Suicide bereavement and mental health:  
a submission to the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau

Thank you for the opportunity to comment on the Government Inquiry into Mental Health and Addiction – Oranga Tāngata, Oranga Whānau. 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, Mani Mitchell, Mark Wilson, Michele Elliott, Dr Chris Bowden, Paul Martin and Witi Ashby.

The group acknowledges the past input of members Dr Jemaima Tiatia-Seath and Dr Lynne Russell, who have not been involved in developing this submission because of their roles with the Inquiry into Mental Health and Addictions. Ngā mihi aroha ki a korua.

We would welcome further discussion with the Inquiry Panel on this submission.

This submission comments on how New Zealand’s suicide response needs to be strengthened for people bereaved by suicide, and how it can learn from those with lived experience of suicide loss.

We believe that our national suicide response needs to:

- Provide accessible support options for those bereaved after each suicide death
- Strengthen national leadership and coordination of suicide prevention and postvention initiatives, information, linking, training and research
- Build up and enable more supportive systems and organisations across the country

Listen to and support people bereaved by suicide

People bereaved by suicide are a vulnerable, priority population requiring meaningful support. In most instances, suicide has devastating effects on those bereaved by the death: close family members, whānau, close friends, community members connected in some way with the person who has died, first responders attending the death scene, and others who are exposed to the death. Suicide grief is often complicated by social rejection and blame, shame, secrecy and stigma.

Considered as a population group, people bereaved by suicide are at significantly elevated risk of negative health and social outcomes. These include higher rates of suicidal behaviour as well as depression, anxiety, post-traumatic stress disorder and other adverse outcomes.

Those bereaved by suicide are a large and growing group. In the past, discussion about suicide bereavement has often referred to Schneidman’s conservative estimate that six people are “intimately affected” by each death, however this is now widely acknowledged to be a significant underestimate. It is increasingly being recognised that suicide loss affects not only close family
members, but can affect a wide range of people who has a relationship with the person who died: wider whānau, chosen family, friends, schools, workplaces, faith communities, sports organisations, and the communities where the person lived. In the case of a celebrity death, the range of people who may genuinely need support may include strangers.

Recent research suggests that each suicide leaves behind as many as 135 grieving people who knew the person who died. Not all of these people will experience significant bereavement, but suicide will affect them in different ways. For example, a recent population study in Kentucky found that 48% of participants reported lifetime exposure to suicide, and that any level of exposure was associated with increased incidence of depression, anxiety and suicidal ideation. The risk of developing depression, anxiety or post-traumatic stress disorder increased with closeness to the person who died by suicide.

Given that New Zealand has around 500 suicide deaths each year, there is a significant number of people in New Zealand who experience trauma and grief after the suicide of a loved one.

Our national response to mental health and suicide prevention needs to recognise people who are bereaved by suicide as a priority population who require specific, appropriate, trauma-informed support options to address their unique experiences and needs. Bereavement support should address grief, distress, stigma, social support, health and wellbeing rather than being solely focused on reducing suicide risk.

Listen to people with lived experience of suicide loss

People who are bereaved by suicide have significant contributions to make to suicide prevention and postvention. Currently, people who have lost loved ones to suicide are significant contributors to our national suicide response through service design, research, education, advocacy, and facilitation of support groups.

Our national response to suicide must include mechanisms to keep learning. It should be referring to and learning from local research (such as the 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 and postvention initiatives should be informed by lived experience of suicide – both the experience of bereavement and the experience of being suicidal. Our group is an example of a structure that informs the design, delivery and evaluation of suicide prevention and postvention initiatives run by the MHF, from a range of lived experience perspectives. We strongly recommend that all actions planned, resourced and funded as part of the national mental health and suicide response are informed by lived experience leadership.

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Provide support options for those bereaved after each suicide death

As a specific group exposed to significant trauma and grief, people bereaved by suicide need to have access to nationally consistent and specialised support when required. This could be provided through a nationally accessible non-medical pathway such as ACC or Whānau Ora that could assess needs and provide options that address specific individual and whānau circumstances.

