Suicide Postvention: Support for Pacific Communities

Report for Waka Hourua - National Suicide Prevention Programme for Maori and Pasifika Communities

Jemaima Tiatia-Seath

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Hibiscus Research LIMITED

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This report was prepared by:

Dr Jemaima Tiatia-Seath
Hibiscus Research Ltd

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Contents

EXECUTIVE SUMMARY 8

1. RECOMMENDATIONS 10

2. INTRODUCTION 15

2.1 Aims 15

2.2 Background 15

2.3 Limitations 17

3. LITERATURE REVIEW 17

4. RESEARCH DESIGN AND METHODS 24

5. FINDINGS 27

5.1 Online Surveys 28

5.1.1 Pacific Communities 28

5.1.1.1 Discussion of Pacific Community Survey Responses 41

5.1.2 Service Providers 44

5.1.1.2 Discussion of Service Provider Survey Responses 51

5.2. Focus Groups 52

5.3 *Fono* and the Development of Pacific Postvention Guidelines 59

REFERENCES 63

APPENDICES 66

Index to Figures and Tables

Figure 1: Project Design and Phases 27

Figure 2: Distribution of Respondents' Relationship to the Decedent 29

Figure 3: Summary of the Distribution of Respondents' Relationships to Decedent 30

Figure 4: Distribution of the Time Lapse since the Event 31

Figure 5: First at the Scene 32

Figure 6: Immediate Support Received 33

Figure 7: Effective Immediate Support 35

Figure 8: Distribution of Agencies with Guidelines to Support the Suicide Bereaved 45

Figure 9: Distribution of Postvention Services for Pacific Youth 46

Figure 10: Level of Comfort Working with those Bereaved by Suicide 47

Figure 11: Breakdown of Focus Group Participants by Ethnicity and Gender 53

Figure 12: Breakdown of Focus Group Participants by Age 53

Table 1: Age Group of Decedent 30

Table 2: Appropriate Immediate Support 33

Table 3: Timeframe of Support Received 34

Table 4: Unmet Support Needs 36

Table 5: Short-term Support Needs 36

Table 6: Long-term Support Needs 37

Table 7: Resource Awareness 37

Table 8: Satisfaction with Current Resources 38

Table 9: Effectiveness of Current Resources 38

Table 10: Barriers to Accessing Resources 39

Table 11: Preferred Formats 40

Table 12: Potential Leaders for the Provision of Postvention Support 41

Table 13: Effects of Media Interviews with the Bereaved 41

Table 14: The Type of Service Provided 44

Table 15: Support Provided for the Bereaved 46

Table 16: Resource Awareness 48

Table 17: Satisfaction with Current Resources 49

Table 18: Effectiveness of Current Resources 49

Table 19: Potential Leaders for the Provision of Postvention Support 50

Table 20: Age of Focus Group Participants 54

Table 21: Residence of Focus Group Participants by District Health Board Region 54

EXECUTIVE SUMMARY

Introduction

This research was funded by Waka Hourua's *Te Rā o Te Waka Hourua* stream. The primary aim was to engage Pacific communities in examining appropriate and effective components for inclusion in Pacific suicide postvention[1] activities and in the development of Pacific suicide postvention guidelines.

Methods

Primarily an adaption of the South Australian Suicide Postvention Project, this research involved a mixed methods approach with two phases over an 18-month period (October 2014 to April 2016). Phase one comprised two online surveys targeting Pacific communities bereaved by suicide and service providers working with suicide-bereaved Pacific communities or have themselves been impacted by a suicide death. Focus groups in Auckland and Christchurch were also undertaken. Phase two comprised *fono* (workshops) in Auckland, Christchurch, Hamilton and Wellington with representatives from a mix of service providers and families present, some of whom were impacted by suicide bereavement. Additionally, there were contributors whom attended of their own accord and not in the capacity of representing their respective organisations.

[1] Postvention is a term used to describe activities that assist those bereaved by suicide in coping with the event.[1]

Results

A total of 397 participants were involved in this research. There were 173 Pacific community respondents bereaved by suicide who took part in an online survey, and 70 service provider respondents who work with Pacific communities and/or have also been impacted by a suicide death. A further 74 Pacific peoples impacted by suicide engaged in focus group discussions in Auckland and Christchurch, and 80 community and support services people contributed to the *fono* in Auckland, Christchurch, Hamilton and Wellington.

Some key findings to better support Pacific communities bereaved by suicide include:

- The need for more Pacific-appropriate information and to grow the Pacific workforce in suicide postvention (paid and voluntary).
- Considerations made for Pacific ethnic-specific postvention initiatives as well as recognising Pacific diversity, be it, multi-ethnic, gender identities, age, or spiritual or non-religious affiliation.
- Establishing family support groups is believed to be an effective strategy for postvention support as opposed to engaging in community support groups amongst strangers and with very little Pacific perspective.
- Recognising that there is no such thing as an ideal timeframe to stop grieving or for counselling and support to cease until the individual or family is ready. Consistent, effective and appropriate short-term and long-term support are key to good recovery.
- The workplace is also an important site outside the home that could play a major part in providing suicide postvention support.

It was crucial to this research that in any attempt to address Pacific suicide postvention, the voices of Pacific peoples impacted by the loss of a loved one are what matters. Therefore, it is their views that are the foundation of this research. There was a good number of responses particularly considering the sensitivities around the topic and that suicide is still very much a *tapu* (forbidden, sacred) discussion for many Pacific communities.

1. RECOMMENDATIONS

The following recommendations are based on the views of Pacific communities bereaved by suicide as well as service providers working with Pacific families or are themselves bereaved by suicide. It is hoped this information will contribute to informing better ways of supporting the suicide postvention needs of Pacific individuals, families and communities.

Pacific Communities

Support

- Pacific peoples bereaved by suicide strongly agree with benefits of support groups. However, there is a lack of knowledge around how one may set up these groups.
- Generally, participating in community support groups amongst strangers has very little appeal, as is the option of support groups in church due to privacy issues.
- Family and friends are considered the most effective means of immediate support for a bereaved individual or family. Therefore, training should target individuals within these informal networks and provide guidance on creating a support group around this. The family can share and grieve in a setting that is familiar to them, is comfortable and safe, and emphasises the process of *'healing together as a family'.*
- Encouraging families to establish and engage in their own support groups may also assist in providing consistent long-term support.
- If supporting a family through bereavement, follow-up and consistency is crucial as it allows for stronger relationship building and gaining trust.
- South Australia's Living Beyond Suicide (LBS) programme, examined ways of providing a more culturally appropriate intervention to support Indigenous families bereaved by suicide.[2] The findings may be useful for Pacific approaches. For instance: providing information on funeral options; coordinating with coroners, courts and police departments; advocating on behalf of the family for superannuation; attending to insurance or government matters; facilitating debriefing sessions for workplaces; supporting families in household issues; providing information on available and appropriate counselling services; and simply sitting with the family as they share their stories.[2]

- There needs to be an adequate level of Pacific cultural competency training for non-Pacific support services and individuals.
- Empathetic and well-trained support is needed.
- Support in the workplace should include: sympathetic employers, access to counselling services, sufficient time off work and an area in the workplace to escape to for quiet time. Employers should therefore be made aware of the impact of suicide bereavement on their employees and make an effort to promote workplace mental health.
- Financial advice and support is needed, particularly if the person who has passed on is the primary income earner.
- More communication is needed between the coroner and the family concerned.
- Family counselling and spiritual guidance are the two most important preferences for short-term and long-term support.
- Be mindful that not all Pacific peoples are affiliated to churches, therefore support from spiritual leaders/groups may only be helpful to those who are, or identify with Christianity/religion.
- Consider the specific support needs of the person(s) who discovered their loved one (i.e. the first at the scene). A different approach may be required. It is important to examine what this support may look like.

Resources and Training

- There is some awareness of current postvention resources, however not nearly enough and with little impact for Pacific communities. This is primarily due to the lack of culturally relevant and appropriate materials.
- The preferred and most effective support structures and resources were discussion groups and support groups. These preferences should be prioritised in the planning and development of resources.
- Face-to-face interaction remains popular amongst Pacific peoples, particularly regarding a sensitive area.

- Specific training is needed for church leaders who are well placed to deliver faith-based suicide postvention support for families. Religious/spiritual material was also a common request.
- Social workers, churches, community leaders and youth workers need to be involved at all stages of development, planning and training in Pacific suicide postvention.
- Training should include how one may deal with public questioning and the media. The media can also provide safe spaces for interviews. Pacific media guidelines for reporting suicide in New Zealand can be accessed at http://www.leva.co.nz/library/leva/pasifika-media-guidelines-for-reporting-suicide-in-new-zealand
- Organisations should ensure they have search optimisation strategies so their support and information websites can be found more easily.
- Supporting those bereaved by suicide can at times be hampered by the stigma associated with suicide and for some, there are traditional beliefs, religious and *tapu* (forbidden, sacred) observances around the topic and of the death. Being mindful and non-judgemental of these values within the family and learning to respect these views should be a requirement in postvention training.
- Incorporating Pacific specific methods into training where one can feel comfortable in supporting older people or at least having access to people of a similar age range to the person being supported.
- Any organisation that works with Pacific families should be trained in suicide postvention with a Pacific focus so they are equipped should there be a need.
- Ensuring everyone is aware of the Pacific suicide postvention guidelines requires high-quality and consistent marketing.

SERVICE PROVIDERS

Support

- A service dedicated to Pacific suicide postvention is needed and plays an integral part in building healthy Pacific communities. Adding further to the lack of research, is the obscurity of Pacific-focused suicide postvention knowledge, information and

understandings. A structured and feasible method for provision of Pacific postvention services and referrals is required.

- There is real concern that most organisations do not follow any guidelines to support employees who are suicide bereaved in either their professional or personal lives. Their wellbeing is just as important as the communities they serve.
- There is a need for training in Pacific approaches to suicide postvention.
- More research is needed around the mental health needs of those who are bereaved by suicide.
- Postvention support should be for all ages.
- The message that suicide postvention is in fact, suicide prevention, needs to be clearly communicated to Pacific families and communities.
- More recognition is needed of Pacific diversities (i.e. gender identities, sexual orientation, peoples with disabilities, age, ethnicity, birthplace, spiritual beliefs).
- Victim Support (a charitable organisation offering support for victims of crime and trauma) and NZ Police liaisons are highly valuable. Ongoing Pacific workforce development is key.

USEFUL SUICIDE POSTVENTION RESOURCES AND SUPPORT GROUPS

Resources: http://www.casa.org.nz/resources.html http://www.leva.co.nz/suicide-prevention/professional-help/postvention-services
Starting a Support Group: https://www.mentalhealth.org.nz/assets/Suicide/Bereavement-Handbook-Online-Sept.pdf
Support Groups: http://skylight.org.nz/Waves http://skylight.org.nz/Support+Groups+available+for+those+Bereaved+by+Suicide Skylight - 0800 299 100 (for support through trauma, loss and grief; 9-5pm weekdays)
Counselling and Support: Tautoko Suicide Crisis Helpline - 0508 828 865 Lifeline - 0800 543 354
Counselling for Youth and Children Youthline - 0800 376 633, free text 234, email www.talk.youthline.co.nz What's Up - 0800 942 8787 (5-18 years of age; 1-11pm) Kidsline - 0800 54 37 54 (up to 14 years; 4-6pm weekdays)

2. INTRODUCTION

2.1 Aims

The primary aim of this research was to engage Pacific communities in exploring considerations of the most important, appropriate and effective components to include in building a knowledge base for Pacific suicide postvention and in the development of Pacific suicide postvention guidelines. This information would then provide better information and support for Pacific individuals, families and communities bereaved by suicide.

2.2 Background

Waka Hourua is a government response to the New Zealand Suicide Prevention Action Plan for Māori and Pacific peoples. The proposed four-year programme is a partnership between national Māori health workforce development organisation Te Rau Matatini and national Pacific non-governmental organisation, Le Va. In April 2014, a one-off funding pool was allocated to a specific Māori and Pacific suicide prevention strategic research agenda - *Te Rā o Te Waka Hourua* with the objective of detailing what specifically works for Māori and Pacific. This current research was one of four successful applications to the *Te Rā o Te Waka Hourua* fund.

Objective 2 of the New Zealand Suicide Prevention Action Plan 2013-2016, aims to *'support families, whanau, hāpu, iwi and communities after a suicide'* with a focus around action areas 4 and 5: the former, to '*ensure a range of accessible support services is available for families, whānau and others who are bereaved by suicide';* and the latter, to *'support communities to respond following suicides, especially where there are concerns of suicide clusters and suicide contagion.'* The Suicide Prevention Action Plan also considers that coordinated community responses are imperative to dealing with suicide clusters and that communities impacted by suicide contagion are often experiencing this for the first time and need advice and guidance to react swiftly and appropriately. This research is a direct

response to supplement these areas and contributes Pacific-centred information to an area we know very little about, that being, suicide postvention.[2]

To the best of our knowledge, there also appears to be a lack of Pacific-focused postvention research, other than a literature review by Beautrais in 2004 'Suicide postvention support for families, whānau and significant others after a suicide: A literature review and synthesis of evidence'[1] and Henare Ehrhardt Research's 2004 'Support for Māori whānau and Pacific and Asian families and significant others who have been affected by suicide attempts - an analysis of the published and grey literature.'[4] It is also recognised that most New Zealand District Health Boards have suicide prevention and postvention plans in place, and a recent study 'Suicide Prevention for Tongan Youth in New Zealand' in part, provides an ethnic-specific overview of suicide postvention.[5] Yet, this knowledge gap only reaffirms the urgency in addressing Pacific-specific suicide postvention concerns. The strength of this research is that suicide postvention needs are based on the views of Pacific communities themselves who have experienced the loss of a loved one to suicide or have worked in the capacity of supporting someone or families bereaved by suicide.

The research design was based loosely on the 2005 South Australian Suicide Postvention Project.[6] It involved consultation with suicide postvention experts, a review of the literature and a mixed methods approach, which amassed data through the application of a survey, focus groups and fono (meetings) with Pacific communities.

It is recognised that partnership and cooperation are crucial to this project, and that existing activities contributing to suicide postvention are further developed.[7] 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 is the ability to alter Pacific understandings and transfer

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[2] The term "postvention" was coined by psychologist Edwin Shneidman in the 1970s, who considered that postvention is in fact, prevention for the next generation, in that it helps the suicide bereaved to live longer, more productively and less stressfully than they would be likely to do otherwise.[3]

knowledge about Pacific suicide postvention and enable Pacific communities themselves to respond to the issue with approaches and solutions that resonate with the way they describe, understand and experience the loss of a loved one through suicide.

2.3 Limitations

Due to time and budget constraints, not all geographical areas or Pacific ethnicities throughout New Zealand were included in the conduct of focus groups and *fono*. However as is the preliminary nature of this particular study, there are components identified throughout this report that highlight areas for further development and evidence-based growth, rural and more isolated regions as well as the diversity among Pacific peoples are two examples.

3. LITERATURE REVIEW

Suicide is a significant global health issue with approximately 800,000 suicide deaths per year.[8] The impact becomes even more substantial for those left behind as this equates to between 48 to 500 million people who experience suicide bereavement every year.[2] At least 7 percent of people are exposed to suicide bereavement with 60 people on average directly affected by a suicide death (i.e. family, friends, colleagues, school peers).[2]

Traditionally, much of the evidence around suicide in New Zealand and internationally has focused on suicide prevention. Yet the argument remains that the reduction of suicide deaths requires a commitment to intervention at all levels of the mental health sector, with suicide postvention being no exception as it is a vital component in the management of suicide contagion.[2] There is a clear need for better understandings and more effective responses to the support needs of the suicide bereaved.[1]

A study by Andriessen conducted in 2014 involving a review of suicide bereavement and postvention topics in core international suicidology journals over a 40-year time span, found that there was a very modest focus on these particular topics published in the journals. Results also showed that there was a Western-dominated focus. Andriessen argued that

future research should focus on populations that are under investigated; the example given included bereavement after elderly suicide, however, in the context of this current study, suicide postvention support for Pacific communities.[9]

Controversies exist around whether suicide bereavement is different from other types of death.[10] More recent accounts affirm that it is in that those bereaved by suicide have poorer bereavement outcomes than groups who have lost through other forms of death.[6, 11] For instance, evidence suggests that those bereaved by suicide, experience high levels of suicidality,[2, 11, 12] making up a significant proportion of the population with an increased risk for suicide that is between 2 and 10 times greater in comparison to the general population.[12] The suicide bereaved may also experience elevated stress levels, guilt, shame,[8] depression,[2] social alienation,[3] increased stigma and poor mental health.[6] There is also in many cases, a lack of support received after the death, the disarray of family relationships, poor coping skills and financial difficulties.[6]

The complexities of the grieving process for a population with a high risk of suicide and mental health issues is testimony to the prominence of suicide postvention support not only as a means to addressing grief, healing and mental illness, but being as a vital inclusion in suicide prevention.[6]

Access to resources has been implicated by inadequate referral systems that fail for many who are bereaved by suicide.[13] Andriessen and Krysinski argue that effective suicide postvention ensures that the suicide bereaved—family members, friends and also those indirectly affected by a suicide, can receive the optimal support and help required.[11]

Listening to the suicide bereaved and examining their needs and experiences should be the first step in formulating effective postvention services.[11] Brent et al. found that the children of parents who died by suicide demonstrated a higher risk of ensuing depression for up to 21 months after the death in comparison to children of parents who died by sudden natural causes.[11] Furthermore, often forgotten are the siblings of the deceased. Usually attention is given to their parents. Evidence has shown that siblings often grieve alone as they do not want to add to the burden of grief experienced by their parents. Furthermore, 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.[1] Employers should be aware of the impact of suicide bereavement on

occupational functioning and make adjustments to promote workplace mental health.[12] Timely and suitable services and support for the bereaved, requires an understanding of the bereavement process and the needs of those left behind as well as the distinct diversities between the bereaved.[11] There is also the misconception that grieving has a timeframe;[14] this does little for the support needs of Pacific communities bereaved by suicide.

