Submission on

A Strategy to Prevent Suicide in New Zealand 2017: Draft for public consultation
from the Suicide Bereavement Advisory Group

This submission is made by the Suicide Bereavement Advisory Group. The group was brought together by the Mental Health Foundation (MHF) in 2014, and guides the MHF’s work in suicide bereavement and prevention.

The group shares perspectives from peer and professional suicide bereavement support group facilitation, mental health peer support, research, and Māori, Pacific, and Rainbow/LGBTI communities. The group includes Tricia Hendry, Amanda Christian, Dr Jemaima Tiatia-Seath, Mani Mitchell, Mark Wilson, Dr Lynne Russell, Michele Elliott, Chris Bowden and Paul Martin.

This submission comments on where the Strategy needs to be strengthened for people bereaved by suicide. We believe that our national response to suicide prevention needs to:

- Recognise people who are bereaved by suicide as a priority population
- Recognise suicide postvention as essential for effective suicide prevention
- Learn from lived experience
- Provide support options for those bereaved after each suicide death
- Include strong national leadership and coordination, including lived experience voices

We appreciate the Ministry taking time to meet with our group and other bereaved people at the May consultation meeting in Auckland. We welcome further discussion with the Ministry of Health on this submission, and on strengthening the lived experience voice in the new strategy.

Recognise people who are bereaved by suicide as a priority population

The Strategy must recognise people bereaved by suicide as a population who experiences higher rates of distress and suicidal behaviour. The Strategy’s language needs to change to recognise this high risk and vulnerable population (suicide-loss survivors, or the suicide bereaved) and not just those ‘affected by suicide’. There is a significant body of research and literature that shows that the bereaved population have unique needs and experiences very different to those who live with and are affected by people who engage in non-fatal suicidal behaviour. There may be overlap between these groups, but they require different types of support.

The suicide bereaved are a significant at-risk population. Recent evidence shows that the suicide bereaved are at significantly higher risk of suicidal behaviour/attempt.

Research supports this. For example:

- A 2004 evidence review of suicide postvention needs for families, whānau and significant others notes that “In comparison to those who are not bereaved, individuals who are bereaved following death from any cause experience poorer psychosocial functioning in the aftermath of the death. These poorer outcomes include the typical grief processes (as described above), poor mental health functioning, notably increased risks of depression,
anxiety disorders, PTSD, and other adverse outcomes including impaired cognitive, social and emotional functioning.\textsuperscript{iv}

- More recently, a 2014 meta-analysis\textsuperscript{v} found that suicide of a close contact is associated with several negative health and social outcomes, particularly noting increased risk of suicide for partners and mothers of adult children who died by suicide.
- A 2016 study of 3432 young adults in the UK found that bereavement by suicide is a specific risk factor for suicide attempt\textsuperscript{vi}.
- In a large study of exposure to suicide in Kentucky, individuals exposed to suicide were twice as likely as those not exposed to have diagnosable depression and anxiety. Suicide-exposed individuals were more likely than suicide-unexposed individuals to report suicide ideation (9% vs. 5%)\textsuperscript{vii}.

Studies note that as well as being more likely to experience suicidal ideation or attempt suicide, people bereaved by suicide are more likely to leave education or work, and are more likely to become depressed or experience disruptive complicated grief effects\textsuperscript{viii}. These factors can contribute to an ongoing increase in their suicide risk over time.

The size of the bereaved population is significant. Given that New Zealand has around 500 suicide deaths each year and between 20 and 50 people are impacted by each suicide, there is a significant number of people in New Zealand who experience trauma and grief after the suicide of a loved one.

As a specific group exposed to significant trauma, people bereaved by suicide need to have access to nationally consistent and specialised support when required (such as through ACC), as well as the capacity to have sufficient paid time off work after their loss to manage the complex aftermath. The standard workplace provision of three days’ bereavement leave is not enough.

People bereaved by suicide include immediate family, but also include friend groups, chosen family, members of community/social groups, classmates and colleagues\textsuperscript{ix}. Support needs to be available to a wider group of people\textsuperscript{x} than the immediate family, and to those affected by or exposed to suicide as well as those very closely affected by a loss\textsuperscript{xi}. In the case of a celebrity death, the range of people who may genuinely need support may include strangers.

Recognise suicide postvention as essential for effective suicide prevention

Given that those bereaved by suicide are at increased risk of suicidal behaviour, “postvention is prevention”. In other words, supporting people after a suicide death is not just about healing their loss and trauma through the grief process, but also minimising risk of further tragedy\textsuperscript{xii}. The draft Strategy makes no mention of suicide postvention, suggesting that this concept is poorly understood. This does not stand well in the face of international research or best practice.

The Strategy must provide for strong, research-based national leadership in suicide postvention best practice, and the allocation of sufficient resources towards much needed New Zealand postvention research.

Postvention should be acknowledged in four areas of the strategy:

- 4. Improved mental health literacy and suicide prevention literacy (include trauma literacy and postvention literacy)
- 6. Strengthen systems to support people who are in distress (recognising the distress associated with suicide loss, and including development of consistent access pathways)
- 7. Build and support capability of workforces
- 8. Strengthen systems to support whānau/families and friends and communities.
Postvention needs to include trauma-informed, suicide-literate practice among counsellors, psychologists, educational psychologists, social workers, Youth One Stop Shops, NGOs, Iwi services, churches and faith centres, and others providing support in their community (e.g., Supporting Families).

