase One.

The community survey used a structured questionnaire with both close-ended (quantitative) and open-ended (qualitative) items. The target population comprised Pacific peoples (aged 16 years and over) in the community (i.e. family members, friends, peers, and colleagues) who had experienced suicide bereavement. A purposive sample was recruited through community and service provider networks with the goal of a final sample size of 100-200, to ensure a level of representation and to enable sub-group analyses. As this is a pioneering study for which the location and size of the target population of bereaved was unknown, designating a sampling frame and implementing a sampling regime was problematic. The study questionnaire was implemented online, or posted to those without internet access. Translation of the questionnaire in to a Pacific language was also made available, though none was requested.

Survey questions for Pacific communities included: socio-demographic information; the respondents' relationship to the suicide decedent(s); the type of support they received and services involved; their satisfaction with the support offered; identified barriers in accessing support and resources; identifying who was first at the scene; support preferences immediately after the event; and an indication of their awareness of any postvention type services. Free-text responses were also provided for further comments.

The survey was administered online via Survey Monkey (www.surveymonkey.com). The quantitative data were then exported to Microsoft Excel and processed for final analysis in IBM SPSS Statistics 22. The small number of surveys

that were completed in hard copy were entered directly into this SPSS data set.

For the analysis, we produce descriptive tables of quantitative variables. For each variable, we show the number of respondents, and the percentage of respondents in various categories. Note that tables include valid responses (i.e. exclude missing data), so the total numbers—and associated percentages—may differ from table to table. For the multiple response questions, numbers represent how many people gave each response.

Results

The Pacific community survey drew a total of 173 unique responses, 153 conducted online and 20 via hard copy.

Table 1: Demographic characteristics of respondents

Variable	Level	n	% of respondents
Region (n=173)	Auckland	137	79.2
	Waikato	6	3.5
	Wellington	19	11.0
	Christchurch	3	1.7
	Dunedin	1	0.6
	Other	7	4.0
Ethnicity (n=173) [a]	Samoan	99	57.2
	Cook Islands	21	12.1
	Tongan	39	22.5
	Niuean	12	6.9
	Fijian	8	4.6
	Tokelauan	7	4.0
	Tuvaluan	3	1.7
	Māori	6	3.5
	European	11	6.4
Birth country (n=173)	New Zealand	124	71.7
	Samoa	17	9.8
	Cook Islands	7	4.0
	Tonga	8	4.6
	Niue	2	1.2
	Fiji	5	2.9
	Tokelau	6	3.5
	Tuvalu	2	1.2
	Other	2	1.2
Gender (n=166)	Male	33	20.8
	Female	133	79.2
Age group (n=167)	15–24	57	34.1
	25–44	67	40.1
	45–54	29	17.4
	55+	14	8.4
Employment (n=173)	Full-time paid employee	85	49.1
	Part-time paid employee	13	7.5
	Self-employed	6	3.5
	Beneficiary	5	2.9
	Student	46	26.6
	Home duties	7	4.0
	Other	11	6.4

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

Table 1 shows the ethnic make-up of respondents with larger representation of Samoans (57.2%), Tongans (22.5%) and Cook Islands (12.1%) peoples. The majority of participants who took part were females (79.2%) and in the younger age groups: 15-24 years (34.1%), and 25-44 years (40.1%). Most were born in New Zealand (NZ-born; 71.7%) with the remaining born in Samoa, the Cook Islands, Tonga, Niue, Fiji, Tokelau, Tuvalu or other. The majority also resided in more urbanised locations in Auckland (79.2%), Wellington (11.0%), and the Waikato (3.5%) regions with 49.1% in full-time employment, and 26.6% were students.