Pacific Learnings

There is wide acceptance that commonalities exist in psychological experiences for the suicide bereaved, irrespective of culture.[15] Yet, the ways in which grief is dealt with by various cultures, and the diverse social attitudes toward suicide, affirms that culturally relevant and appropriate postvention support, services and resources need particular attention.[15]

This section was communicated by Community Postvention Response Service (CPRS)/Clinical Advisory Services Aotearoa (CASA), as a result of working with the Auckland Pacific communities in 2011-2012 as part of a response to youth suicide contagion within the wider Auckland region.[16]

In 2011/12, CPRS worked in partnership with the local communities (Pacific and non-Pacific) to support postvention responses being put in place to manage and contain the contagion. This account derives from identified gaps and challenges during that time. It must be acknowledged that these observations were specific to the context as it was in 2011/12 and that significant changes have been made in the Pacific postvention arena since this time (e.g. Tongan Suicide Prevention Coordinator contracted for Waitematā District Health Board/Auckland District Health Board, resources developed by Le Va, and Waka Hourua funding for Pacific suicide prevention and postvention community projects..

- Lack of reliable historical death data for Pacific suicides. There were no baseline rates of suicides in the Pacific Auckland community for CPRS to be able to clearly identify that a cluster existed and whether numbers or rates were higher than usual.

- CPRS identified a lack of Pacific resources on suicide postvention. There needed to be documents developed on basic concepts such as warning signs, how to talk about suicide, when to call services and available services with contact details. There needed to be both English and translations into the various Pacific languages, all using key Pacific concepts, values and beliefs.
- There was little research about Pacific suicide to help inform the development of the aforementioned resources.
- There was a lack of appropriate and available services for Pacific families and communities to access. This ranged from a lack of support for youth identified as potentially at risk of suicide, to support immediately after a suicide.
- There was a lack of regional mapping (identification of those potentially vulnerable after a suicide), after a death by suspected suicide and monitoring of those impacted by, or exposed to the suicides. This is a common scenario in many Auckland wide contexts, and not exclusive to Pacific communities. As with many Auckland occurrences of contagion, young people were highly mobile, therefore the impact of a suicide has far reaching geographic and social impacts in multiple different communities. For example, a young person might live in one suburb, attend school in another, go to church in another suburb and play sport in another geographical area. Thus, the ripple effects of suicide contagion can be widespread. Responses at the time to a suspected suicide were local where no agencies had a mandate to map or follow up those impacted by a suspected suicide. Local responses meant that follow up on a regional scale (across services, District Health Boards and geographical communities), did not eventuate, for instance, to map friends at different schools, boyfriends at sports clubs, peers at church youth groups, and/or family in a different part of Auckland etc.
- Pacific leadership – CPRS uses a community development response, supporting local leadership of postvention community working groups. In this situation, CPRS had difficulty identifying who should be leading a Pacific postvention response, given that the contagion spread across at least two of the District Health Boards, and across many Pacific ethnicities. It was challenging for CPRS to identify appropriate key stakeholders to lead responses as the few key Pacific peoples with relevant experience, were in heavy demand working at the coalface and did not have the capacity to undertake other roles. CPRS identified that a Pacific Suicide Prevention

Coordinator would have been beneficial to undertake a coordination and liaison role with Auckland Pacific communities, District Health Boards, other government services and the Ministry of Health (working from bottom up, and top down).

- Lack of coordination amongst agencies – where a death by suicide occurred, there were well-intentioned however ill-informed groups offering their services. In some cases schools would be inundated with phone calls from services offering to work with their students, yet, not all the programmes/services offered had an evidence base to them.
- Agencies were not aware of what each other were offering or doing for suicide postvention. There needed to be a central point of coordination in the case that when an event did occur, the best service was identified and offered. For instance, where there were requests for help (e.g. speaking with suicide-bereaved young athletes at sports clubs), the appropriate service could be brought in effectively and in a timely manner.
- Challenges in communication – it was problematic distributing facts among Pacific communities. A communication plan was designed to send out emails to Pacific-based services, media and so forth with evidence-based material. Issues out of CPRS' control meant that the communication plan was put on hold. This resulted in community panic and speculation as the information was not reaching those at grassroots level.
- Unsafe community meetings held – the lack of knowledge and awareness of safe messaging or professional support in some community meetings was concerning at the time. These were considered particularly unsafe for young people needing support to attend.

CPRS reported that what did work well was:

- Pacific ethnic specific approaches e.g. Samoan or Tongan as separate responses.
- Specific local responses e.g. texts from a Pacific centred agency to young people.
- Using existing networks e.g. Pasifikology to coordinate responses and take leadership

There is a knowledge gap regarding the effectiveness of suicide bereavement support groups for Pacific peoples. A 2013 study by Goodwin and colleagues involved focus groups and in-depth interviews with Aboriginal communities in South Australia investigated the Anglicare Living Beyond Suicide (LBS) intervention's cultural relevancy as there were concerns of its underutilisation by Aboriginal people. The service supports the suicide bereaved, and works closely with police and ambulance personnel, and provides families with an immediate link to their services. Trained volunteers visit homes in the hours and days post suicide and have themselves experienced suicide bereavement. They provide information about funeral options and counselling services; liaise with coroners, courts and police; assist with insurance and other financial matters; and also sit down with families purely to listen.[2]

Goodwin et al. found that in order to serve Aboriginal communities effectively there had to be considerable Aboriginal involvement, appropriate engagement and leadership. As the LBS model stood, the service model needed to be reconfigured and this could only happen if the service worked with, for, and was driven by Aboriginal people.[2]

In the same way, current suicide postvention support services must also recognise remodelling as an effective strategy for being useful to Pacific communities.

Support

The most common and recommended form of postvention assistance is suicide bereavement support groups,[4] which consists of a group of people with shared experiences and believed to be the only ones who completely understand the suicide bereaved.[14 17] Support groups provide a safe, empathic and non-judgemental space for participants to open up about their journeys and share thoughts around coping and resources. They empower those that have been bereaved by suicide for some time or multiple times and then assist novice members with suicide grief.[18] However, the stigma and shame often attached to suicide as well as, in some cases, cultural expectations can become a hindrance in accessing help for some who have been impacted by suicide bereavement. There are also feelings of trauma, fatigue and a lack of confidence to ask for help.[6] Evidence demonstrates that those bereaved by suicide tend to engage with interventions if they are actively offered

to them, rather than seeking assistance for themselves.[19] Other barriers identified include: a lack of information and awareness of services; support not offered within critical periods; financial pressures; and religious prejudices.[17]

There is the view that postvention research should pay particular attention to the function of social support, online support, and the development and evaluation of resources. Moreover, support would hugely benefit from the inclusion of people bereaved by suicide in the research process.[9]

Resources

Services should include appropriate websites to recommend to those who prefer online engagement.[20] The discoveries of a recent study by Thornton may be of benefit for improvements in accessing suicide postvention resources online. The investigators found that 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 ideation 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.[20]

Training is vital for all services to increase awareness of the needs of people bereaved by suicide and available support services and resources.[14] Whilst training is available to provide postvention support, there appears to be no specific Pacific-focused suicide postvention training, so there is a reliance upon mainstream frameworks which may be irrelevant to Pacific contexts.

4. RESEARCH DESIGN AND METHODS

In line with Health Research Council of New Zealand (HRC) Guidelines for Pacific research, appropriate Pacific cultural protocols and processes were embedded in the design, analysis, report writing as well as the dissemination of findings.[21, 22] The processes that underpin this project are guided by the Guidelines' 12 ethical principles: relationships, respect, cultural competency, meaningful engagement, reciprocity, utility, rights, balance, protection, capacity building, and participation.[22]

Based on the methodology of the South Australian Suicide Postvention Project,[6] this research involved a mixed method concurrent approach facilitated by the collection of mixed data through the application of a survey, focus groups and *fono* (forums). 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, discussions with postvention experts and key stakeholders, and focus groups, and phase two involved community *fono.* The project was conducted over an 18-month period (October 2014-April 2016). Figure 1 illustrates the steps in each phase of the project.

Phase One

A survey was first employed using a structured questionnaire with both close-ended (quantitative) and open-ended (qualitative) items. Surveys were administered mainly on the Internet via Survey Monkey. The data was exported to Microsoft Excel and processed into a data set in IBM SPSS Statistics 22. The small number of surveys that were completed in hard copy were entered directly into this data set, and analysis of the quantitative data was undertaken. Free-text responses to questions were entered into an NVivo 10 project with links back to the SPSS data set for demographic breakdowns.

For the multiple response questions, numbers represent how many people gave each response. For these, percentages are not provided.

The target population comprised Pacific peoples in the community i.e. family members, friends, peers, 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 into Pacific languages was also made available. There were no translations requested.

Survey questions included: socio-demographic information; their relationship to the deceased; the type of support they received and potential services involved; their satisfaction with the support offered; barriers in accessing support and resources; identifying who was first at the scene; preferred support immediately after the event; and awareness of postvention services. For service providers questions included: the type of services and resources they offer as part of Pacific postvention; the types of challenges they faced when supporting suicide-bereaved families; what has worked; postvention training; improvements for future postvention support; and the type of support systems, protocols and processes they have in place to support Pacific individuals, families and communities bereaved by suicide as well as themselves for a colleague and/or client bereaved by suicide.

Analysis of the survey data set the scene for more in-depth investigations through focus group discussions. Focus group participants were recruited mainly through Pacific community networks. The session was guided by a semi-structured questionnaire that explored perspectives around the best ways of supporting Pacific peoples who have lost a loved one to suicide; whether they believed current strategies were culturally appropriate and meaningful in supporting Pacific individuals, families and communities; the types of support they considered should be offered; discussing what has/has not worked; their views of what Pacific suicide postvention guidelines could look like; and the best way to distribute this information. All data was entered into NVivo 10 for coding and arranged under corresponding questions.

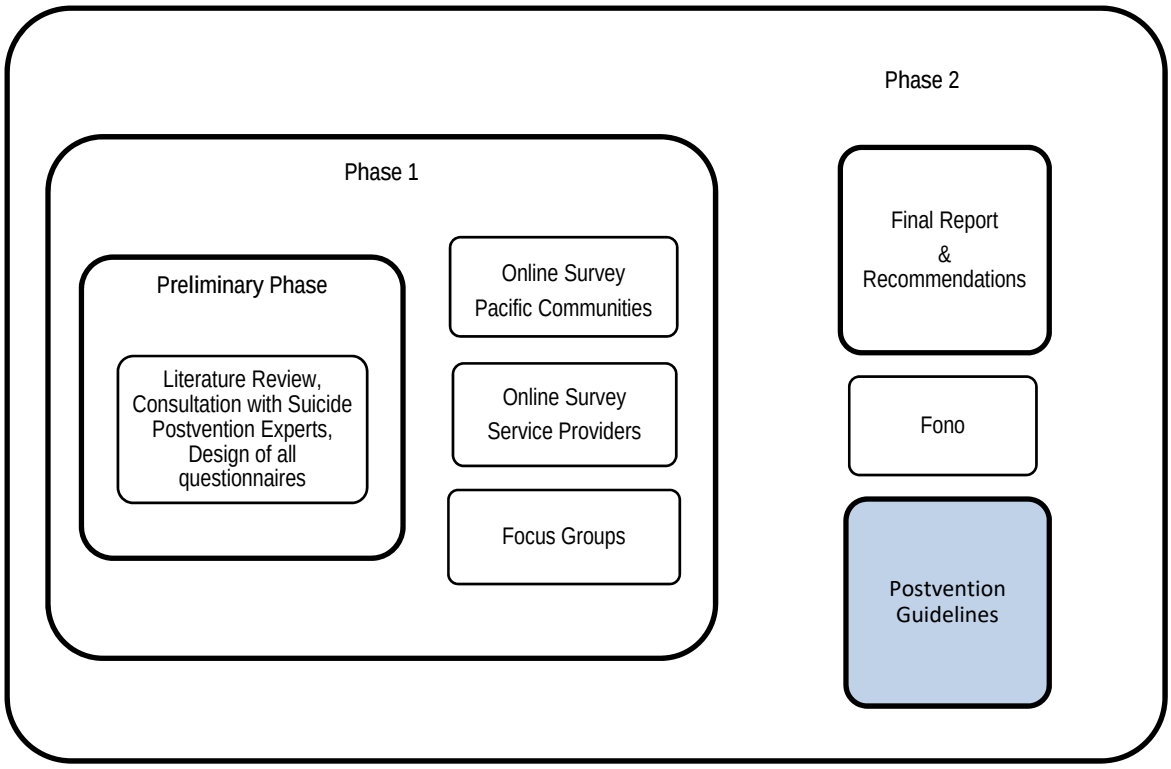
Phase Two

The second phase of the project involved a series of *fono* or workshops in four sites - Auckland, Christchurch, Hamilton and Wellington, open to Pacific communities and service providers in those areas where findings from phase one of the research were presented. Vaka Tautua was the Pacific community conduit for Auckland, Christchurch and Wellington *fono* and K'Aute Pasifika Services for Hamilton.

Participants were required to register their interest in a *fono* and sent a summary report of phase one research findings two weeks prior in preparation for *fono* discussions around the findings. Advertisements went out to networks and invites were also emailed or posted out to Auckland and Christchurch-based focus group participants along with the phase one summary of findings.

Ethics approval for this research was granted by the Southern Health and Disability Ethics Committee (Ethics Reference Number: 14/STH/100).

Figure 1: Project Design and Phases



5. FINDINGS

Phase one online survey findings will first be discussed for both Pacific communities and service providers, along with the qualitative free-text responses. This will be followed by focus groups findings. Finally, all phase one findings in culmination with phase two *fono* results will be presented, which specifically focused on the development of Pacific suicide postvention guidelines.

5.1 Online Surveys

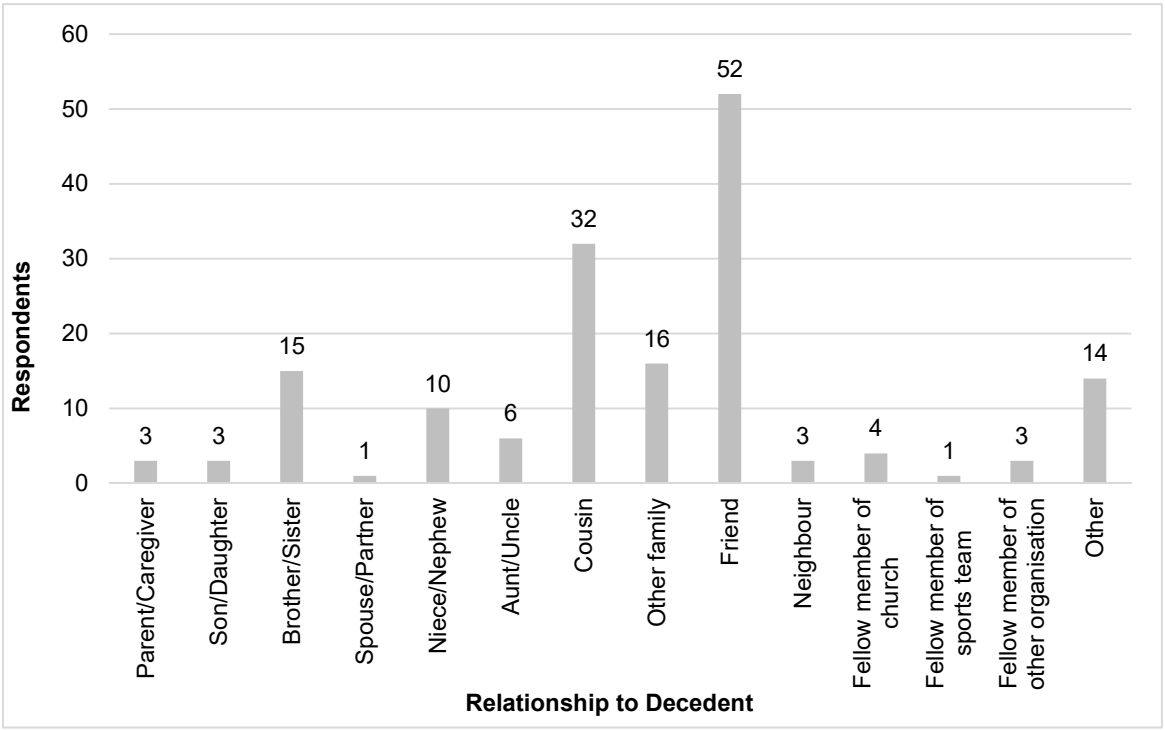
5.1.1 Pacific Communities

The Pacific communities survey drew a total of 173 unique responses, with 153 responding online, and 20 via hard copy. The majority of participants were female (79.2%), and of Samoan (48.1%), followed by Tongan (18.9%) and Cook Island (10.2%) ethnicities. Most respondents were NZ-born (71.9%) and resided in Auckland (79.2%), followed by Wellington (11.1%) and Waikato (3.5%). Detailed demographic information of respondents have been included in the appendices (Appendix 2). Analyses of demographic breakdowns by gender (Appendix 3), age group (Appendix 4) and by ethnicity (Appendix 5) are also included.