Learn from lived experience
The Strategy must include mechanisms to keep learning. It should be referring to and learning from local research (such as the trial Suicide Mortality Review Committee), and taking the best from international evidence and best practice. It should include ways of learning from experiences of suicide (including regularly reviewing and making changes based on Coroner’s findings, serious incident investigations in healthcare, deaths in custody and Police attendance to suicide attempts).

The Coroner’s process needs to be resourced adequately so that it happens in a timely way, investigates every death satisfactorily, and provides a positive opportunity to learn from relevant data and stories. The experience of family, friends and those close to someone who has died are invaluable in understanding what went wrong and what our communities and services can learn to prevent further tragedy. For example, for every suicide death of a child, the parents should be offered an in-depth interview for the purpose of data collection. There is enormous value in hearing and learning from the psychosocial stories surrounding each death, if families and support networks are willing to share.

All suicide prevention activities undertaken as part of this Strategy need to be informed by lived experience of suicide – both the experience of bereavement and the experience of being suicidal. Our advisory group is a good example of a mechanism that has been providing lived experience advice to the Mental Health Foundation for the last three years. As part of the new Strategy, a national lived experience network should be established to allow those with lived experience to not only have a voice, but also an opportunity to influence policy and services.

Lived experience leadership is relevant to every action area in the Strategy, but particularly:

- 5. Support and partner with communities
- 9. Strengthen and broaden collaboration among those working to prevent suicidal behaviour.
- 10. Strengthen systems for collecting and sharing evidence and knowledge

Provide support options for those bereaved after each suicide death
Specialist support should be available for people after a suicide death, including:

- Low- or no-cost specialist counselling from people with training in suicide bereavement, and trauma support, available without time restrictions to enable people to access support at different points in their grief process.
- Wrap-around support for family, whānau and friends, to equip them to support each other well.
- Practical support through a high-quality Victim Support service, with ongoing training for new volunteers and staff.
- Clear written information resources, in print and online, preferably in more than one language. Navigating the aftermath of a sudden, suicide death is demanding, at times overwhelming, and up to date information on all the roles involved in what happens is essential to ease the way for those bereaved. These could also support different cultural understandings and needs.
- An information-based service to assist those affected by suicide loss to navigate available services. This could be provided through a phone line, where a support person could listen to what’s going on for the person and help match their needs with what’s available.
- Suicide loss should receive the same practical level of support as homicide loss (for example, provision of house cleaning immediately after a suicide death in the home).
- Psychosocial support during the Coronial process.
- Financial support is needed immediately after a death, particularly if a family has lost the income of the person who has died. Workplaces could be encouraged/required to provide leave policies which allow more discretionary time off, given the level of trauma.
- Peer support groups provide essential support for some. Other types of peer support, including online support, needs to be supported and resourced as well.
- Intentional suicide postvention support is needed for children and young people – for example free counselling, well-trained school counsellors and children’s/youth workers, wrap-around supports that consider all of a young person’s needs. This population remains at increased risk of suicide as they grow up into adulthood.
- Trauma first aid responses are also needed for people who find a person who has died by suicide, whether or not they personally knew the individual.
- Supervision, counselling and support needs to be available for clinicians, counsellors or support workers who lose a client to suicide.

All support activities need to be gender-responsive, as well as culturally-responsive and age-appropriate.

Providing adequate, timely and good quality support services will require a growth in a skilled, knowledgeable and supervised workforce (professionals and skilled volunteers) as well as increasing the amount of service provision (face to face; educational institution-based, community and workplace-based, internet, telehealth, apps).

As part of action area 4, “Improved mental health literacy and suicide prevention literacy” or 7, “build the support and capability of workforces”, specific evidence-informed suicide training needs to be provided for professionals who offer counselling or support to the suicide bereaved, as well as support workers and volunteers (e.g., Victim Support).

**Include strong national leadership and coordination, including lived experience voices**

The draft Strategy includes just one reference to those bereaved by suicide, and that is as recipients of support. The Strategy must recognise that people who have lost loved ones to suicide are also significant contributors to suicide postvention and prevention, through service design, research, education, advocacy, and facilitation of support groups.

The Strategy should focus on strong national leadership, and should resource a readily accessible postvention hub that:

- provides a central connection point for postvention information and activities across NZ
- coordinates aspects of services / community response – to aid in establishing and facilitating clear pathways of support for those impacted and bereaved by suicide.
- stays updated with research and best practice locally and internationally.
- shares recent New Zealand suicide research
- provides regular professional development and networking opportunities for those working in the area
• communicates understanding of what postvention is, and advocates for postvention activities & research

We strongly recommend that all actions planned, resourced and funded through the new Strategy should be informed by lived experience leadership.

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References


ii For example:

iii Survivors of Suicide Loss Taskforce (2015) Responding to Grief, Trauma and Distress After a Suicide, U.S National Guidelines


xi see The Continuum Model: Effects of Suicide Exposure, table 1, p10, in Survivors of Suicide Loss Taskforce (2015) Responding to Grief, Trauma and Distress After a Suicide, U.S National Guidelines