Table 2: Relationship of respondents to the decedent, and decedent's characteristics

Relationship to decedent (n=163)	n	% of respondents
Friend	52	31.9
Cousin	32	19.6
Other family	16	9.8
Brother/Sister	15	9.2
Niece/Nephew	10	6.1
Aunt/Uncle	6	3.7
Fellow member of church	4	2.5
Parent/Caregiver	3	1.8
Son/Daughter	3	1.8
Neighbour	3	1.8
Fellow member of other organisation	3	1.8

Spouse/Partner	1	0.6
Fellow member of sports team	1	0.6
Other	14	8.6
Decedent characteristics (n=163)	**n**	**% of respondents**
Gender		
Male	94	57.7
Female	68	41.7
Fa'afafine	1	0.6
Age group (years)		
10-15	14	8.6
16-24	101	62.0
25-39	32	19.6
40+	16	9.8

In terms of their relationship to the suicide decedent (Table 2), most had been either a friend (31.9%), a cousin (19.6%), other family member (9.8%) or a sibling (9.2%). The gender identities of the suicide decedent as indicated by respondents were 57.7% males, 41.7% females and 1 (0.6%) *fa'afafine* (third gender identity for a Samoan male, literally meaning 'in the manner of a woman'). The most common age range was between 16-24 years (62.0%), followed by the 25-39 year age range (19.6%), 40+ year (9.8%), and 10-15 years of age (8.6%).

Table 3: Time lapse since the event

Time lapse (n=163)	**n**	**% of respondents**
0-6 months	14	8.6
6-12 months	10	6.1
12-18 months	12	7.4
18-24 months	10	6.1
>24 months	117	71.8

Table 3 demonstrates that 71.8% (n=117) of the events occurred more than two years prior to the respondents taking part in the survey.

Table 4: First at the scene

First at the scene (n=160)	**n**	**% of respondents**
Family	96	60.0
Stranger/member of the public	23	14.4
Friend	16	9.4
Neighbour	5	3.1
Respondent	4	2.5
Police	3	1.9
Don't know	14	8.8

When asked, who was first at the scene of the death (Table 4), 60% identified a family member, 14.4% a stranger or member of the public and 9.4% a friend, with smaller numbers who reported themselves, neighbours or the Police.

Support

Table 5: Immediate support

Type of immediate support [a] (n=160)	**Immediate support received**		**Immediate support that would be appropriate**	
	n	% of respondents	**n**	% of respondents
Family	122	76.3	139	86.9
Friends	79	49.4	82	51.3
Police	72	45.0	48	30.0
Pastor/church leader	56	35.0	62	38.8
Victim support	27	16.9	70	43.8
Health professional	24	15.0	54	33.8
Stranger/ member of the public	8	5.0	-	-

[a]. A respondent could report more than one type of support.

Multiple response options were selected with regards to the type of support available to the families immediately after the event. Common responses included: Family (76.3%), Friends (49.4%), Police (45.0%) and Pastor or church leader (35.0%). Table 5 shows the number of people that reported each source of support.

Participants were also asked what support they believed is appropriate immediately after the event. Responses included: Family (86.9%), Friends (51.3%), the Victim Support organisation (43.8%), Pastor/church leader (38.8%), a Health professional (33.8%) and Police (30.0%). The opportunity was open to enter free-text responses in this regard. Popular responses indicated that organisations that support suicide bereaved families should have adequate levels of Pacific cultural competency, empathy and recognition of the importance of spirituality in the lives of some Pacific families.

Table 6: Support received by respondents

Support characteristics	Levels	n	% of respondents
When support first received (n=155)	Within 6 months	80	51.6
	In 6–12 months	13	8.4
	In 12–24 months	2	1.3
	In more than 24 months	1	0.6
	No support at all	59	38.1
Effective types of support [a] (n=96) [b]	Family	83	86.5
	Friends	66	68.8
	Pastor/church leader	28	29.2
	Health professional	25	26.0
	Victim support	20	20.8
Unmet need for support [a] (n=59) [c]	Family	27	45.8
	Health professional	24	40.7
	Friends	21	35.6
	Victim support	18	30.5
	Pastor/church leader	17	28.8

[a]. A respondent could report more than one type of support.
[b]. The number of respondents that received some kind of support
[c]. The number of respondents that did not receive any support.

For those who indicated that they had received suicide bereavement support (n=155; Table 6), 51.6% reported they had received support within six months of their loss, and 38.1% reported they had never received any kind of support at all (i.e. within 6-24+ months).

Those who had indicated they had received support, were then asked to select multiple responses pertaining to the type of support they believed proved effective (Table 6).

Further descriptions were provided in free-text form primarily addressing effective immediate support mechanisms. Common responses included: reading about other Pacific families bereaved by suicide; being able to talk with colleagues in the workplace; having sympathetic employers that allowed sufficient time away from work (i.e. six months unpaid leave); legal advice; engagement and access to key people in the military, school, and community environments.