Tables include valid responses, so the total numbers may differ from table to table, and associated percentages. This is especially the case for the demographic breakdown tables, for age group, sex and ethnicity for Pacific community respondents (Appendices 3,4,5), so missing values, including *'don't know'* responses for many questions, may be more in one age group, for example.

Respondents were asked to indicate their relationship to the suicide decedent (Figures 2 and 3); most had been a friend (31.9%), followed by a cousin (19.6%), other family member (9.8%) and a sibling (15%).

Figure 2: Distribution of Respondents' Relationship to the Decedent



NB: *10 people did not answer this question or any further ones.*

The gender identities of the suicide decedent were 94 males, 68 females and 1 *fa'afafine*. The most common age range was between 16-24 years (62%) followed by the 25-39 age range at 19.6% (Table 1).

Figure 3: Summary of the Distribution of Respondents' Relationships to Decedent

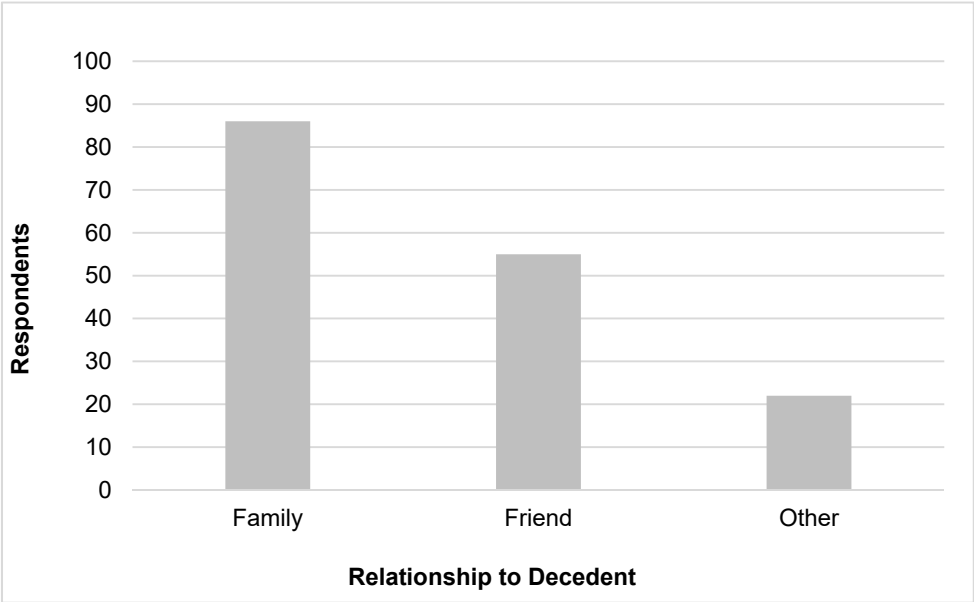


Table 1: Age Group of Decedent

Age group	n	%
10–15 years	14	8.6
16–24 years	101	62.0
25–39 years	32	19.6
40+ years	16	9.8
Total	163	100%

Figure 4: Distribution of the Time Lapse since the Event

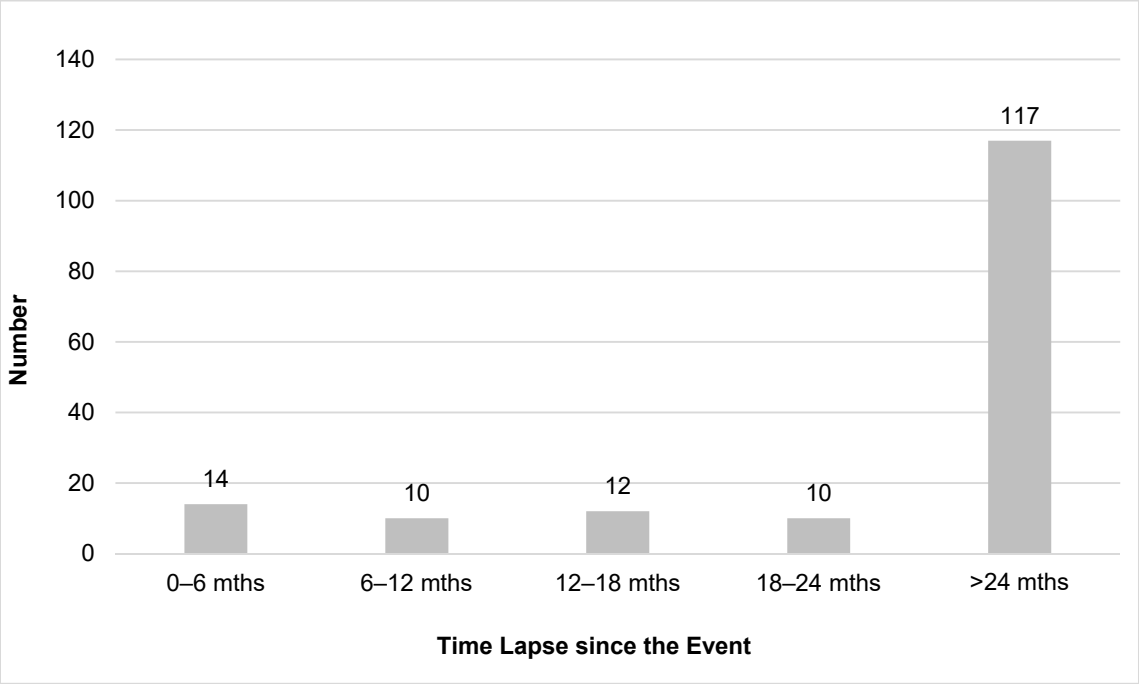
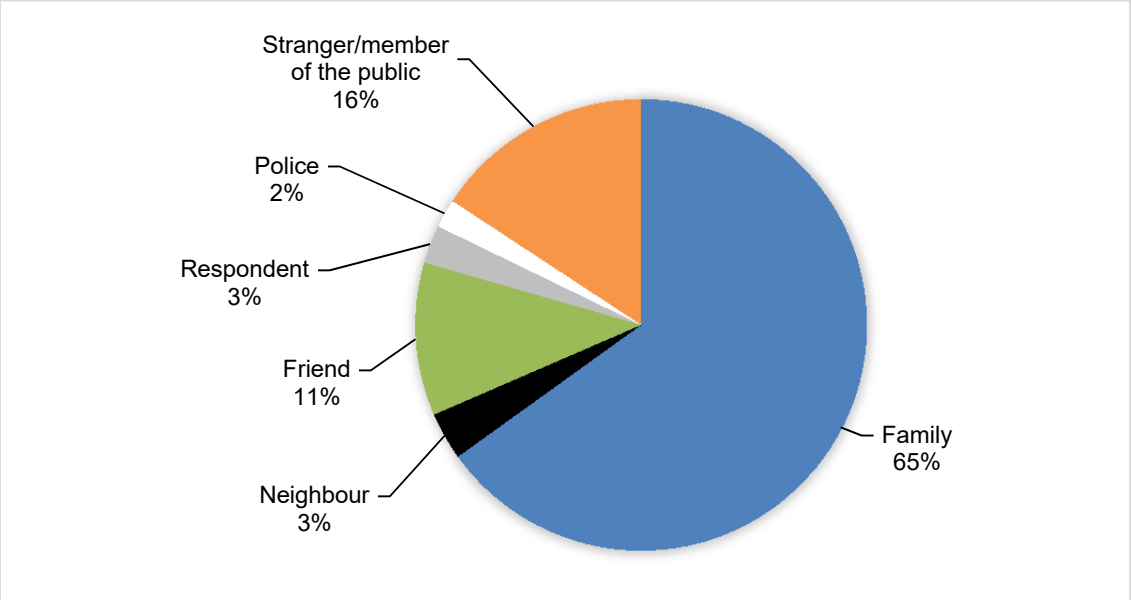


Figure 4 indicates that 71.8% (n=163) of the events occurred more than two years prior to taking part in the survey.

The next question asked was who was first at the scene (Table 5), 60% identified the person(s) as a family member, a stranger/member of the public (14.4%) or a friend (9.4%).

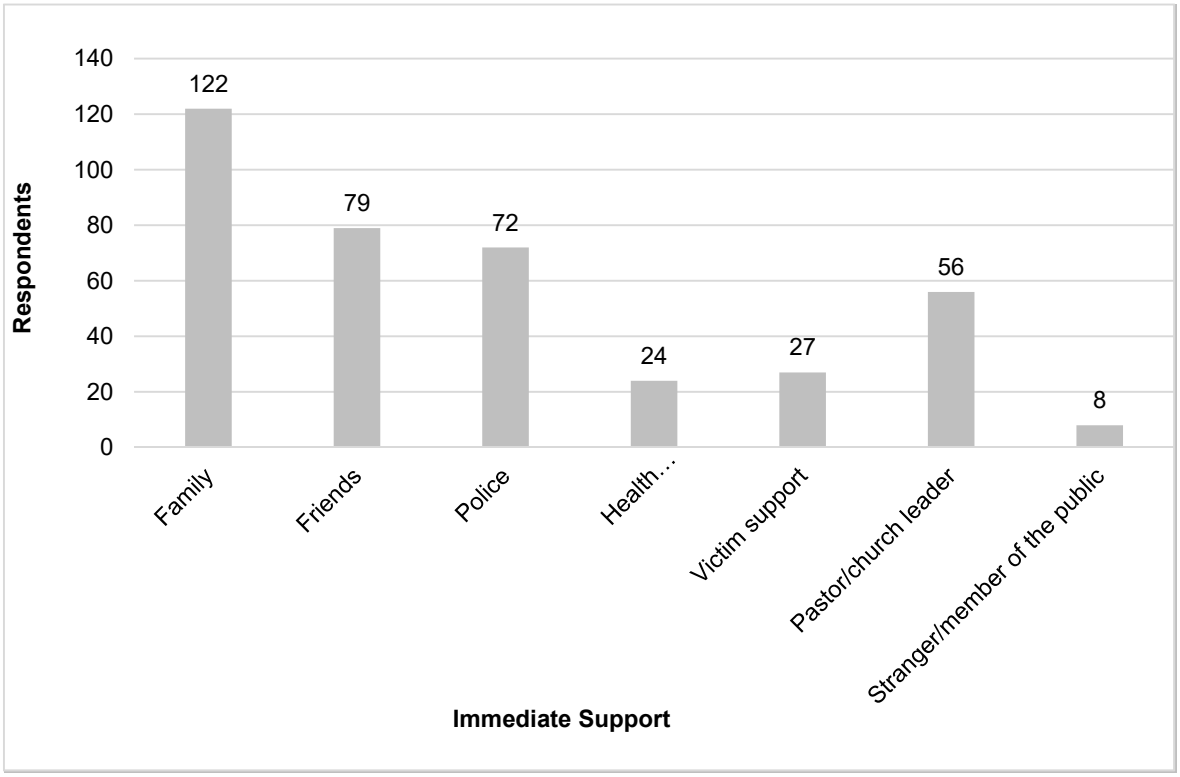
Figure 5: First at the Scene



Support

Figure 6 shows the multiple response options selected with regard to the type of support respondents could recall was provided for the family when they first heard that the event had occurred. Common answers included: family (31.4%), friends (20.4%), police (18.6) and pastor/church Leader (14.4%). Table 2 shows the number of people that reported each source of support.

Figure 6: Immediate Support Received



Respondents were also asked what support they considered was appropriate in the immediate term after the event.

Table 2: Appropriate Immediate Support

Support	n
Family	139
Friends	82
Police	48
Health professional	54
Victim support	70
Pastor/church leader	62

Participants could also enter a free-text response for this question. Most considered that organisations supporting families bereaved by suicide must 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. Results indicate that spiritual support remains an important element to include when working alongside grieving families.

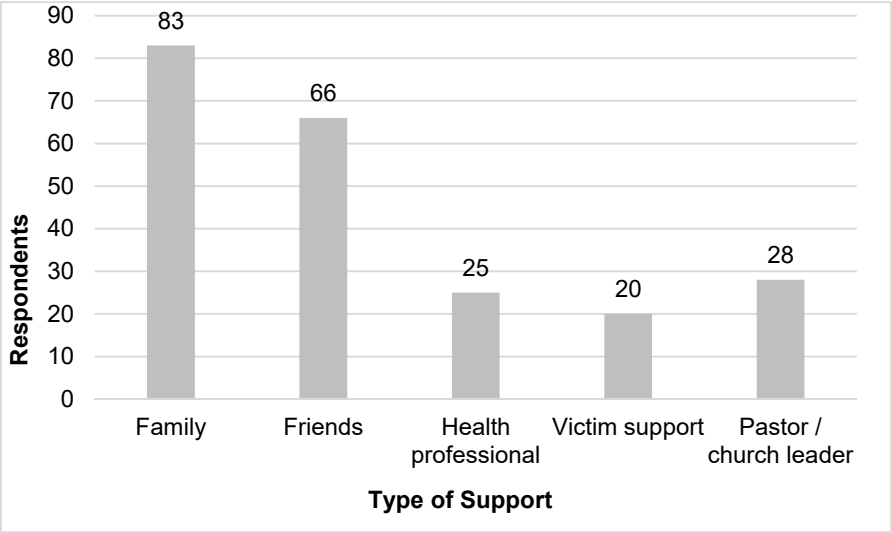
For those who reported having received support personally, 51.6% had been supported within six months of the event and 38.1% reported never having received any type of support at all (Table 3).

Table 3: Timeframe of Support Received

Timeframe	n	%
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
Total	155	100%

Those indicating they had received support were then asked to choose, if applicable, multiple responses regarding the type of support they believed was effective (Figure 7).

Figure 7: Effective Immediate Support



Further details were provided in free-text responses around what was believed to be effective immediate support mechanisms and included: reading about other Pacific families who are suicide bereaved; being able to share with work colleagues and having sympathetic employers who would allow sufficient time off for the individual (i.e. six months unpaid leave); legal advice; as well as key military, school and community liaison personnel and knowing how to access these people.

The 59 respondents who had not received any support (Table 3) were asked what form was needed but not given. Five common responses are presented in Table 4.

Table 4: Unmet Support Needs

Support needed but not received	n	%
Family	27	45.8
Friends	21	35.6
Health professional	24	40.7
Victim support	18	30.5
Pastor/church leader	17	28.8

Respondents could provide further detail via a free-text response. Views included: the need for extended paid bereavement leave; better coroner liaison with families; a police 'clean up' team at the scene (rather than leaving grieving and families in shock to attend to); some form of government financial support for the family i.e. if the primary income earner for the family is the suicide decedent; inclusion of Pacific healers; culturally appropriate and qualified grief counsellors with knowledge of supporting the suicide bereaved; more support given in schools; and support for younger family members from child and adolescent services.

Respondents were asked to select up to two types of short-term (immediately after losing a loved one) and long-term support they needed (Tables 5 and 6). Family counselling and spiritual guidance were the most favourable preferences.

Table 5: Short-term Support Needs

Short-term support	n
Family counselling	121
Health professional	65
Victim support	67
Spiritual guidance	100

Table 6: Long-term Support Needs

Long-term support	n
Family counselling	115
Health professional	62
Victim support	62
Spiritual guidance	92

Resources

This purpose of this section of the survey was to gauge respondents' awareness of suicide postvention support resources (Table 7); their satisfaction with and perceived effectiveness of current resources (Tables 8 and 9); identified barriers and access to resources (Tables 9 and 10); and preferred formats for resources (Table 11).

Table 7: Resource Awareness

Resources	n
Pamphlets	51
DVDs	11
Group Discussions	52
Websites	53
0800 Telephone Support	45
Suicide Bereavement Support Groups	58

Additional free-text responses comprised: 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/peers.

Those aware of at least one type of suicide postvention resource were asked how satisfied (or not) (Table 8) they were with known resource(s), and how effective they considered them to be (Table 9).

Table 8: Satisfaction with Current Resources

Level of satisfaction	n
Very satisfied	9
Satisfied	21
Fairly satisfied	50
Not very satisfied	22
Not at all satisfied	8

Generally, most participants were satisfied with current suicide postvention resources. Free-text responses allowed them the opportunity to share views about resource gaps and suggested improvements. These views are as follows: 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; financial advice; faith-based resources; avoiding messages that assume people feel a certain way; and a lot more ongoing support needed for students.

Largely, respondents considered current suicide postvention resources were ‘Fairly effective’ (Table 9).

Table 9: Effectiveness of Current Resources

Level of Effectiveness	n
Very effective	6
Effective	18
Fairly effective	52
Not very effective	22
Not at all effective	12

Free-text responses alluded to ‘what works’ for respondents, which were primarily centred around messages reinforcing the strength of informal support networks such as family and friends as well as the positive impact of family counselling. Group discussions are most effective and reflect the collective nature of Pacific communities. Therapeutic and healing interventions for families bereaved by suicide were believed to bring the family together to openly share about their grief journeys and work as a collective in the healing process.