Specialised support should include:

- Low- or no-cost specialist counselling and clinical support when needed, from people with training in suicide bereavement and trauma support. This should be available without time restrictions to enable people to access support at different points in their grief process. Suicide grief can take longer to process than other forms of grief.
- Wrap-around support for family, whānau and friends, to equip them to cope with grief and trauma, and to support each other well.
- Practical support (for example, provision of professional house cleaning immediately after a suicide death in the home) through a high-quality Victim Support service, with ongoing training for new volunteers and staff.
- Easy access to clearly written information resources, in print and online, preferably in more than one language. Navigating the aftermath of a sudden, suicide death is demanding, complex, at times overwhelming, and up to date information on all the roles and steps involved in what happens is essential. It can help ease the way for those bereaved. Resources could also support different cultural understandings and needs, and inform those wanting to offer help. All resources must be well promoted, and print resources must be promptly reprinted as needed, to ensure ready supply and access.
- A suicide-specific information 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.
- Access to spiritual guidance and support, for example blessings of the home or the death site.
- Guidelines and support for planning suicide funerals and tangihanga, especially when there is a concern of elevated suicide risk.
- Family financial support immediately after a death, particularly if a family has lost the income of the person who has died. This could include access to immediate funds to support with funeral costs, for example by expanding availability of ACC funeral grants.
- Supportive employment policies, including 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.
- Psychosocial and individual advocacy support during the Coronial process.
- Peer support groups provide essential support for some. Other types of peer support, including online support, needs to be informed, supported and resourced as well.
- Intentional suicide postvention support is needed for children and young people. This population remains at increased risk of suicide as they grow up into adulthood. For example, youth-friendly information, free counselling, well-trained school counsellors and children’s/youth workers, and wrap-around supports that consider all of a young person’s needs.
- Trauma first aid responses are also needed for first responders and people who find a person who has died by suicide, whether or not they personally knew the individual. Not all those bereaved of affected by suicide know how to access Victim Support services.
- Supervision, counselling and support needs to be available for all clinicians, counsellors or support workers who lose a client to suicide.
Currently there are major differences in support for families who have lost loved ones to suicide compared with homicide or accidental sudden death. There is no good rationale for this disparity; suicide loss can be just as shocking, traumatic and devastating as other forms of sudden loss. Our national response to mental health and suicide needs to address these disparities and include genuine, proactive support for people exposed to or bereaved by suicide.

All support activities need to be accessible and relevant, informed by understanding of gendered differences in grief and bereavement, culturally-responsive\textsuperscript{xxx}, able to be provided in different languages, accessible for disabled people, and age-appropriate. They need to be available regardless of when the death occurred, recognising that suicide loss may affect people in different ways for years after the event.

Build more supportive systems and organisations – recognise that postvention is prevention

Providing adequate, timely and good quality support services will require 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). Specific evidence-informed suicide training needs to be provided for professionals who offer counselling or support to the suicide bereaved, as well as for support workers and volunteers.

It will also require reviewing agencies and processes from the perspective of how they can be more supportive to whānau pani and anyone else bereaved or affected by suicide.

Given that those bereaved by or exposed to suicide are at increased risk of suicidal behaviour, “postvention is prevention”. In other words, supporting people after a suicide death is both about healing their loss and trauma through the grief process, but also minimising risk of further tragedy\textsuperscript{xxx}. In New Zealand it is not uncommon, for example, for families to have had several family members die by suicide, from different generations. Investing in postvention and building supportive and resilient communities will reduce the burden of trauma, distress and complicated grief, as well as contributing to preventing further suicides.

Building more supportive systems and organisations should include:

- Improving the interface between individuals, whānau and Coronial Services – ensuring coroners can provide pathways to support, that coronial reviews are conducted in a timely way (within a year after the death), and that those bereaved by suicide are engaged and informed, including being informed about progress on changes made as a result of coroners’ findings and recommendations.