Of the 59 respondents that indicated that they had not received any type of support (see Table 6), free-text responses were available for further comments. These views included: the need for extended paid bereavement leave; better communication between families and coroners; a police clearing up team at the scene (rather than leaving the grieving family to clear the scene); some form of government financial support for the family, particularly where the primary income earner for the family was the deceased; recognition of the value of traditional healers; culturally appropriate and qualified grief counsellors with knowledge of supporting the suicide bereaved; more support provided within schools; and support for younger family members from child and adolescent services.

Table 7: Types of community support needed after bereavement

Community support type [a] (n=163)	n	Short-term % of respondents	n	Long-term % of respondents
Family counselling	121	74.2	115	70.6
Spiritual guidance	100	61.3	92	56.4
Victim support	67	41.1	62	38.0
Health professional	65	39.9	62	38.0

[a]. A respondent could report up to two types of support.

Respondents were asked to select up to two forms of short-term (immediately after the event) and long-term support needed from a list of Family counselling, a Health professional, Victim Support, Spiritual guidance or Other (see Table 7). In order of importance this included: Family counselling (74.2); Spiritual guidance (61.3); Victim Support (41.1) and a Health professional (39.9). In relation to Long-term support preferences the needs were fairly similar: Family counselling (70.6); Spiritual guidance (56.4); and both Victim Support and a Health professional (38.0).

Table 8: Resources for the bereaved

Resource characteristics	Type or level	n	% of respondents
Aware of the resource [a]	Suicide bereavement groups	58	35.6
(n=163)	Websites	53	32.5
	Group discussions	52	31.9
	Pamphlets	51	31.3
	0800 telephone support	45	27.6
	DVDs	11	6.7
Satisfied with resources	Very satisfied	9	8.5
(n=106) [b]	Satisfied	21	19.8
	Fairly satisfied	49	46.2
	Not very satisfied	20	18.9
	Not at all satisfied	7	6.6
Resources were effective	Very effective	6	5.7
(n=106) [b]	Effective	18	17.0
	Fairly effective	49	46.2
	Not very effective	21	19.8
	Not at all effective	12	11.3
Barriers to access	Cultural differences	29	17.8
(n=163) [c]	Shame	20	12.3
	Guilt	19	11.7
	Lack of finances	13	10.0
	Lack of transport	9	5.5
	Lack of Internet access	9	5.5
	Language	4	2.5
	Lack of telephone	2	1.2
Resources preferred	Group discussions	87	53.4
(n=163) [a]	Suicide bereavement groups	74	45.4
	Websites	44	27.0
	0800 telephone support	35	21.5
	Pamphlets	32	19.6
	DVDs	32	19.6

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

[b]. Number of respondents aware of at least one type of resource.

[c]. A respondent could report more than one barrier to access.

Resources

The survey was able to gauge respondents' awareness of suicide postvention support resources, their satisfaction with and perceived effectiveness of current resources, identified barriers and access to resources and preferred formats for resources (Table 8).

In terms of Resource Awareness, there was a fairly even spread across Pamphlets, Group Discussions, Websites, 0800 Telephone support and Suicide bereavement support groups ranging between 27.6% and 35.6% with only 11 people (6.7%) who were aware of DVD's (Table 8). Additional free-text responses mentioned: church prayer groups, mothers' church groups and community groups, Biblical teachings and spiritual guidance, Solace (suicide bereavement group support), community counsellors, health professionals, Anamata (suicide intervention course), family and friends and or peers.

Those that reported an awareness of at least one type of suicide postvention resource were asked about their level of satisfaction with this

resource(s), and how effective they believed they were (Table 8).

Generally, most participants were satisfied with current suicide postvention resources (74.5%). Free-text responses allowed them to share views about resource gaps and suggested improvements. The feedback included: a need for more culturally appropriate and relevant Pacific-focused material; finding ways to increase accessibility particularly for Pacific communities in rural or more isolated areas; free or subsidised costs for suicide postvention-related courses; more opportunities for face-to-face support; access to financial advice; faith-based resources; messaging that assumes people should feel a certain way; and a lot more ongoing support needed for high school students.