Table 10 provides a breakdown of the type of barriers experienced by respondents that had stopped them from accessing resources to assist in their bereavement.

Table 10: Barriers to Accessing Resources

Barriers	n
Lack of transport	9
Language	4
Cultural differences	29
Shame	20
Guilt	19
Lack of Internet access	9
Lack of finances	13
Lack of telephone	2

Additional views were shared via free-text responses. Identified barriers included: Families refusing access to support due to shame; lack of Pacific resources specifically addressing the loss of a sibling, parent/caregiver, spouse, a child and so forth; the absence of support groups in smaller towns and rural areas; the unwillingness to openly talk about the person and his/her death; the lack of planning, coordination and support for the loss of one of a school’s students; the feeling of disconnect when speaking to a stranger over the phone; not knowing where to start in forming a suicide bereavement support group.

The question was asked about the types of resources one would prefer to learn from (Table 11). ‘Group Discussions’ and ‘Suicide Bereavement Support Groups’ were highly favoured.

Table 11: Preferred Formats

Resources	n
Pamphlets	32
DVDs	32
Group Discussions	87
Websites	44
0800 Telephone Support	35
Suicide Bereavement Support Groups	74

Further information given as free-text responses around preferred resources included: DVDs translated into Pacific languages; safe messaging via various forms of performing arts; Pacific narratives of those who have experienced suicide bereavement; Pacific service provider follow-up; school counsellors; family counsellors; workplace counsellors; books; blogs; a Pacific-focused smart device app to assist during difficult times and with general advice for someone bereaved by suicide; recognising the importance of face-to-face support; the importance 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 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, 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.

Respondents were also asked to identify who they deemed would be well placed to provide leadership around Pacific postvention support initiatives (Tables 12) and finally the potential effects of media interviews with people bereaved by suicide (Table 13).

Table 12: Potential Leaders for the Provision of Postvention Support

Leaders	n
Churches	76
Health professionals	56
Youth workers	69
Social workers	77
Community leaders	74
Police	22
Educational institutions	51

In addition to identified leaders in Table 12, other suggestions included: family leaders; families willing to share their experiences with those families who have lost in recent times and to be 'champions'; schools; grief counsellors; and family counsellors.

Table 13: Effects of Media Interviews with the Bereaved

Media Interviews	n
Helpful	67
Damaging	22
Don't know	47

NB: A large number did not answer this question.

5.1.1.1 Discussion of Pacific Community Survey Responses

Respondents were predominantly female—where are Pacific males? Most respondents knew the suicide decedent as a friend or were cousins. As expected the suicides were primarily in the youth age range and mainly males. This is still very much a population at increased risk.

There was an overwhelming response by those who were bereaved by suicide for two or more years prior to participating 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 years timeframe or if less time is an inappropriate period to talk about it, or in fact both. This would be a worthwhile topic for further investigation.

It was common that the first person to find their loved one was a family member. This may suggest that most suicides were at a familiar location (i.e. at their own or at a family member's home). A different type of support may be required for this person(s) particularly if they repeatedly revisit that moment mentally and are constantly reminded of that moment when in the vicinity of the area they discovered them.

Generally when one first heard of the incident, family were their immediate support, then their followed by friends. In terms of what is considered to be appropriate immediate support, most affirmed that it is 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. It is also required that any support person have been trained and at best be empathetic.

Just over half of all respondents had personally received support within six months of the event (n=80). There were still a concerning number however who had not received any type of support at all (n=59).

The 80 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 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 found them to have only a moderate impact. Major barriers and access to resources primarily focused on the lack of Pacific cultural appropriateness (i.e. Pacific values, concepts, languages, visual appeal and narratives) as well as 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 initiatives is believed to derive mainly 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 Le Va's recently developed *Pasifika Media Guidelines* to create safe spaces for Pacific peoples to publicly speak about the event or of their loved one.

5.1.2 Service Providers

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 bereaved Pacific individuals, families and communities. The majority of respondents were female (78.3%) and of Samoan (41.3%), followed by Tongan (6.6%) and Tokelauan (6.6%) 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%). Detailed demographic information of respondents is included in Appendix 4. Unlike the Pacific communities survey, demographic breakdowns for gender, age groups and ethnicity were not analysed.

Support

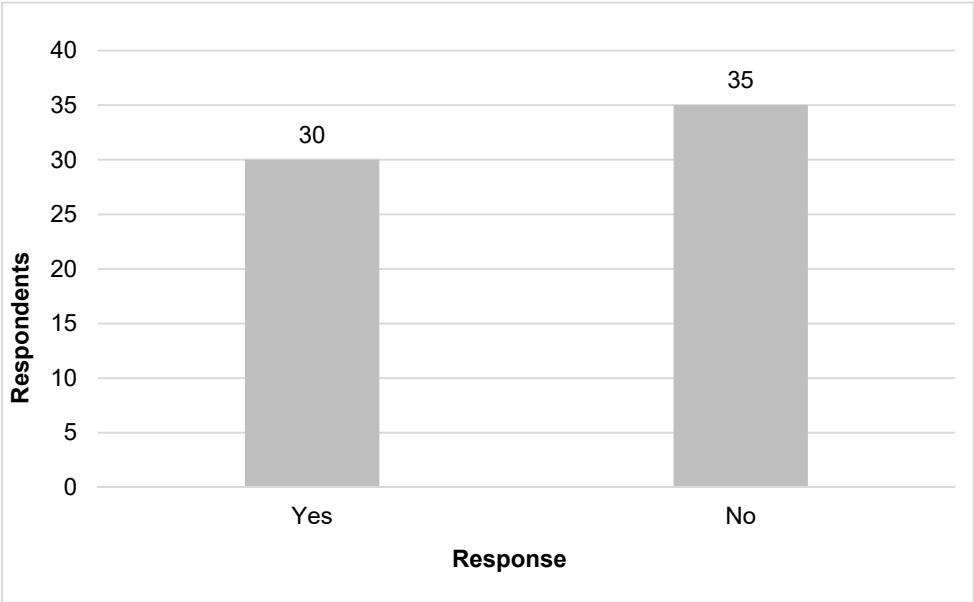
The types of agencies respondents worked for are summarised in Table 14.

Table 14: The Type of Service Provided

Type of agency	n	%
Family Services	4	5.7
Child and Youth Services	5	7.1
Mental Health	15	21.4
Healthcare	12	17.1
Church	2	2.9
Social Services	9	12.9
Justice	2	2.9
Education	8	11.4
Pacific Health	4	5.7
Other	9	12.9
Total	70	100%

Only 42.9% of respondents worked for organisations with guidelines within their organisations to help support those bereaved by suicide (Figure 8).

Figure 8: Distribution of Agencies with Guidelines to Support the Suicide Bereaved



There were various guidelines mentioned by respondents that were referred to in their practice of supporting families bereaved by suicide. These included: Traumatic Incidents guidelines; Youth Development Unit Suicide guidelines; DHB postvention guidelines; Clinical Advisory Group Services (CASA) guidelines; Recovery Pathways models; Victim Support guidelines; Best Practice guidelines from Victim Support; NZ Police guidelines for suicide; Ministry of Youth Development's Guidance for Community Organisations involved in Suicide Prevention; Youth Horizons suicide prevention training; and American Foundation for Suicide Prevention guidelines.

Table 15 refers to the type of support their service or organisation typically provided to support those bereaved by suicide.

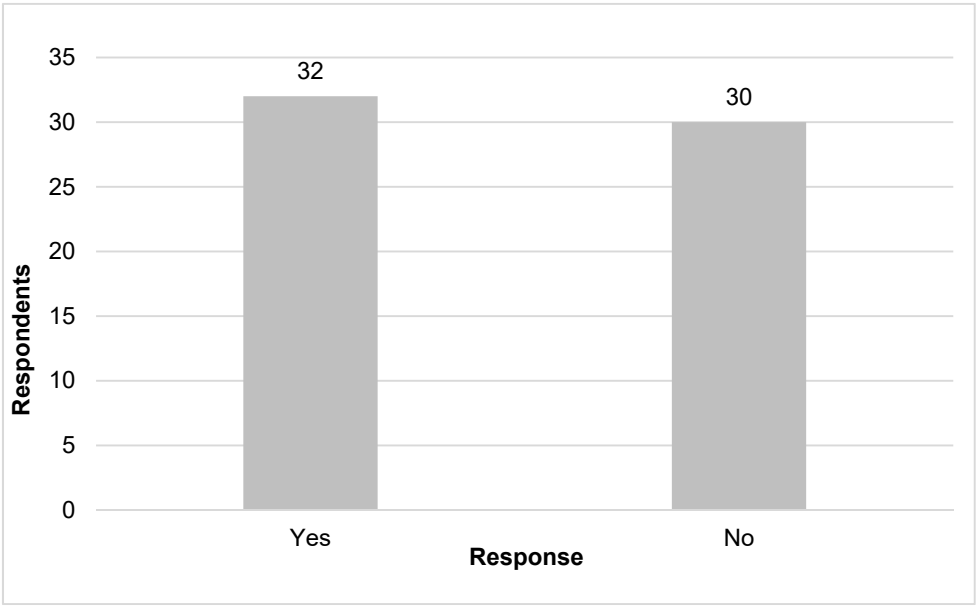
Table 15: Support Provided for the Bereaved

Support	n	%
Mental health support	20	35.1
Spiritual guidance	4	7.0
Family counselling	3	5.3
One-on-one counselling	6	10.5
Other	22	38.6
None	2	3.5
Total	57	100%

Typically, the type of services offered by respondents' organisations to support those bereaved by suicide included: psychosocial support; families referred to Victim Support for grief counselling; linking young people into appropriate services; mental health support, connecting people to suicide-bereaved support groups; liaising between postvention teams and schools; providing general support for the trauma team in school settings; and suicide risk screening.

Slightly under half of the respondents (45.7%) worked in organisations that provided suicide postvention for youth (Figure 9).

Figure 9: Distribution of Postvention Services for Pacific Youth

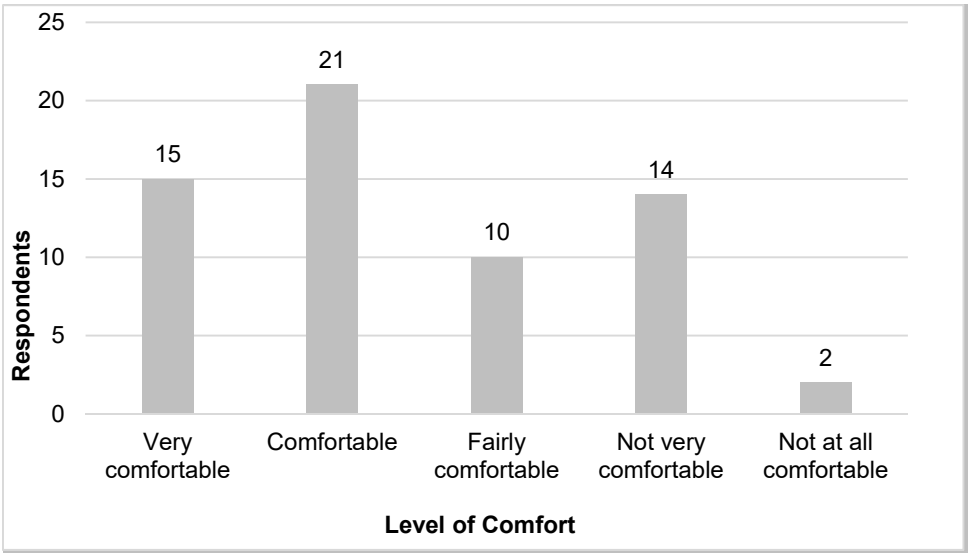


When asked to describe the type of youth suicide postvention services offered, the majority of answers were more suicide prevention focused, rather than postvention. Nonetheless responses were: workshops on youth suicide awareness; Child and Adolescent Mental Health Service (CAMHS) linkages to youth specific NGO/community services; staff undergoing suicide prevention workshops and training to be better equipped to support Pacific youth; immediate postvention engagement by trained volunteer support workers; Victim Support, Pacific Liaison police personnel; staff engaging in youth empowerment initiatives via courses and events; teleconferences with Counties Manukau District Health Board's postvention team; designated staff when notified of a suicide; visit the school and provide additional clinical support for students impacted by the death (with the school's permission); offer counselling and cultural support for the family; attend the funeral of the young person; and grief counselling.

There were 40 respondents who indicated they had supported someone bereaved by suicide at some point in their employment, yet only 14 had had any training on how to do so. Moreover, 43 worked in agencies that had support mechanisms in place if a staff member or client had died by suicide.

Service providers were then asked, to reveal the level of comfort they felt when working with someone bereaved by suicide (Figure 10).

Figure 10: Level of Comfort Working with those Bereaved by Suicide



Not only is it important to capture the views of service providers and the support that they offer (or do not offer) for Pacific communities, but also how their own wellbeing may be serviced within their own organisations if a colleague or client were to die by suicide. Their responses were as follows: Workplace debriefing sessions; ongoing counselling for either the individual or as a group; Employee Assistance Program (EAP) training; Psychological First Aid training; access to spiritual assistance; access to a cultural advisor; Victim Support; and access to grief counsellors.

Resources

As was also asked in the Pacific communities' survey, respondents were asked to specify the types of resources they were aware of in order to provide support to those bereaved by suicide.

Table 16: Resource Awareness

Resources	n	%
Pamphlets	46	65.7
DVDs	15	21.4
Group discussions	27	38.6
Websites	43	61.4
0800 telephone support	37	52.9
Suicide bereavement groups	37	52.9

Additional free-text responses comprised: Victim Support; school counsellors; District Health Board and Public Health Organisation counsellors; community counsellors; Skylight; local community support groups; suicide prevention groups; mental health services support; church support groups and pastoral care; Māori and Pacific support service providers; school counsellors; Clinical Advisory Services Aotearoa (CASA); Pacific Liaison officers; and Life Care Ministries.

Table 17: Satisfaction with Current Resources

Level of satisfaction	n	%
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
Total	54	100%

Similarly, as was also found in Pacific communities' survey responses, most were satisfied with current suicide postvention resources. When free-text responses were allowed, people used the opportunity not only to share additional views about their satisfaction with current resources, but also to recognise gaps and suggest improvements to them. These views were as follows: resources need to be openly advertised; Pacific ethnic-specific materials need to be available; Victim Support is important and an appropriate service to cater for Pacific peoples; NZ Police Pacific liaison and Māori liaison officers provide good support and are extremely valuable for immediate support for the family; Pacific-focused resources need to recognise Pacific diversities (e.g. not all Pacific peoples attend church; the various ethnicities, gender identities and sexual orientations; multi-ethnic families, NZ-born Pacific peoples); resources that acknowledge cultural beliefs and values are required; and also there is a need for Pacific youth-focused material.

Table 18: Effectiveness of Current Resources

Effectiveness	n	%
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
Total	52	100%

Of the respondents that indicated they were aware of suicide postvention resources, the majority considered current suicide postvention resources as 'Fairly effective' (Table 18). Further information via free-text responses comprised: the need to consider the use of information technology particularly for Pacific youth (i.e. as a suicide postvention application) and building the Pacific workforce capacity to specifically deal with suicide grief among Pacific families and communities.

Providing Better Support

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 (Table 19).

Table 19: Potential Leaders for the Provision of Postvention Support

Leaders	n	%
Churches	29	41.4
Health professionals	31	44.3
Youth workers	12	17.1
Social workers	17	24.3
Community leaders	25	35.7
Police	7	10.0
Educational institutions	11	15.7

Other than the preferred leadership demonstrated in Table 19, other suggestions included: youth/sports groups; registered ethnic-specific health organisations (GPs and non-government organisations); Pacific health and social service providers trained in the area; Victim Support but with more Pacific staff and volunteers; trained community and church leaders; the Pacific branch of the Ministry of Health; and a multi-sectoral Pacific body (i.e. health, education, justice WINZ) that covers all, if not most, agencies as the issue is complex.

With regard to the types of challenges respondents faced when supporting Pacific communities bereaved by suicide, free-text views included: the lack of Pacific-focused suicide postvention resources; the stigma attached to suicide and mental health issues; community misunderstandings of mental illness; shame; blaming; accessing skilled people to manage the *talanoa* (discussion) around suicide; lack of follow-up; religious associations acting in a negative light deterring help seeking, enhancing stigmatisation and causing people to avoid any further discussion of suicide; the non-naming of the suicide decedent; a need for Pacific personnel in Victim Support; lack of Pacific cultural competency training by non-Pacific support workers; knowing how to approach the family when they are not aware of the potential risks, especially with younger members, who try to keep the memory of their loved one, however, through glamorised events; knowing how to have safe conversations with suicide-bereaved families and individuals; suppression among family members breeding resentment and disconnection; families trying to deal with it alone; youth not wanting to talk about it within their families as they do not want to burden their parents/caregivers who may also be grieving; the church is considered an effective and safe environment for individuals and families suicide bereaved however, church leaders usually are not trained or have the appropriate networks to provide postvention support; and encounters with people managing the grieving process with substance abuse.