- Mandating and providing specialist training in suicide prevention and the effects of bereavement for those who interact with people bereaved by suicide. For example, certifying counsellors, doctors and mental health professionals who are competent to work with people bereaved by suicide. 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). This should include flexible practice models that allow professionals to work within and with communities.

- Availability of a service that supports whānau and communities to respond to contagion, not only in a current cluster situation. For example, this would recognise contagion issues within
whānau, intergenerational trauma and suicide risk through the lifespan for those bereaved by and exposed to suicidal behaviour.

- Availability of specific support for individuals, whānau, children, adolescents and young adults, including trauma interventions, a focus on grief recovery, wellbeing and developing resilience, as well as practical support to address mental health, social and economic issues that may contribute to suicidality.
- Ongoing training and guidelines for media about how to interact safely and respectfully with bereaved whānau. Media training for individuals and whānau who would like to share their story of suicide loss publically.
- Building the capacity of communities, workplaces, individuals and whānau to be supportive by providing subsidised, user-friendly training opportunities and public speakers to address stigma and develop public empathy, skills and confidence to support people bereaved by suicide, talk safely about suicide and support pathways to recovery and wellbeing.

Training and education opportunities should include voices of people who have lived experience of being bereaved by suicide or experiencing suicidal ideation or behaviour, using the principles of the Power of Contact to change attitudes and understanding. Programmes should recognise diversity, intersectional issues and the range of ways that people can experience exclusion.

**Strengthen national leadership and coordination**

New Zealand is currently lacking a national strategy and visible leadership for suicide prevention and postvention. A national strategy is needed that has clear leadership at government and community levels, and articulates a well-coordinated approach.

This should include:

- A named Minister responsible for Suicide Prevention, who works together with other relevant areas of Government (such as Education, Justice and Corrections, Work and Income, Oranga Tamariki and Te Puni Kōkiri). A joined-up approach is needed that recognises that suicide is not just a health issue, but has a range of social determinants.
- A clear strategy including goals and an articulated national approach to suicide prevention and postvention. This should have a focus on addressing inequalities and discrimination: including poverty, homelessness, unemployment, financial literacy, disability issues, mental distress, racism, homophobia and transphobia. It should target approaches to populations at risk of suicidality, including Māori, rainbow/LGBTI+, Pacific and refugee groups.
- An approach that reflects the disproportionate burden of suicide experienced by Tangata Whenua and upholds indigenous solutions such as the *Turamarama Declaration* and *Turamarama ki te Ora: National Māori Strategy for Addressing Suicide*.
- A well-funded, long-term central structure, such as a Centre of Excellence, that provides:
  - best practice and guidelines
  - research translation and support for design and evaluation of initiatives
  - accessible, up to date information about suicide
  - mechanisms for government to hear from, and work with, communities
  - space for discussion and collaboration
  - a strategic Aotearoa-specific research agenda that informs the design and delivery of resources and services
  - monitoring and certifying of resources and community initiatives
  - accreditation and monitoring of suicide bereavement support groups
- wider understanding of peer support and the value of community and whānau leaders who regularly support others
- development of best practice suicide prevention responses for those at risk, for example effective follow up for post discharge for those who have attempted suicide, recording and monitoring of non-fatalfatal suicidal behaviour, and centres to treat suicidality that are outside of a mental health service paradigm.

Our national approach to suicide prevention should be driven by kāwanatanga - governed by clear principles and values that are enabling and empowering, not re-traumatising or victimising for people who have lived experience. Examples of principles and values include:

- A holistic approach
- A society that is kind and cares, and where people belong and feel connected and purposeful
- Manaakitanga
- Compassion
- Person-centred
- Culturally inclusive, competent, bicultural model
- Tino rangatiratanga, giving the power back to whānau
- Providing choices that are self-determined
- Acknowledges impact of intergenerational trauma and colonisation
- Valuing lived experience

We strongly recommend that all actions should be informed by lived experience leadership.

Contact
Moira Clunie
Research, Development and Advocacy Manager, Mental Health Foundation of New Zealand
moira.clunie@mentalhealth.org.nz
Phone: 021 790 236 | 09 623 4810 ext 810

References