Essentially, respondents considered current suicide postvention resources were effective (68.9%; Table 8). Free-text responses referred to *what works* for respondents primarily focusing on messages reinforcing the benefits of informal support networks such as family and friends and the positive impact of family counselling. The relevancy of group discussions which resonate with most Pacific communities and the value placed on communalism which continues to be instrumental. Therapeutic and healing interventions for families bereaved that bring the family together to openly share their journeys and healing as a collective and considered a powerful tool.

Table 8 also presents the type of barriers experienced by respondents which impeded their access to resources.

Identified barriers via free-text responses included: Families refusing support due to shame; a lack of Pacific resources specifically addressing the loss of a sibling, parent and or caregiver, spouse, and child; the absence of support groups in smaller towns and rural areas; the unwillingness to openly talk about their loved one; the lack of planning, coordination and support for schools who have lost a student; feeling detached when speaking to a stranger over the phone; and not knowing where to start in terms of establishing a suicide bereavement support group.

When queried about the preferred formats for resources, Group discussions (53.4%) and Suicide bereavement support groups (45.4%) were most desirable. This was followed by Websites (27.0%), 0800 Telephone support (21.5%), and with equal numbers in favour of Pamphlets and DVD's (19.6% each).

Where DVD's were suggested, it is important that they are bilingual. Safe messaging could be conveyed in the various forms of performing arts and the sharing of Pacific narratives of the suicide bereaved; Pacific service provider follow-up; more involvement of school counsellors, family counsellors, and workplace counsellors; reading material such as books and online blogs; a Pacific-focused smart device application to assist during difficult times designed specifically for the suicide bereaved; increased recognition of the importance of face-to-face support for Pacific communities; the acknowledgment of faith-based care; and promotional messaging via Pacific language radio talk-back programmes.

Providing Better Support

Respondents were asked to reflect on the relationship they had with their loved one and were then given the opportunity to comment on any resources they thought may have helped them personally or for the bereaved family they were supporting. Comments included: Victim Support and suicide bereavement service personnel should be required as part of their job descriptions, to undergo Pacific cultural competency training as part of their roles; there should be counselling available to employees; training around safe social media messages and access to advice allowing for wider accessibility and community outreach; the provision of long-term free follow-up support for families rather than only within the first month or six weeks of the event, particularly more so on key dates such as birthdays, over the holiday season and on the anniversary of the death; access to family counselling; and availability of suicide postvention training specifically tailored for church leaders.

Table 9: Leadership of Pacific initiatives to support the bereaved

Who should lead support initiatives (n=163) [a]	n	% of respondents
Churches	76	46.6
Social workers	77	47.2
Community leaders	74	45.4
Youth workers	69	42.3
Health professionals	56	34.4
Educational institutions	51	31.3
Police	22	13.5

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

The survey asked respondents to identify who they believed should provide leadership around Pacific postvention support initiatives (Table 9). In addition to the identified leaders listed, feedback included: family leaders; other families willing to share their experiences and become Pacific suicide postvention champions; schools; grief counsellors; and family counsellors.

Table 10: Media interviews of the bereaved

Opinion on media interviews (n=136)	n	% of respondents
Helpful	67	49.3
Damaging	22	16.2
Don't know	47	34.6

It was also important for this survey to consider views on the effects media interviews could have upon suicide bereaved families (see Table 10). A large number did not answer this question, with no certainty as to why, however, for those who did, most indicated that media interviews were Helpful (49.3%), as opposed to those, who believed media interviews were Damaging (16.2%), and a number who reported, Don't know (34.6%).

Discussion

Survey respondents were predominantly female. The concern is where are Pacific males? Whilst this is not uncommon for all other groups, would the reasoning for Pacific males be any different? Our finding that Pacific females were more likely to have engaged with the study may be indicative of their social roles. Clearly, more research is needed in these areas.

Most respondents identified the suicide decedent as a friend or cousin, with lesser numbers reporting *closer* relationships typical of a spouse, child, sibling or parent. In addition, the majority of suicide decedents were reported as young males. This is still very much a population at increased risk where more targeted efforts are needed and where distinct needs will require specifically tailored suicide postvention support.

There was overwhelming engagement by those who had been bereaved by suicide for two or more years prior to taking part in the survey. It is unclear if this was due to the lack of support and or immediate help and follow-up in the two or more year timeframe, or if less time is an inappropriate period to talk about the event, or in fact both. This would be a worthwhile topic for further investigation.