5.1.1.2 Discussion of Service Provider Survey Responses

There is a need for organisations who deal with Pacific communities to have access to, and be assisted by postvention guidelines. Less than half of the respondents indicated that they were not using any type of postvention resource. Relevant national and international postvention and traumatic incident-type guidelines were listed. It is recognised that up until this current project, Pacific-centred postvention guidelines did not exist. It is hoped this resource will be widely used and considered by those who work with 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 who in fact worked in the sector. The field of postvention would hugely benefit from research in this area.

Whether service providers are Pacific youth focused or not, postvention for all ages would be effective, as one is not dealing with only an individual but also their families.

The message that postvention is in fact, suicide prevention needs to be a clearer message that is understood and communicated to Pacific communities.

One must be mindful that support workers too are not immune to the loss of a loved one, a work colleague and/or a client. Therefore, support systems need to be in place and training is needed for all levels in the organisation to provide better support.

Respondents' awareness of the types of resources available for suicide postvention support was similar to the Pacific communities' responses. Specific suicide postvention services such as Skylight and CASA were identified. 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.

Health professionals, churches and community leaders were deemed the most appropriate to lead Pacific postvention. In contrast to Pacific communities' responses, we see opposing views as each regards the other as taking more ownership around the issue. On the surface of things, it appears that each appears to be evading responsibility, however it may also be interpreted that in fact, everyone should be held accountable in owning leadership of Pacific suicide postvention if it is to be effective and sustainable.

5.2. Focus Groups

There were 16 focus groups held in Auckland (n=12) and Christchurch (n=4) for a total of 74 participants. Separate group sessions were held with both youth and adults. There were ethnic-specific focus groups for Samoans, Fijians, Niueans, Tongans, Cook Islanders, Tokelauans, Tuvaluans and three groups comprising a mix of Pacific ethnicities. Tongan and Fijian adult focus group discussions were undertaken in their respective languages. All other sessions were conducted in English. There were eight support people in attendance for all focus groups. In total there were 53 females, 20 males and 1 *fa'afafine* who participated in group discussions.

Basic demographic information in Figure 11 provides a breakdown by ethnicity and gender. Figure 12 is a breakdown of participants by age, with Table 20 classifying residence by District Health Board region.

Figure 11: Breakdown of Focus Group Participants by Ethnicity and Gender

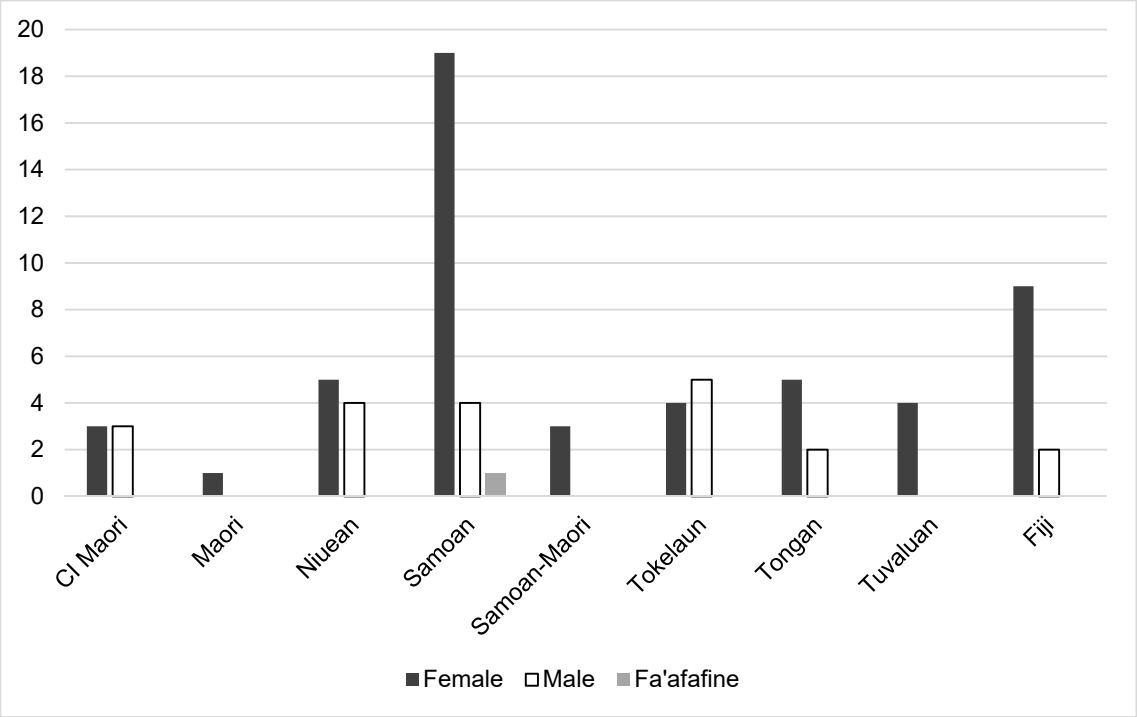


Figure 12: Breakdown of Focus Group Participants by Age

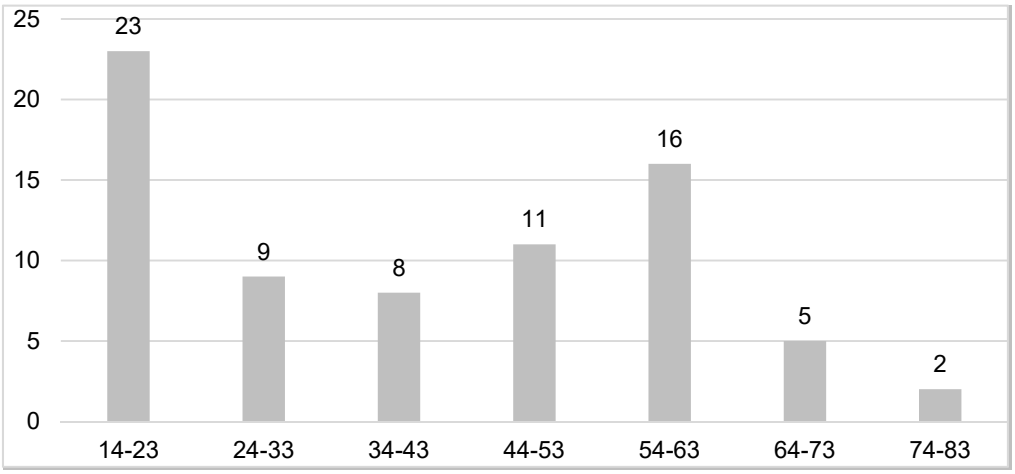


Table 20: Age of Focus Group Participants

Age Range	n
14-23	23
24-33	9
34-43	8
44-53	11
54-63	16
64-73	5
74-83	2
Total	74

Table 21: Residence of Focus Group Participants by District Health Board Region

District Health Board	n
Auckland	16
Canterbury	20
Counties Manukau	31
Capital & Coast	1
Waitematā	5
Unspecified	1
Total	74

The voices of participants across 17 focus groups were organised into common themes and key messages which are presented in this section.

Recognising Family Structures

There were many suggestions regarding the best approach in providing support for Pacific families. Being aware of the structure of the family and recognising the importance placed upon relationships and communalism is fundamental to when supporting bereaved families:

> *"Every family will be different, the hierarchy of every family will be different. Whoever's going to get trained, they need to recognise what sort of family structure they're moving into, otherwise they'll do a hell of a lot of damage."*

"Maybe they [support services], should learn who to greet first. If you were coming into my house, you'd greet my grandmother before greeting me or my mother. In other families, that is very important that you greet the right person."

"In terms of solutions they [family] have to be part of the solution. Much education is required, and much connection. The impact on the potential solution is relationships and the strengths of those relationships inside a family."

"[The grief counsellor] has to have a village mentality, in terms of how do you address the young people. You come to talk, not just to the family represented by aunty, uncle, etc., but you talk to the family, as a family. And I think that must be the key word here, as a whole aiga [family in Samoan]. Kids, everyone who is there and physically resides on that property."

We Don't Talk About Suicide

As mentioned earlier in this report, supporting those bereaved by suicide may be challenging due to the stigma that surrounds the suicide death and for some, any association to the event or person is *tapu* (forbidden, sacred):

"We don't really talk about suicide…We talk about death, we talk about other issues, but we don't talk about suicide much."

"Everybody will think we've got a sick family."

"This needs to come into training as well, because we have this thing in the [Pacific] way, when you're cursing someone or families, you can put a curse on what they say. I'm being very careful here because I've had a client that ended up being suicidal because of this. Sometimes it goes through the family and down the family [line], it's handed from one village to another village, that kind of thing. It's something that I've dealt with myself also. That's [suicide] not talked about outside the family or the villages sometimes, it's really not spoken about."

"Not cursed [from the act] but cursed beforehand and that comes down to [the person who died]. It's a belief but not something for everyone to believe. It's a way of understanding or how they perceive things. There must have been something that happened in the past generation and then it [the curse] comes down like that into the next generation. In the past we always hear that 'A tutulu le matua o lou malaia na' [If your parent cries, that is your curse]."

"People just naturally don't go there. They said when he passed away no one even wanted to go swimming because of the creek thing…There is this whole idea that when someone has died, or someone dies in a particular place, they're still hanging around."

Messaging

Effective ways of disseminating postvention information so there is a wider reach and appeal to ensure messages are suitable for all ages:

Youth responses -

"I'd watch a DVD rather than read, you know what I mean? Have an app."

"Texting – because when people are in that state of mind they only have their phones on them. [The] majority of [us] have our phone on us."

"Websites, YouTube and social media…Youth tend to prefer online support."

Elders' responses -

"Grandma and our older generation, they don't have a clue when they look at the English language. If you give them a leaflet or a book to read in English they just look at the pictures and put it away. It would be good in the Tongan language so a lot of the older Tongan generation will understand."

"I think you need to make the sure that the matua are involved in any training that's put together and it's not just coming from a registered psychologist, because they will have the clinical point of view so there needs to be I suppose a holistic approach to it, not coming from somebody with no life experience."

"Face-to-face personalises it and is the real Pacific way".

In the Workplace

It is believed to be important that those working with Pacific families are trained in suicide postvention and more prepared and equipped to respond. Moreover, spaces in the workplace for staff to take some time out are needed:

> *"I'm thinking about my own team [in the workplace] and if someone was to end their own life and people were to turn to us and my team and say, 'we have an expectation of you and your mental health team to support us,' I guess I would wonder how equipped my team would deal with it [a suicide] if it was to happen tonight and we were getting calls tomorrow. Absolutely the reach needs to be open to everybody."*

> *"Tell your bosses that the time you need to go have a tangi [cry] somewhere that you can – if you disappear, they can understand where you've gone, and that they may need to seek help for you."*

Training

There needs to be *matua* involvement. It is imperative to have qualified support who have experienced suicide bereavement. Pacific-specific training should not rely on Western frameworks. There is a need for support people to be trained in Pacific protocols (i.e. wearing appropriate attire, appropriate greetings, knowing family dynamics). Pacific cultural competency training is a must for those who provide immediate support (i.e. Victim Support, NZ police, bereavement support-type services, etc.).

> *"I think a more cultural response rather than a service response will be effective."*

> *"There is a lot of training, but it's based on Western theories and their interventions are totally different to ours."*

> *"It's awkward for me to try offering help to someone whose older than me, there's just that barrier."*

Formal Support

At the scene, one should refrain from bombarding the family with questions and 'do's and don't's' to give them some space. Support needs a communal approach, that is, for example, not dealing with only one person in the family. In providing immediate support, do not promote your presence but wait until you are given the go ahead to become a lot more visible to the family. Counselling and support is needed for the children in the family. There is also a need for ongoing face-to-face support.

> *"You need that time and space just to collect your thoughts and be with immediate family, and then you can start to communicate what can happen. Often you're just pushed around, you're pushed away by strangers, ambulance men, police. And I think our people don't say 'Stop, could you just give us a minute?' I've seen Palagi's [Caucasians] do it [ask for some space], but I haven't seen our people do it. They suddenly get ordered about. And you're standing there wanting to do something but can't."*

> *"The children were devastated. I think that's one of the things I really want the helping agency to attend to that because adults, we're so busy trying to come to terms with it ideally you'd want someone totally different to come and take the children and explain you know, what's happening, so it's not so daunting and trying to explain to the little ones because they were devastated too. It's the fact that the parents were not available to comfort them…I really think there should be counsellors specifically for the children."*

> *"The safe place for you to be is over there. Just observe and just watch. Try your best to be as invisible as possible. But try and show that you're present but stay out of people's way. I think that's really important because when you do turn up the week after you can at least say, 'oh I was here.'"*

The Resource

Bilingual resourcing around suicide postvention is needed. The guidelines should be appropriate for all ages. One cannot assume all Pacific peoples go to church, thus there should not be an overemphasis on religiosity/spirituality. There also needs to be more recognition of the multi-ethnic make-up of Pacific peoples, particularly of youth.

How to Support the Bereaved

Knowing how to comfort a person bereaved by suicide involves simply listening and allowing the bereaved to 'feel'. Allowing sufficient time for the family to spend with the deceased immediately after the event and prior to police investigation. Recognising that once all funeral activities have settled (i.e. 2 weeks after), this is when support will be needed the most. The need for more information to avoid glamorisation of the event and direction in forming Pacific support groups for families bereaved by suicide.

5.3 *Fono* and the Development of Pacific Postvention Guidelines

Four *fono* were undertaken in Auckland (n=25), Christchurch (n=13), Hamilton (=13) and Wellington (n=29) and solely focused on the development of Pacific suicide postvention guidelines. These guidelines are not intended to provide a 'Band-Aid solution' but rather to build a Pacific-specific suicide postvention evidence base and produce an evolving resource that can better support the needs of the suicide bereaved. This section comprises an amalgam of viewpoints from the surveys, focus groups and *fono* where participants were asked to share their views on what suicide postvention guidelines should look like. Whilst all information cannot be included in the guidelines, it is hoped that this information may help to inform further development of suicide postvention resources and research. Results are as follows:

What should the guidelines look like (physically) and why?

- They must be easily understood, concise, simple and with clear messages which may then also be translated into the various Pacific languages and potentially reproduced into a bilingual resource.
- Short, bullet-pointed messages void of clinical language or jargon.
- Positive poetry, narratives, proverbial sayings, incorporating traditional and contemporary concepts, colourful artwork/photos, and showcasing Pacific diversity are all important as these resonate for Pacific peoples. They also provide a sense of

Pacific ownership. All these factors will do well to increase the guidelines' appeal and uptake.

- Must be relevant for all ages and occupations.
- An evolving document that can easily be adapted and amended to serve Pacific diversity, underpinned by an empowerment model and strengths-based approach.
- Available as a booklet in both hard and soft copy forms.
- Develop an app for smart devices that are suicide postvention focused.
- Have a supplementary video to accompany the guidelines.
- Blend the traditional and contemporary (images, language).

What information has been difficult to access regarding support after the suicide of a loved one?

- A stocktake of culturally appropriate services available to families and communities by region.
- Resources about the processes for the family to take and the expectations after the event regarding the authorities, court system, coroners, media, etc.
- Information and advice about dealing with the immediate grief and managing further suicide risk among the family.
- How to cope in the long term as the grief is always there even after a long period of time.
- Lived experiences and the voices of Pacific peoples in current resources are absent from current resources.
- Lack of trained Pacific suicide postvention support.
- The lack of a Pacific-informed evidence base.
- Pacific-specific guidance on how one can initiate a conversation to support someone bereaved by suicide.
- Information on ways in which the family may contribute to the coroners' process, whether writing for an inquest or a hearing. It was suggested that support could be made available to work with a family through this (i.e. to listen and organise this in writing to send to the coroner. Unbeknown to most, coroners are open to family input.

What are the most important things to include in these guidelines?

- Suicide postvention and bereavement support group contacts and links.
- Self-care tactics, which may include taking time out, being assured that it is normal that things seem surreal, tips on how to stay mentally well, reminders to take care of one's physical health (taking rests, getting enough sleep, eating well, praying, etc.).
- Anti-stigma messages reinforcing that suicide is not a sin, or a cowardly or selfish act.
- Sign-posts in dealing with the coroner, the police, funeral arrangements, and key contacts to make the funeral process easier.
- As is the challenge of including each Pacific group's cultural protocols and processes, there are some values that apply to most and should be incorporated in Pacific-centred postvention training. There may include for example, knowing the Pacific ethnicity or ethnicities of the family before arriving, removing footwear when entering a home, wearing appropriate attire, not standing directly over the person lying in state, allowing loved ones enough time with the deceased at the scene before the investigation takes place.
- Emphasising a communal approach in providing support for the family.
- Safe ways of talking through the grief.

What training/cultural models do you think will work?

- Ethnic-specific support groups which are culturally, spiritually (for some) and linguistically appropriate.
- Pacific models that are suited to the group that will be served. There are a host of models in the health, education and justice sectors (e.g. Nga Vaka, Get Real, Sei Tapu, Niu, Paopao, Fofola e fala, Va Tapuia, Te Vaka Kainga, Faikaua, taro model, etc.)
- Training needed for Pacific communities in suicide postvention who can then provide immediate support for families. This would also build Pacific capacities.

- Cultural competence training is needed particularly for those involved in the initial interaction with the grieving family i.e. NZ Police, ambulance staff, Victim Support, and the Coroner's office and non-Pacific peoples in supporting roles.
- Face-to-face engagement, building rapport and listening are vital.
- Include guidelines on how to maintain a well-moderated website.
- Specific knowledge and training required to support the person(s) who found the deceased.
- A cultural response first before a clinical one.
- Ensure that the support person is well connected or has established networks with translators, legal advisors, financial advisors, NZ Police, mental health services, and child and youth services.
- Identify the key person(s) to liaise with the family and to link them into services and resources that will benefit the family. Stay connected with this conduit(s).
- Separate support groups offered for adults, elderly and youth.
- It is believed that often, all families need is a trained and supported community peer to help the family grieve and recover.
- Students usually do not have the capabilities to provide support for a peer. They need information and improved access to resources to provide support for friends affected by suicide. The school plays a key role in supporting suicide-bereaved youth.
- Use cultural reference points that remind Pacific peoples of their historical resilience. When speaking to Pacific *matua* it is crucial to use their mother tongues.
- Helicoptering by health professionals to counsel the bereaved family may not work. There needs to be a focus on human solutions that address the root issues rather than medicalising the situation.
- As gatekeepers and knowledge holders, Pacific *matua* (elders) need to be included in the dialogue around suicide postvention.
- Be familiar with cultural protocols surrounding death.
- There need to be trained community leaders who know how to support families in initial and ongoing stages of bereavement. Church ministers will also need training in this area. Promoting Pacific resilience is a strength.

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APPENDICES

Appendix 1: Online Pacific Community Survey

Pacific Community Survey for those Bereaved by Suicide

You are invited to take part in this survey if you have lost a loved one to suicide. We would like you to share your experiences because the information you provide will help us understand, address and develop ways of supporting our Pacific peoples who have lost a loved one to suicide.

The aim of this survey is to engage Pacific communities and examine what they feel are the most important and appropriate factors to include in the development of guidelines as a means of providing the best possible support for our Pacific individuals, families and communities who have lost a loved one to suicide. This opportunity allows you to respond to this important issue in ways that you describe, understand and experience suicide bereavement that will benefit Pacific peoples.

The language used is mainly English, but if you would prefer to have the survey in your first language, this can be arranged. You will also be asked if you would like to take part further, via a focus group interview. These will be held in Auckland and Christchurch between 27 October and 8 December 2014.

Whether you take part or not is your choice. By completing this survey, you are giving your consent for the information that you have supplied to be used by us for research purposes. The information you provide will not be linked to you specifically – this is an anonymous survey. If you would like to enter the prize draw for a $100 Westfield gift voucher, please

enter your email address where prompted at the end of the survey. This will also be used to contact you if you want to be in a focus group. The winner of the prize draw will be contacted once the survey is closed (May 2015). Emails will not be used for any other purposes, and will be deleted from the database as soon as the draw is over.

1. Date of survey

Day	Month	Year
(e.g. 31)	(e.g. 03)	(e.g. 2014)
☐☐	☐☐	☐☐☐☐

The Context

2. Which ethnic group or groups do you belong to?

Tick the boxes that apply to you.

- ☐ Samoan
- ☐ Cook Islands
- ☐ Tongan
- ☐ Niuean
- ☐ Fijian
- ☐ Tokelauan
- ☐ Tuvaluan
- ☐ Other – Please specify: _
- ☐ Don't know

3. Which country were you born in?

Tick the box that applies to you.

1. ☐ New Zealand
2. ☐ Samoa
3. ☐ Cook Islands
4. ☐ Tonga
5. ☐ Niue
6. ☐ Fiji
7. ☐ Tokelau
8. ☐ Tuvalu
9. ☐ Australia
10. ☐ Other – Please specify: _

4. If you live in New Zealand but were not born here, when did you first arrive to live in New Zealand?

Month if known Year

(e.g. 11) (e.g. 1945)

☐☐ ☐☐☐☐

5. Are you:

Tick the box that applies to you.

1. ☐ Male
2. ☐ Female
3. ☐ Other (i.e. transgender, intersex, etc.)

6. When were you born?

Day	Month	Year
(e.g. 31)	(e.g. 03)	(e.g. 1956)
☐☐	☐☐	☐☐

7. Where do you live?

Tick the box that applies to you.

1. ☐ Northland
2. ☐ Auckland
3. ☐ Waikato
4. ☐ Wellington
5. ☐ Christchurch
6. ☐ Dunedin
7. ☐ Other – Please specify: _

8. What is your employment status?

Tick the box that most applies to you.

1. ☐ Full-time paid employee
2. ☐ Part-time paid employee
3. ☐ Self-employed (own business)
4. ☐ Working in family business without pay
5. ☐ Beneficiary
6. ☐ Student
7. ☐ Taking care of the home or children

8. ☐ Other – Please specify: _
9. Relationship to the deceased:

Tick the box that most applies to you. She or he was my:

1. ☐ Parent/Caregiver
2. ☐ Son/Daughter
3. ☐ Sister/Brother
4. ☐ Spouse/Partner
5. ☐ Niece/Nephew
6. ☐ Aunt/Uncle
7. ☐ Grandparent
8. ☐ Grandchild
9. ☐ Cousin
10. ☐ Other Family/Relative
11. ☐ Boyfriend/Girlfriend
12. ☐ Friend
13. ☐ Work Colleague
14. ☐ Neighbour
15. ☐ Fellow Member of Church
16. ☐ Fellow Member of Sports Team
17. ☐ Fellow Member of Other Organisation
18. ☐ Other – Please specify: _ _ _ _ _ _

10. Age of the deceased:

Tick the box that applies.

1. ☐ Under 10 years of age
2. ☐ 10–15 years
3. ☐ 16–24 years
4. ☐ 25–39 years
5. ☐ 40+ years
6. ☐ Don’t know

11. Gender of the deceased:

Tick the box that applies.

1. ☐ Male

2. ☐ Female
3. ☐ Other (i.e. transgender, intersex, etc.)

12. How long ago did the event occur?

Tick the box that applies.

1. ☐ 0–6 months ago
2. ☐ 6–12 months ago
3. ☐ 12–18 months ago
4. ☐ 18–24 months ago
5. ☐ More than 24 months ago
6. ☐ Don't know

Immediate support

13. Who was first at the scene?

Tick the box that applies.

1. ☐ Family
2. ☐ Neighbour
3. ☐ Friend
4. ☐ Yourself
5. ☐ Stranger/Member of the Public
6. ☐ Other – Please specify: _

14. What support can you recall was provided for the family when you first heard of the news?

Tick the boxes that apply.

- ☐ Police
- ☐ Family
- ☐ Friends
- ☐ Health Professional
- ☐ Victim Support
- ☐ Pastor/Church Leader
- ☐ Stranger/Member of the Public
- ☐ Other – Please specify: _
- ☐ Don't know

15. What immediate support do you feel is appropriate when one first hears of the news?

Tick the boxes that apply.

- ☐ Police
- ☐ Family
- ☐ Friends
- ☐ Health Professional
- ☐ Victim Support
- ☐ Pastor/Church Leader
- ☐ Other – Please specify: _
- ☐ Don't know

16. Did you receive any support within the first six months of losing your loved one?

Tick the box that applies.

1. ☐ Yes
2. ☐ No

17. If you answered No to question 16, when did you receive support after losing your loved one?

Tick the box that applies.

1. ☐ Within 12 months
2. ☐ Within 12–24 months
3. ☐ In more than 24 months
4. ☐ No support at all

18. If you did receive support, what types of support do you feel were effective for you?

Tick the boxes that apply.

☐ Family
☐ Friends
☐ Health Professional
☐ Victim Support
☐ Pastor/Church leader
☐ Other – Please specify: _
☐ Don't know

19. If you did not receive support, what types of support did you feel you needed?

Tick the boxes that apply.

- ☐ Family
- ☐ Friends
- ☐ Health Professional
- ☐ Victim Support
- ☐ Pastor/Church leader
- ☐ Other – Please specify: _
- ☐ None
- ☐ Don't know
- ☐ Do not want to answer

20. What community support do you feel is needed immediately after losing your loved one?

Tick two boxes at the most.

- ☐ Family Counselling
- ☐ Health Professional
- ☐ Victim Support
- ☐ Spiritual Guidance
- ☐ Other – Please specify: _
- ☐ None
- ☐ Don't know

21. What community support do you feel is needed in the long term after losing your loved one?

Tick two boxes at the most.

- ☐ Family Counselling
- ☐ Health Professional
- ☐ Victim Support
- ☐ Spiritual Guidance
- ☐ Other – Please specify: _
- ☐ None
- ☐ Don't know

Resources and Access

22. What resources were/are you aware of that support those bereaved by suicide?

Tick the boxes that apply.

- ☐ Pamphlets
- ☐ DVDs
- ☐ Group Discussions
- ☐ Websites
- ☐ 0800 Telephone Support
- ☐ Suicide Bereavement Support Groups
- ☐ Other – Please specify: _
- ☐ None

23. If you were aware of resources, how satisfied were you with them?

Tick the box that most applies.

1. ☐ Very satisfied
2. ☐ Satisfied
3. ☐ Fairly satisfied
4. ☐ Not very satisfied
5. ☐ Not at all satisfied

Please explain your answer: _

24. If you were aware of resources, how effective did you feel they were?

    Tick the box that most applies.

1. ☐ Very effective
2. ☐ Effective
3. ☐ Fairly effective
4. ☐ Not very effective
5. ☐ Not at all effective

Please explain your answer: _

25. Is there anything that stopped you from using resources that were available to support you through your bereavement?

Tick the boxes that apply.

- ☐ Lack of transport
- ☐ Language
- ☐ Cultural differences
- ☐ Shame
- ☐ Guilt

- ☐ No Internet access
- ☐ Lack of finances
- ☐ No telephone
- ☐ Other – Please specify: _
- ☐ Nothing stopped me

26. What types of resources do/would you prefer to learn from?

Tick the boxes that apply.

- ☐ Pamphlets
- ☐ DVDs
- ☐ Group Discussions
- ☐ Websites
- ☐ 0800 Telephone Support
- ☐ Suicide Bereavement Support Groups
- ☐ Other – Please specify: _
- ☐ None
- ☐ Don't know

Providing better support

27. Within the context of your relationship with your loved one (sports team mate, family, work colleague, friend, peer) do you know of any resources that could help you better support the/your bereaved family?

Tick the box that applies.

1. ☐ Yes

2. ☐ No

If yes, please specify: _

28. Who do you believe should be leading Pacific initiatives that support those bereaved by suicide, assuming all are Pacific led.

Tick two boxes at the most.

☐ Churches
☐ Health Professionals
☐ Youth Workers
☐ Social Workers
☐ Community Leaders
☐ Police
☐ Educational Institutions
☐ Other – Please specify: _
☐ Don't know

29. Do you consider media interviews of those who have lost a loved one to suicide to be:

Tick the box that applies.

1. ☐ Helpful
2. ☐ Damaging
3. ☐ Don't know

30. What types of things should we include in Pacific guidelines to help support those who have lost someone to suicide? In other words, what do you think will work?

Please describe: _

Do you have any other comments at all?

_ _

Thank you very much for your time. We appreciate your important contribution, which will assist in finding ways to better support our Pacific peoples who have lost a loved one to suicide.

Would you like us to contact you about taking part in a focus group in Auckland or Christchurch?

1. ☐ Yes
2. ☐ No

If you ticked yes, we will contact you by email. For this purpose, or if you just want to enter into the prize draw for a $100 Westfield gift voucher, please provide your email address below:

_ _

If you have any questions about the study, please contact:

Dr Jemaima Tiatia-Seath

Principal Investigator

Email: XXXX

Phone: XXXX

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
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 ETHICS (0800 438 4427)

Email: hdecs@moh.govt.nz

If you feel this survey has impacted you in any way, there is further support available. Below are services available to you in your area - *List compiled by Clinical Advisory Services Aotearoa (CASA)/Community Postvention Response Service (CPRS).*

AUCKLAND

Solace Support Group

Facebook: https://www.facebook.com/pages/Solace-Support-Group-suicide-bereavement-support-based-in-Auckland/128420340655782

Co-coordinators: Mark Wilson 09 360 6410 & Robyn Duffy 09 425 6750

solacesupport@paradise.net.nz

NORTH SHORE/RODNEY

Empathy Support Group

Contact Maureen 09 424 5135 or 021 513506

The Grief Centre 09 418 1457, http://www.griefcentre.org.nz/

Bereaved by Suicide Support Group 8 week course

http://www.griefcentre.org.nz/site/dilsgriefcentre/Bereaved%20By%20Suicide%20Support%20Group.pdf

WAVES Bereaved by Suicide Groups

North Shore group contact: Amanda Christian 027 2843012, amanda@griefmatters.co.nz

Hibiscus Coast group contact: Marina Young at Equip 09 477 2448, marina.young@equip.net.nz

WAIHEKE

Piripoho/Consolation Support Group, Waiheke Island

Hau Ora (Judy Davies or Lisa Smith) 372 0022; or Tina Sailer 372 9061; or Puhi Reweti 021 0230 0622

HAMILTON

Solace Support Aynsley and Dennis Parker (07) 846 3550, parkers@wave.co.nz

TAURANGA

Bereaved by Suicide Support Group/Grief Support Services 07 578 4480, support@griefsupport.org.nz, www.griefsupport.org.nz

TARANAKI

Touched by Suicide Support Group

Contactable through: Supporting Families 06 757 9300

Like Minds, Like Mine 06 759 0966

Victim Support 06 759 5519

Hawera Group contactable through South Taranaki Victim Support 06 278 0274

PALMERSTON NORTH

Levin, Otaki, Manawatu and Horowhenua Bereaved by Suicide Support Groups ACROSS: Te Kotahitanga o te Wairua, www.across.org.nz

Groups run by Rose Allan, 06 356 7486, rallan@across.org.nz or enquiries@across.org.nz

WHANGANUI

Support Group for Those Bereaved by Suicide

Bonny 06 343 7573 or 027 684 3386; Chris 06 344 2223

WAINUIOMATA

Grief Support Network 04 564 1338

The WGSN is a link and resource service only, and can advise of local professional support services. They do not provide grief counselling or crisis services.

WELLINGTON

WAVES – Bereaved by Suicide Support Group

The group is facilitated by professional counsellors and educators and runs over 8 weeks. For more information visit www.skylight.org.nz or contact Skylight 0800 299 100, rs@skylight-trust.org.nz

CANTERBURY

Waves Suicide Grief Education Programme 03 366 9284 or 0800 876 682, developed by Skylight

Waimakariri Bereaved by Suicide Group

Frances Knight 03 327 3454 or 027 651 4854

Appendix 2: Demographics of Pacific Community Survey Respondents

Table 2a: Gender

Gender	n
Male	36
Female	137
Total	173

Table 2b: Age

Age group	n
15–24	57
25–44	67
45–54	29
55+	14
Total	167

Table 2c: Ethnicity

Ethnicity	n
Samoan	99
Cook Islands	21
Tongan	39
Niuean	12
Fijian	8
Tokelauan	7
Tuvaluan	3
Māori	6
European	11
Total	206

Table 2d: Country of Birth

Country	n
New Zealand	124
Samoa	17
Cook Islands	7
Tonga	8
Niue	2
Fiji	5
Tokelau	6
Tuvalu	2
Other	2
Total	173

Table 2e: Residence by Region

Region	n
Auckland	137
Waikato	6
Wellington	19
Christchurch	3
Dunedin	1
Other	7
Total	173

Table 2f: Employment Status

Employment status	n
Full-time paid employee	85
Part-time paid employee	13
Self-employed	6
Beneficiary	5
Student	46
Home duties	7
Other	11
Total	173

Appendix 3: Demographic Breakdowns of Pacific Community Respondents by Sex

Table 3a: Age

Age group	Male n	Male %	Female n	Female %
15–24	8	24.2	49	36.8
25–44	12	36.4	54	40.6
45–54	7	21.2	22	16.5
55+	6	18.2	8	6.0
Total	33	100%	133	100%

Table 3b: Ethnicity

Ethnicity	Male n	Female n
Samoan	19	79
Cook Islands	1	20
Tongan	10	29
Niuean	2	10
Fijian	3	5
Tokelauan	-	7
Tuvaluan	1	2
Māori	1	4
European	1	10

Table 3c: Country of Birth

Birth country	Male n	Male %
New Zealand	23	65.7
Samoa	2	5.7
Cook Islands	1	2.9
Tonga	4	11.4
Niue	1	2.9
Fiji	2	5.7
Tokelau	-	-
Tuvalu	1	2.9
Other	1	2.9
Total	35	100%

Table 3d: Residence by Region

Region	Male n	Male %	Female n	Female %
Auckland	30	85.7	106	77.4
Waikato	-	-	6	4.4
Wellington	1	2.9	18	13.1
Christchurch	-	-	3	2.2
Dunedin	-	-	1	0.7
Other	4	11.4	3	2.2
Total	35	100%	137	100%

Table 3e: Employment Status

Status	Male n	Male %	Female n	Female %
Full-time paid employee	21	60.0	64	46.7
Part-time paid employee	2	5.7	11	8.0
Self-employed	-	-	6	4.4
Beneficiary	1	2.9	4	2.9
Student	8	22.9	38	27.7
Home duties	1	2.9	5	3.6
Other	2	5.7	9	6.6
Total	35	100%	137	100%