Usually the first person to find their loved one was a family member. This may suggest that most suicides were undertaken at a familiar location (i.e. at their own, or family member's home). An alternative type of support may be required for this person(s) especially if they are constantly reminded of the event when in proximity of the location their loved one was found.

Generally, where a respondent first heard of the incident, they reported that their family members were their immediate support, followed by friends. Appropriate immediate support for respondents was family, friends, Victim Support and pastoral care. It is also vital for effective Pacific postvention, that mainstream organisations providing suicide-bereaved support have an adequate level of Pacific cultural competency. In addition, what would prove more effective is that there should also be a requirement that there is empathy for specifically, the suicide bereaved. In addition, spiritual support remains an important element to include when working alongside grieving Pacific families.

Just over half of all respondents had personally received support within six months of the event (51.6%). Yet there are concerns for those who had not received any type of support at all (38.1%). Most respondents who participated in the survey indicated that the event occurred at 24+ months. Would this suggest that this is a safe period for communities to talk about the event?

Or is it that support services are not accessed up to the 24+ month mark? If there were consistently accessible and available follow-up, could families talk about the event a lot earlier? This study has exposed a significant gap in knowledge where an increase in awareness and more definitive research will do much to build an evidence base informing relevant and more targeted postvention support initiatives.

The respondents that received support believed that the most effective support systems were their family and or friends. This would suggest that for Pacific suicide postvention initiatives to be effective, informal networks must be included as they are extremely important in providing better outcomes for the suicide bereaved. In addition, it appears then that suicide postvention training and support groups should be encouraged and established for and amongst family and or friends.

Effective suicide postvention support also involves sympathetic employers and colleagues who may be called upon as a sounding board. It appears workplace postvention training is of worth for employees at all levels of an organisation.

There were also strong views around improved coroner liaisons; sensitivities and cultural appropriateness shown at the scene during the investigation; and the need for financial guidance especially when faced with trauma and decision making may be clouded.

The essentials for both immediate and long-term support for those bereaved by suicide are: 1) family; 2) grief counselling; 3) spiritual guidance; 4) Victim Support; and 5) health professionals. These five focused areas need to be strengthened to better support Pacific communities.

There was some awareness of existing suicide postvention resources with which respondents were relatively satisfied. Yet most considered these only a moderate impact. Major barriers and access to resources focused mainly on the lack of Pacific cultural appropriateness (i.e. Pacific values, concepts, languages, visual appeal and narratives), alongside dealing with feelings of guilt, shame and financial obstacles. Emphasis needs to be placed on Pacific-centred group discussions and support groups as they were considered priority areas, and therefore a must for inclusion in the planning and development of Pacific suicide postvention resourcing, which in turn may also be an opportunity to address barriers.

Leadership around Pacific postvention support should derive primarily from social workers, churches, community leaders and youth workers. A starting point in suicide postvention is involving these people very early on in the development, planning and training of Pacific-specific postvention activities.

Whilst media attention around a suicide death of a loved one is believed to be helpful, particularly for bereaved relatives, and as long as reports are accurate, there remains uncertainty of whether it may be beneficial or damaging for Pacific families bereaved by suicide. As part of postvention training, references should be made to the recently developed Pasifika Media Guidelines to create safe spaces for Pacific peoples to publicly speak about the event or when referring to their loved one (Le Va, 2016).

This study is a global first and focuses specifically on the suicide postvention needs of Pacific communities in New Zealand. It is informed by the experiences of their loss or by those who have worked in the capacity of supporting someone or families bereaved by suicide. This paper derives from the final report of the study—*Suicide Postvention: Support for Pacific Communities* (Tiatia-Seath, 2016).

It is acknowledged that partnership and cooperation are crucial to this project, and that existing activities contributing to suicide postvention are further developed (Yip, 2011). This project aims to provide information to enhance health outcomes for Pacific communities and help inform future service delivery with the goal of supporting Pacific communities bereaved by suicide.

The impact this project brings has been the ability to reconfigure Pacific understandings and the transferring of knowledge about Pacific suicide postvention, which enables Pacific communities themselves to respond to an issue with worldviews that resonate with the way they express, appreciate and have experienced the loss

of a loved one through suicide (Tiatia-Seath, 2017).

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