Table 3f: Relationship to the Suicide Decedent

Relationship	Male n	Male %	Female n	Female %
Parent/Caregiver	1	3.0	2	1.6
Son/Daughter	2	6.1	1	0.8
Brother/Sister	3	9.1	12	9.3
Spouse/Partner	1	3.0	-	-
Niece/Nephew	3	9.1	7	5.4
Aunt/Uncle	-	-	6	4.7
Cousin	5	15.2	27	20.9
Other family	1	3.0	15	11.6
Friend	-	-	1	0.8
Neighbour	1	3.0	2	1.6
Fellow member of church	1	3.0	3	2.3
Fellow member of sports team	-	-	1	0.8
Fellow member of other organisation	1	3.0	2	1.6
Other	6	18.2	8	6.2
Total	33	100%	129	100%

Table 3g: Gender of Suicide Decedent

Gender	Male n	Male %	Female n	Female %
Male	25	75.8	68	52.7
Female	8	24.2	60	46.5
Other	-	-	1	0.8
Total	33	100%	129	100%

Table 3h: Age of Suicide Decedent

Age group	Male n	Male %	Female n	Female %
10–15 years	4	12.1	10	7.8
16–24 years	21	63.6	79	61.2
25–39 years	3	9.1	29	22.5
40+ years	5	15.2	11	8.5
Total	33	100%	129	100%

Table 3i: Timeframe of Support Received

Timeframe	Male n	Male %	Female n	Female %
0–6 months	5	15.2	9	7.0
6–12 months	2	6.1	8	6.2
12–18 months	1	3.0	11	8.5
18–24 months	1	3.0	9	7.0
>24 months	24	72.7	92	71.3
Total	33	100%	129	100%

Table 3j: First at the Scene

First at the Scene	Male n	Male %	Female n	Female %
Family	22	71.0	73	64.0
Neighbour	1	3.2	4	3.5
Friend	4	12.9	11	9.6
Respondent	2	6.5	2	1.8
Police	-	-	3	2.6
Stranger/member of the public	2	6.5	21	18.4
Total	31	100%	114	100%

Table 3k: Immediate Support Received

Support	Male n	Female n
Family	25	97
Friends	14	65
Police	10	61
Health professional	5	19
Victim support	5	22
Pastor/church leader	10	46
Stranger/member of the public	1	7

Table 3l: Appropriate Immediate Support

Support	Male n	Female n
Family	29	110
Friends	14	68
Police	5	43
Health professional	15	38
Victim support	15	54
Pastor/church leader	14	47

Table 3m: Timeframe of Support Received

Timeframe	Male n	Male %	Female n	Female %
Within 6 months	13	41.9	66	54.1
In 6–12 months	3	9.7	10	8.2
In 12–24 months	-	-	2	1.6
In more than 24 months	-	-	1	0.8
No support at all	15	48.4	43	35.2
Total	31	100%	122	100%

Table 3n: Effective Immediate Support

Effective support	Male n	Male %	Female n	Female %
Family	14	87.5	70	88.6
Friends	12	75.0	55	69.6
Health professional	4	25.0	22	27.8
Victim support	4	25.0	16	20.3
Pastor/church leader	5	31.3	24	30.4

Table 3o: Unmet Support Needs

Support needed but not received	Male n	Male %	Female n	Female %
Family	9	60.0	18	41.9
Friends	5	33.3	16	37.2
Health professional	7	46.7	17	39.5
Victim support	5	33.3	13	30.2
Pastor/church leader	5	33.3	12	27.9

Table 3p: Short-term Support Needs

Short-term support	Male n	Female n
Family counselling	25	95
Health professional	16	49
Victim support	9	58
Spiritual guidance	19	81

Table 3q: Long-term Support Needs

Long-term support	Male n	Female n
Family counselling	23	91
Health professional	12	50
Victim support	11	51
Spiritual guidance	17	75

Table 3r: Resource Awareness

Resources	Male n	Female n
Pamphlets	9	41
DVDs	3	8
Group discussions	7	45
Websites	11	41
0800 telephone support	6	39
Suicide bereavement groups	10	48

Table 3s: Satisfaction with Current Resources

Level of satisfaction	Male n	Male %	Female n	Female %
Very satisfied	2	11.1	7	8.0
Satisfied	2	11.1	19	21.6
Fairly satisfied	7	38.9	41	46.6
Not very satisfied	6	33.3	15	17.0
Not at all satisfied	1	5.6	6	6.8
Total	18	100%	88	100%

Table 3t: Effectiveness of Current Resources

Level of effectiveness	Male n	Male %	Female n	Female %
Very effective	2	11.1	4	4.5
Effective	1	5.6	17	19.3
Fairly effective	6	33.3	42	47.7
Not very effective	5	27.8	17	19.3
Not at all effective	4	22.2	8	9.1
Total	18	100%	88	100%

Table 3u: Barriers to Accessing Resources

Barriers	Male n	Female n
Lack of transport	1	7
Language	2	1
Cultural differences	5	23
Shame	4	15
Guilt	3	15
Lack of Internet access	3	5
Lack of finances	4	8
Lack of telephone	1	1

Table 3v: Preferred Resources

Resources	Male n	Female n
Pamphlets	10	22
DVDs	9	23
Group discussions	19	67
Websites	11	33
0800 telephone support	8	27
Suicide bereavement groups	16	57

Table 3w: Potential Leaders for the Provision of Postvention Support

Leaders	Male n	Female n
Churches	17	58
Health professionals	11	45
Youth workers	12	57
Social workers	14	63
Community leaders	17	57
Police	5	17
Educational institutions	10	41

Table 3x: Effects of Media Interviews with the Bereaved

Media interviews	Male n	Male %	Female n	Female %
Helpful	14	66.7	53	77.9
Damaging	7	33.3	15	22.1
Total	21	100%	68	100%

NB: A large number did not answer this question.

Appendix 4: Demographic Breakdowns of Pacific Community Respondents by Age Group

Table 4a: Gender

Sex	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Male	8	14.0	12	18.2	7	24.1	6	42.9
Female	49	86.0	54	80.8	22	75.9	8	57.1
Total	57	100%	66	100%	29	100%	14	100%

Table 4b: Ethnicity

Ethnicity	15–24 n	25–44 n	45–54 n	55+ n
Samoan	35	37	17	7
Cook Islands	7	9	2	3
Tongan	17	14	4	1
Niuean	5	3	4	-
Fijian	3	5	-	-
Tokelauan	-	3	4	-
Tuvaluan	-	1	-	2
Māori	4	2	-	-
European	6	1	3	1

Table 4c: Country of Birth

Country	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
New Zealand	53	93.0	50	74.6	13	44.8	6	42.9
Samoa	2	3.5	4	6.0	7	24.1	2	14.3
Cook Islands	1	1.8	3	4.5	-	-	3	21.4
Tonga	-	-	4	6.0	2	6.9	1	7.1
Niue	-	-	-	-	2	6.9	-	-
Fiji	1	1.8	4	6.0	-	-	-	-
Tokelau	-	-	1	1.5	4	13.8	1	7.1
Tuvalu	-	-	1	1.5	-	-	1	7.1
Other	-	-	-	-	1	3.4	-	-
Total	57	100%	67	100%	29	100%	14	100%

Table 4d: Residence by Region

Region	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Auckland	57	100.0	47	70.1	18	62.1	11	78.6
Waikato	-	-	3	4.5	2	6.9	-	-
Wellington	-	-	9	13.4	7	24.1	2	14.3
Christchurch	-	-	1	1.5	2	6.9	-	-
Dunedin	-	-	1	1.5	-	-	-	-
Other	-	-	6	9.0	-	-	1	7.1
Total	57	100%	67	100%	29	100%	14	100%

Table 4e: Employment Status

Employment status	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Full-time	9	15.8	45	67.2	19	65.5	8	57.1
Part-time	7	12.3	3	4.5	1	3.4	1	7.1
Self-employed	-	-	2	3.0	1	3.4	2	14.3
Beneficiary	2	3.5	-	-	2	6.9	1	7.1
Student	37	64.9	7	10.4	1	3.4	1	7.1
Home duties	1	1.8	4	6.0	1	3.4	1	7.1
Other	1	1.8	6	9.0	4	13.8	-	-
Total	57	100%	67	100%	29	100%	14	100%

Table 4f: Relationship to the Suicide Decedent

Relationship	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Parent/Caregiver	-	-	-	-	1	3.6	2	15.4
Son/Daughter	-	-	1	1.6	1	3.6	1	7.7
Brother/Sister	6	11.3	7	10.9	2	7.1	-	-
Spouse/Partner	-	-	-	-	1	3.6	-	-
Niece/Nephew	-	-	4	6.3	2	7.1	2	15.4
Aunt/Uncle	-	-	3	4.7	3	10.7	-	-
Cousin	7	13.2	19	29.7	4	14.3	2	15.4
Other family	5	9.4	8	12.5	2	7.1	1	7.7
Friend	29	54.7	15	23.4	6	21.5	1	7.7
Neighbour	1	1.9	-	-	1	3.6	1	7.7
Fellow member of church	-	-	2	3.1	-	-	1	7.7
Fellow member of sports team	-	-	1	1.6	-	-	-	-
Fellow member of other organisation	2	3.8	1	1.6	-	-	-	-
Other	3	5.7	3	4.7	5	17.9	2	15.4
Total	53	100%	64	100%	28	100%	13	100%

Table 4g: Gender of Suicide Decedent

Gender	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Male	20	37.7	40	62.5	21	75.0	11	84.6
Female	32	60.4	24	37.5	7	25.0	2	15.4
Other	1	1.9	-	-	-	-	-	-
Total	53	100%	64	100%	28	100%	13	100%

Table 4h: Age Group of Suicide Decedent

Age group	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
10–15 years	7	13.2	5	7.8	1	3.6	-	-
16–24 years	42	79.2	34	53.1	15	53.6	7	53.8
25–39 years	3	5.7	20	31.3	7	25.0	2	15.4
40+ years	1	1.9	5	7.8	5	17.9	4	30.8
Total	53	100%	64	100%	28	100%	13	100%

Table 4i: Timeframe of Support Received

Timeframe	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
0–6 months	4	7.5	5	7.8	1	3.6	2	15.4
6–12 months	2	3.8	6	9.4	2	7.1	-	-
12–18 months	3	5.7	6	9.4	2	7.1	-	-
18–24 months	5	9.4	3	4.7	1	3.6	1	7.7
>24 months	39	73.6	44	68.8	22	78.6	10	76.9
Total	53	100%	64	100%	28	100%	13	100%

Table 4j: First at the Scene

First at the scene	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Family	28	53.8	38	59.4	17	65.4	9	69.2
Neighbour	-	-	2	3.1	2	7.7	1	7.7
Friend	2	3.8	9	14.1	3	11.5	1	7.7
Respondent	1	1.9	2	3.1	-	-	1	7.7
Police	-	-	1	1.6	2	7.7	-	-
Stranger	15	28.8	7	10.9	1	3.8	-	-
Total	52	100%	64	100%	26	100%	13	100%

Table 4k: Immediate Support Received

Support	15–24 n	25–44 n	45–54 n	55+ n
Family	38	45	23	13
Friends	27	30	14	6
Police	21	29	12	7
Health professional	6	6	7	4
Victim support	9	7	7	3
Pastor/church leader	17	23	9	4
Stranger/member of the public	2	3	1	-

Table 4l: Appropriate Immediate Support

Support	15–24 n	25–44 n	45–54 n	55+ n
Family	49	49	24	12
Friends	29	32	14	5
Police	13	23	5	5
Health professional	12	25	8	7
Victim support	17	36	8	7
Pastor/church leader	14	29	7	9

Table 4m: Timeframe of Support Received

Timeframe	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Within 6 months	39	78.0	20	32.8	13	50.0	6	46.2
In 6–12 months	3	6.0	6	9.8	3	11.5	1	7.7
In 12–24 months	-	-	2	3.3	-	-	-	-
In more than 24 months	-	-	-	-	1	3.8	-	-
No support at all	8	16.0	33	54.1	9	34.6	6	46.2
Total	50	100%	61	100%	26	100%	13	100%

Table 4n: Effective Immediate Support

Effective support	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Family	37	88.1	25	89.3	14	82.4	7	100.0
Friends	30	71.4	18	64.3	12	70.6	6	85.7
Health professional	7	16.7	8	28.6	7	41.2	3	42.9
Victim support	6	14.3	8	28.6	3	17.6	2	28.6
Pastor/church leader	10	23.8	10	35.7	3	17.6	5	71.4

Table 4o: Unmet Support Needs

Support needed but not received	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Family	3	37.5	15	45.5	3	33.3	5	83.3
Friends	3	37.5	11	33.3	1	11.1	5	83.3
Health professional	-	-	18	54.5	4	44.4	2	33.3
Victim support	1	12.5	13	39.4	2	22.2	2	33.3
Pastor/church leader	1	12.5	11	33.3	2	22.2	2	33.3

Table 4p: Short-term Support Needs

Short-term support	15–24 n	25–44 n	45–54 n	55+ n
Family counselling	38	54	17	9
Health professional	13	29	15	6
Victim support	20	31	10	4
Spiritual guidance	31	38	18	10

Table 4q: Long-term Support Needs

Long-term support	15–24 n	25–44 n	45–54 n	55+ n
Family counselling	33	50	19	10
Health professional	11	31	12	5
Victim support	19	31	6	3
Spiritual guidance	27	33	18	10

Table 4r: Resource Awareness

Resources	15–24 n	25–44 n	45–54 n	55+ n
Pamphlets	11	24	12	2
DVDs	1	3	5	-
Group discussions	20	16	11	3
Websites	19	20	10	2
0800 telephone support	16	19	7	1
Suicide bereavement groups	20	18	14	4

Table 3s: Satisfaction with Current Resources

Level of satisfaction	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Very satisfied	4	10.0	4	9.8	1	5.9	-	-
Satisfied	9	22.5	4	9.8	5	29.4	2	28.6
Fairly satisfied	22	55.0	20	48.8	4	23.5	3	42.9
Not very satisfied	3	7.5	9	22.0	6	35.3	2	28.6
Not at all satisfied	2	5.0	4	9.8	1	5.9	-	-
Total	40	100%	41	100%	17	100%	7	100%

Table 4t: Effectiveness of Current Resources

Level of effectiveness	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Very effective	2	5.0	3	7.3	1	5.9	-	-
Effective	10	25.0	4	9.8	3	17.6	-	-
Fairly effective	24	60.0	16	39.0	4	23.5	5	71.4
Not very effective	3	7.5	11	26.8	5	29.4	2	28.6
Not at all effective	1	2.5	7	17.1	4	23.5	-	-
Total	40	100%	41	100%	17	100%	7	100%

Table 4u: Barriers to Accessing Resources

Barriers	15–24 n	25–44 n	45–54 n	55+ n
Lack of transport	7	1	1	-
Language	1	1	1	1
Cultural differences	5	12	7	5
Shame	6	7	5	2
Guilt	10	3	5	1
Lack of Internet access	2	3	4	-
Lack of finances	4	5	4	-
Lack of telephone	-	2	-	-

Table 4v: Preferred Resources.

Resources	15–24 n	25–44 n	45–54 n	55+ n
Pamphlets	5	14	9	3
DVDs	7	12	8	4
Group discussions	30	31	14	10
Websites	10	20	9	4
0800 telephone support	7	16	5	6
Suicide bereavement groups	20	33	14	6

Table 4w: Potential Leaders for the Provision of Postvention Support

Leaders	15–24 n	25–44 n	45–54 n	55+ n
Churches	22	33	13	7
Health professionals	12	28	10	5
Youth workers	24	30	9	5
Social workers	29	30	11	6
Community leaders	22	31	13	7
Police	7	8	5	1
Educational institutions	18	19	8	5

Table 4x: Effects of Media Interviews with the Bereaved

Media interviews	15–24 n	15–24 %	25–44 n	25–44 %	45–54 n	45–54 %	55+ n	55+ %
Helpful	21	48.8	29	50.9	10	45.5	6	50.0
Damaging	11	25.6	6	10.5	1	4.5	3	25.0
Don’t know	11	25.6	22	38.6	11	50.0	3	25.0
Total	43	100%	57	100%	22	100%	12	100%

Appendix 5: Demographic Breakdowns of Pacific Community Respondents by Ethnicity

Table 5a: Gender

Sex	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Male	19	19.2	1	4.8	10	25.6	2	16.7
Female	79	79.8	20	95.2	29	74.4	10	83.3
Other	1	1.0	-	-	-	-	-	-
Total	98	100%	21	100%	39	100%	12	100%

Table 5b: Age Group

Age group	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
15–24	35	36.5	7	33.3	17	47.2	5	41.7
25–44	37	38.5	9	42.9	14	38.9	3	25.0
45–54	17	17.7	2	9.5	4	11.1	4	33.3
55+	7	7.3	3	14.3	1	2.8	-	-
Total	96	100%	21	100%	36	100%	12	100%

Table 5c: Country of Birth

Country	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
New Zealand	80	80.8	14	66.7	29	74.4	9	75.0
Samoa	17	17.2	-	-	-	-	1	8.3
Cook Islands	-	-	7	33.3	1	2.6	-	-
Tonga	-	-	-	-	8	20.5	-	-
Niue	1	1.0	-	-	-	-	2	16.7
Fiji	1	1.0	-	-	-	-	-	-
Tokelau	-	-	-	-	-	-	-	-
Tuvalu	-	-	-	-	-	-	-	-
Other	-	-	-	-	1	2.6	-	-
Total	99	100%	21	100%	39	100%	12	100%

Table 5d: Residence by Region

Region	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Auckland	79	79.8	20	95.2	36	92.3	11	91.7
Waikato	4	4.0	-	-	1	2.6	1	8.3
Wellington	11	11.1	-	-	-	-	-	-
Christchurch	2	2.0	-	-	1	2.6	-	-
Dunedin	1	1.0	-	-	-	-	-	-
Other	2	2.0	1	4.8	1	2.6	-	-
Total	99	100%	21	100%	39	100%	12	100%

Table 5e: Employment Status

Employment status	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Full-time	45	45.5	8	38.1	14	35.9	7	58.3
Part-time	8	8.1	1	4.8	3	7.7	-	-
Self-employed	3	3.0	1	4.8	1	2.6	1	8.3
Beneficiary	2	2.0	-	-	1	2.6	-	-
Student	28	28.3	7	33.3	16	41.0	4	33.3
Home duties	6	6.1	3	14.3	-	-	-	-
Other	7	7.1	1	4.8	4	10.3	-	-
Total	99	100%	21	100%	39	100%	12	100%

Table 5f: Relationship to the Suicide Decedent

Relationship	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Parent/Caregiver	2	2.2	-	-	-	-	-	-
Son/Daughter	2	2.2	-	-	-	-	-	-
Brother/Sister	7	7.5	4	20.0	8	22.2	3	30.0
Spouse/Partner	1	1.1	-	-	-	-	1	10.0
Niece/Nephew	4	4.3	2	10.0	2	5.6	-	-
Aunt/Uncle	4	4.3	1	5.0	2	5.6	-	-
Cousin	16	17.2	2	10.0	6	16.7	1	10.0
Other family	8	8.6	3	15.0	4	11.1	1	10.0
Friend	34	35.5	5	25.0	12	33.3	3	30.0
Neighbour	2	2.2	1	5.0	-	-	-	-
Fellow member of church	3	3.2	-	-	1	2.8	-	-
Fellow member sports team	1	1.1	-	-	-	-	-	-
Fellow member of other organisation	1	1.1	2	10.0	-	-	-	-
Other	8	8.6	-	-	1	2.8	1	10.0
Total	93	100%	20	100%	36	100%	10	100%

Table 5g: Gender of Suicide Decedent

Gender	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Male	54	58.1	10	50.0	18	50.0	5	50.0
Female	38	40.9	10	50.0	18	50.0	4	40.0
Other	1	1.1	-	-	-	-	1	10.0
Total	93	100%	20	100%	36	100%	10	100%

Table 5h: Age Group of Suicide Decedent

Age group	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
10–15 years	9	9.7	2	10.0	2	5.6	-	-
16–24 years	58	62.4	14	70.0	23	63.9	-	-
25–39 years	18	19.4	2	10.0	7	19.4	8	80.0
40+ years	8	8.6	2	10.0	4	11.1	2	20.0
Total	93	100%	20	100%	36	100%	10	100%

Table 5i: Timeframe of Support Received

How long ago	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
0–6 months	5	5.4	3	15.0	3	8.3	-	-
6–12 months	5	5.4	1	5.0	2	5.6	1	10.0
12–18 months	6	6.5	2	10.0	-	-	-	-
18–24 months	5	5.4	1	5.0	3	8.3	-	-
>24 months	72	77.4	13	65.0	28	77.8	9	90.0
Total	93	100%	20	100%	36	100%	10	100%

Table 5j: First at the Scene

First at the scene	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Family	57	70.4	12	66.7	16	47.1	5	55.6
Neighbour	3	3.7	-	-	-	-	-	-
Friend	6	7.4	2	11.1	6	17.6	-	-
Respondent	3	3.7	1	5.6	1	2.9	-	-
Police	2	2.5	-	-	-	-	-	-
Stranger	10	12.3	3	16.7	11	32.4	4	44.4
Total	91	100%	64	100%	34	100%	9	100%

Table 5k: Immediate Support Received

Support	Samoan n	Cook Is. n	Tongan n	Niuean n
Family	68	14	28	9
Friends	43	10	21	4
Police	38	10	16	3
Health professional	8	4	7	2
Victim support	13	3	9	-
Pastor/church leader	30	8	11	-
Stranger	1	1	4	-

Table 5l: Appropriate Immediate Support

Support	Samoan n	Cook Is. n	Tongan n	Niuean n
Family	80	16	32	10
Friends	46	10	20	6
Police	24	6	9	3
Health professional	27	4	12	3
Victim support	37	5	16	2
Pastor/church leader	32	6	14	1

Table 5m: Timeframe of Support Received

Timeframe	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Within 6 months	43	50.0	10	55.6	18	51.4	6	60.0
In 6–12 months	6	7.0	2	11.1	2	5.7	2	20.0
In 12–24 months	1	1.2	1	5.6	1	2.9	-	-
In more than 24 months	-	-	1	5.6	-	-	-	-
No support at all	36	41.9	4	22.2	14	40.0	2	20.0
Total	86	100%	18	100%	35	100%	10	100%

Table 5n: Effective Immediate Support

Effective support	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Family	46	92.0	12	85.7	19	90.5	8	100.0
Friends	38	76.0	9	64.3	14	66.7	5	62.5
Health professional	11	22.0	3	21.4	5	23.8	3	37.5
Victim support	8	16.0	4	28.6	3	14.3	2	25.0
Pastor/church leader	19	38.0	4	28.6	-	-	3	37.5

Table 5o: Unmet Support Needs

Support needed but not received	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Family	18	94.7	1	25.0	5	35.7	-	-
Friends	14	73.7	2	50.0	3	21.4	1	50.0
Health professional	14	73.7	2	50.0	5	35.7	-	-
Victim support	11	57.9	1	25.0	3	21.4	-	-
Pastor/church leader	11	57.9	1	25.0	3	21.4	1	50.0

Table 5p: Short-term Support Needs

Short-term support	Samoan n	Cook Is. n	Tongan n	Niuean n
Family counselling	68	14	28	8
Health professional	35	6	13	3
Victim support	34	6	13	3
Spiritual guidance	58	11	22	5

Table 5q: Long-term Support Needs

Long-term support	Samoan n	Cook Is. n	Tongan n	Niuean n
Family counselling	67	14	27	6
Health professional	36	7	11	3
Victim support	34	5	16	2
Spiritual guidance	50	12	22	6

Table 5r: Resource Awareness

Resources	Samoan n	Cook Is. n	Tongan n	Niuean n
Pamphlets	30	7	15	1
DVDs	6	2	1	1
Group discussions	26	7	16	3
Websites	31	6	14	2
0800 telephone support	24	5	14	2
Suicide bereavement groups	36	5	13	2

Table 5s: Satisfaction with Current Resources

Level of satisfaction	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Very satisfied	5	7.7	4	26.7	3	10.3	-	-
Satisfied	8	12.3	4	26.7	6	20.7	2	50.0
Fairly satisfied	31	47.7	5	33.3	11	37.9	2	50.0
Not very satisfied	15	23.1	1	6.7	7	24.1	-	-
Not at all satisfied	6	9.2	1	6.7	2	6.9	-	-
Total	65	100%	15	100%	29	100%	4	100%

Table 5t: Effectiveness of Current Resources

Level of effectiveness	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Very effective	2	3.1	1	6.7	3	10.3	-	-
Effective	9	13.8	3	20.0	5	17.2	2	50.0
Fairly effective	31	47.7	8	53.3	8	27.6	2	50.0
Not very effective	13	20.0	2	13.3	10	34.5	-	-
Not at all effective	10	15.4	1	6.7	3	10.3	-	-
Total	65	100%	15	100%	29	100%	4	100%

Table 5u: Barriers to Accessing Resources

Barriers	Samoan n	Cook Is. n	Tongan n	Niuean n
Lack of transport	6	-	-	1
Language	3	-	-	1
Cultural differences	17	5	6	1
Shame	14	3	5	1
Guilt	12	3	6	2
Lack of Internet access	8	1	2	1
Lack of finances	9	2	1	1
Lack of telephone	1	-	1	-

Table 5v: Preferred Resources.

Resources	Samoan n	Cook Is. n	Tongan n	Niuean n
Pamphlets	17	2	9	3
DVDs	20	4	6	2
Group discussions	47	9	24	5
Websites	28	5	7	3
0800 telephone support	22	2	7	2
Suicide bereavement groups	42	7	22	2

Table 5w: Potential Leaders for the Provision of Postvention Support

Leaders	Samoan n	Cook Is. n	Tongan n	Niuean n
Churches	38	10	21	5
Health professionals	29	5	13	4
Youth workers	38	8	18	5
Social workers	45	7	20	5
Community leaders	36	11	19	4
Police	7	3	7	2
Educational institutions	26	5	15	4

Table 5x: Effects of Media Interviews with the Bereaved

Media interviews	Samoan n	Samoan %	Cook Is. n	Cook Is. %	Tongan n	Tongan %	Niuean n	Niuean %
Helpful	44	58.7	8	47.1	15	41.7	3	30.0
Damaging	10	13.3	4	23.5	7	19.4	3	30.0
Don't know	21	28.0	5	29.4	14	38.9	4	40.0
Total	75	100%	17	100%	36	100%	10	100%

Appendix 3: Online Service Provider Survey

Pacific Service Provider Survey

You are invited to take part in this survey as you have dealt with Pacific peoples who have lost a loved one to suicide. We would like you to share your experiences because the information you provide will help us understand, address and develop ways of better supporting our Pacific communities who have lost a loved one to suicide.

The aim of this survey is to engage Pacific communities and examine what they feel are the most important and appropriate factors to include in the development of guidelines as a means of providing the best possible support for our Pacific individuals, families and communities who have lost a loved one to suicide. As someone who provides support for the overall health and wellbeing of Pacific communities, if relevant, you are asked to provide further information to include in the compilation of a Pacific-focused directory for Pacific individuals, families and communities to access should they need suicide postvention support.

Whether you take part or not is your choice. By completing this survey, you are giving your consent for the information that you have supplied to be used by us for research purposes. The information you provide will not be linked to you specifically – this is an anonymous survey. If you would like to enter the prize draw for a $100 Westfield gift voucher, please enter your email address where prompted at the end of the survey. The winner of the prize draw will be contacted once the survey is closed (May 2015). Emails will not be used for any other purposes, and will be deleted from the database as soon as the draw is over.

The Context

1. Which ethnic group or groups do you belong to?

Tick the boxes that apply to you.

- ☐ Samoan
- ☐ Cook Islands
- ☐ Tongan
- ☐ Niuean
- ☐ Fijian
- ☐ Tokelauan
- ☐ Tuvaluan
- ☐ Other – Please specify: _
- ☐ Don't know

2. Which country were you born in?

Tick the box that applies to you.

1. ☐ New Zealand
2. ☐ Samoa
3. ☐ Cook Islands
4. ☐ Tonga
5. ☐ Niue
6. ☐ Fiji
7. ☐ Tokelau
8. ☐ Tuvalu
9. ☐ Australia
10. ☐ Other – Please specify: _

3. If you live in New Zealand but were not born here, when did you first arrive to live in New Zealand?

Month if known Year

(e.g. 11) (e.g. 1945)

☐☐ ☐☐☐☐

4. Are you:

Tick the box that applies to you.

1. ☐ Male
2. ☐ Female
3. ☐ Other (i.e. transgender, intersex, etc.)

5. When were you born?

Day Month Year

(e.g. 31) (e.g. 03) (e.g. 1956)

☐☐ ☐☐ ☐☐

6. Where do you live?

Tick the box that applies to you.

1. ☐ Northland

2. ☐ Auckland
3. ☐ Waikato
4. ☐ Wellington
5. ☐ Christchurch
6. ☐ Dunedin
7. ☐ Other – Please specify: _

7. What type of agency do you work for?

Tick the box that most applies to you.

1. ☐ Family Services
2. ☐ Child and Youth Services
3. ☐ Mental Health
4. ☐ Church
5. ☐ Social Services
6. ☐ Justice
7. ☐ Education
8. ☐ Other – Please specify: _

Service Provision

8. Do you follow any type of guidelines that help you support those bereaved by suicide?

Tick the box that applies.

1. ☐ Yes
2. ☐ No

If yes, what are they? _

What type of support does your service typically provide to support those bereaved by suicide?

Tick the box that most applies.

1. ☐ Mental health support
2. ☐ Spiritual guidance
3. ☐ Family counselling
4. ☐ One-on-one counselling
5. ☐ Other – Please specify: _
6. ☐ None
7. ☐ Don't know

11. If you answered 'None' to question 10, what do you feel should be a typical response?

_ _

12. Does your service provide suicide postvention for youth?

Tick the box that applies.

1. ☐ Yes
2. ☐ No

If yes, in what ways? _

13. Have you ever supported a bereaved person/family as part of your job?

Tick the box that applies.

1. ☐ Yes
2. ☐ No

14. Have you been trained in supporting Pacific peoples bereaved by suicide?

Tick the box that applies

1. ☐ Yes
2. ☐ No

15. How comfortable are you in working with someone bereaved by suicide?

Tick the box that applies.

1. ☐ Very comfortable
2. ☐ Comfortable
3. ☐ Fairly comfortable
4. ☐ Not very comfortable
5. ☐ Not at all comfortable

16. Is there support in place in your service if a staff member or client should take their life?

Tick the box that applies.

1. ☐ Yes

2. ☐ No

If yes, what type of support? _

Resources & Access

17. What resources are you aware of that support those bereaved by suicide?

Tick the boxes that apply.

- ☐ Pamphlets
- ☐ DVDs
- ☐ Group Discussions
- ☐ Websites
- ☐ 0800 Telephone Support
- ☐ Suicide Bereavement Support Groups
- ☐ Other – Please specify: _ ☐ None
- ☐ Don't know

18. If you are aware of resources, how satisfied are you with them?

1. ☐ Very satisfied
2. ☐ Satisfied
3. ☐ Fairly satisfied
4. ☐ Not very satisfied
5. ☐ Not at all satisfied

Please explain your answer: _

19. If you are aware of resources, how effective do you feel they are?

1. ☐ Very effective
2. ☐ Effective
3. ☐ Fairly effective
4. ☐ Not very effective
5. ☐ Not at all effective

Please explain your answer: _

Providing better support

20. Who do you believe should be leading Pacific initiatives that support those bereaved by suicide, assuming all are Pacific led?

Tick two boxes at the most.

☐ Churches
☐ Health Professionals
☐ Youth Workers
☐ Social Workers
☐ Community Leaders
☐ Police
☐ Educational Institutions
☐ Other – Please specify: _
☐ Don't know

21. What are the types of challenges you have faced in relation to supporting Pacific communities bereaved through suicide?

Please describe: _

22. What types of things should we include in Pacific guidelines to help support those who have lost someone to suicide? In other words, what do you think will work?

Please describe: _

Do you have any other comments at all?

_ _

Thank you very much for your time. We appreciate your important contribution, which will assist in finding ways to better support our Pacific peoples who have lost a loved one to suicide.

If you would like your organisation to be included in a Pacific suicide postvention directory where Pacific individuals, families and communities can access suicide postvention support, please let us know by emailing tiatiaseath@icloud.com to request a directory form.

If you want to enter into the prize draw for a $100 Westfield gift voucher, please provide your email address below:

_ _

If you have any questions about the study, please contact:

HRL

Dr Jemaima Tiatia-Seath

Principal Investigator

Email: XXXX

Phone: XXXX

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
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 ETHICS (0800 438 4427)

Email: hdecs@moh.govt.nz

HRL

Appendix 4: Demographics of Service Provider Respondents

Table 5a: Gender

Gender	n
Male	15
Female	54
Total	69

Table 5b: Age

Age group	n
25–44	33
45–54	19
55+	9
Total	61

Table 5c: Ethnicity

Ethnicity	n
Samoan	31
European	15
Tongan	9
Tokelauan	7
Cook Islands	3
Niuean	3
Māori	3
Fijian	2
Tuvaluan	1

Table 5d: Country of Birth

Country	n
New Zealand	40
Samoa	12
Tonga	5
Tokelau	5
Cook Islands	1
Niue	1
Fiji	1
Other	5
Total	70

Table 5e: Residence by Region

Region	n
Auckland	43
Waikato	6
Wellington	13
Christchurch	2
Other	6
Total	70

Appendix 5: Focus Group Interview Schedule

Focus Group Interview Schedule

1. How can we best support Pacific peoples who have lost a loved one to suicide?

2. What strategies do you feel are culturally appropriate and meaningful to better support Pacific individuals, families and communities?

3. What types of support do you believe should be made available in providing assistance for Pacific individuals, families and communities who have lost a loved one to suicide?

4. What has not worked in the past?

5. What do you feel will work?

6. What should Pacific postvention guidelines look like?

7. What is the best way to distribute this information?

Fa'afetai tele lava for your time and invaluable contribution

Appendix 6: Fono/Workshop 'Bus Stop' Questions

Fono/Workshop 'Bus Stop' Questions

1. What should the guidelines look like (physically) and why?
2. What information has been difficult to access regarding support after the suicide of a loved one?
3. What are the most important things to include in these guidelines?
4. What training/cultural models do you think will work?
5. How can we make sure everyone is aware of the guidelines?
6. What are the safe ways to talk about suicide postvention?