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

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Disclaimer

1 Executive Summary and Recommendations

1.1 Executive Summary

1.1.3 General

- Very little literature exists relating to the support needs of Māori whānau or Pacific or Asian families and significant others affected by suicide attempts.

1.1.4 Māori

- There is great diversity in the make-up of Māori whānau, and in the degree of acculturation among whānau. This is likely to have an impact on what services are most effective for different whānau and implies that choice is necessary.

- Collective notions of whānau may mean individualistic services are inappropriate for some Māori.

- Whānau may experience emotional outbursts and altercations once the immediate crisis has passed.

- Beliefs about mate Māori and the sanctity of life may influence how some Māori react to a family member's suicide attempt and any diagnosis of mental illness.

- Stresses such as poverty may make it more difficult for whānau to deal with a suicide attempt.

- Whānau affected by suicide attempts may have been under stress prior to the attempt, and these issues may need to be resolved.

- Many Māori want the option of using kaupapa Māori support and mental health services. This is likely to be the case for support services for whānau affected by suicide attempts.

1.1.4 Pacific people

- The diversity of Pacific cultures means that the term 'Pacific peoples' is a label of convenience that encompasses distinct cultural groups. Differences between island-born and New Zealand born Pacific people also exist. Within the Pacific population there are a number of people who identify with more than one ethnic group. Choices within support service provision are likely to be beneficial.

- Some Pacific people stress collective, rather than individual identity.

- Traditional beliefs about mental illness may influence how Pacific people react to a family member's suicide attempt and any diagnosis of mental illness.

- Stresses such as poverty may make it more difficult for Pacific families to deal with a suicide attempt.

- Some Pacific people are not fluent in English and this seriously limits their ability to access and benefit from mainstream support services.

- Many Pacific people want the option of using Pacific support and mental health services, especially where these services cater for their specific island group. This is likely to be the case for support services for Pacific families affected by suicide attempts.

- Pacific people have asked for education on suicide risks and prevention.

1.1.5 Asian

- The diversity of the Asian population in New Zealand makes generalisation about Asian culture unrealistic. Many Asians do, however, share experiences of recent immigration.

- Asians from refugee backgrounds may be vulnerable to retraumatisation.

- Some Asian people stress collective, rather than individual identity.

- Asian cultures tend to highly stigmatise mental illness, which may create added difficulties for the family following a suicide attempt.

- A majority of Asian people are not fluent in English and this seriously limits their ability to access and benefit from mainstream support services.

- Asian families are likely to find it difficult to understand how the New Zealand health system works. This may create added anxiety if their loved one is under mental health or other care, or is in need of care.

1.2 Recommendations for Service Delivery

It is recommended:

- That there be a choice of services for Māori whānau and Pacific and Asian families and significant others affected by suicide attempts in order to provide for both cultural needs and the diversity of these populations. It is acknowledged that in areas with lower populations of Māori, Pacific or Asian peoples these choices may have to be provided from within a mainstream service.

- That kaupapa Māori services be developed in areas with a significant Māori population. These could be developed within existing Māori mental health or suicide prevention services, or autonomously within mainstream services. Māori models of health and kaupapa Māori counselling models should be used as a framework for these services.

- That support services that specifically cater for the needs of people from the various Pacific island groups be provided in areas with significant Pacific populations. These could be located within existing Pacific mental health or suicide prevention services, autonomously within mainstream services, or within a joint Māori-Pacific service. Pacific models of health should be used as a framework for these services.

- That mainstream support services for families, whānau and significant others affected by suicide attempts take account of Māori and Pacific models of health.

- That move to increase the workforce of trained Māori, Pacific and Asian counsellors and mental health professionals be supported.

- That all training programmes for professional and volunteer staff providing support services to families whānau and significant others affected by suicide attempts include significant attention to cultural issues, including
    - Māori and Pacific models of health,
    - the dynamics of working cross-culturally,
    - characteristics of New Zealand's Māori, Pacific and Asian populations
    - culturally specific attitudes towards mental illness and suicide attempts
    - diversity within population groups,
    - where to access cultural advice and support when working with Māori whānau or Pacific or Asian families, and
    - the use of interpreters.

- That whānau, family and community focused services be offered as well individual-focused services.

- That services for Māori whānau and Pacific and Asian families and significant others affected by suicide attempts also address pre-existing stressors and dysfunctions were necessary.

- That wherever possible, families for whom English is not a first language have the option of receiving support from a provider who speaks their language, Where this is not possible a suitable trained interpreter should be made available at no cost to the family.

- That first language service providers or suitable trained interpreters be accessible to non-English-speaking individuals who are receiving care following a suicide attempt in order to reduce stress on family members who might otherwise have to

interpret. This should be at no cost to the individual or the family.

- That the provision of culturally and linguistically appropriate respite care for individuals who are at further risk of suicide following an attempt be investigated to reduce stress on whānau, families and significant others.

- That the provision of an information resource for Pacific families affected by suicide attempts be investigated

- That Asian language pamphlets be produced for families and significant others and that these include information about the New Zealand mental health system and sources of support as well as information about mental health and understanding suicide attempts.

1.3 Recommendations for Evaluation

It is recommended:

- That given the absence of research on support needs for whānau affected by suicide attempts, kaupapa Māori support services should initially have a strong learning focus and be evaluated to learn what works, when and for whom.

- That given the absence of research on support needs for Pacific families and significant others affected by suicide attempts, Pacific support services should initially have a strong learning focus and be evaluated to learn what works, when and for whom.

- That mainstream post-attempts support services be evaluated for their accessibility and effectiveness for Māori whānau.

- Mainstream post-attempts support services be evaluated for their accessibility and effectiveness for Pacific families.

- Mainstream post-attempts support services be evaluated for their accessibility and effectiveness for Asian families.

1.4 Further Research

It is recommended that field research be undertaken into the support needs of Māori whānau and Asian and Pacific families and significant others who have been affected by suicide attempts. This research should prioritise the voices of the affected families, whānau and significant others. The use of an action research model would be appropriate.

- It is recommended that the following issues be researched in relation to Māori whānau:
    - the meanings and causes whānau ascribe to suicide attempts, and the implications of these for supporting whānau.

- financial and material support needs of whānau following suicide attempts.
- accessibility of support services for whānau following suicide attempts (including awareness of services, cost barriers, cultural barriers and the impact of stigma).
- the suitability of western and kaupapa Māori models of counselling, therapy and support in assisting whānau following suicide attempts.
- the extent to which pre-existing stress or dysfunction affects the ability of whānau to deal with suicide attempts.
- the impacts of suicide attempts on different members of whānau (eg partners, parents, children, younger siblings, wider whānau).

- It is recommended that the following issues be researched in relation to Pacific families and significant others :
  - the meanings and causes Pacific families ascribe to suicide attempts, and the implications of these for supporting these families.
  - financial and material support needs of Pacific families following suicide attempts.
  - accessibility of support services for Pacific families following suicide attempts (including awareness of services, cost barriers, language barriers, cultural barriers and the impact of stigma).
  - the suitability of western and Pacific models of counselling, therapy and support in assisting Pacific families following suicide attempts.
  - the extent to which pre-existing stress or dysfunction affects Pacific families' abilities to deal with suicide attempts.
  - the impacts of suicide attempts on different members of relationship groups (eg partners, parents, children, younger siblings, brother-sister relationships, specific wider kin-group relationships).

- It is recommended that the following issues be researched in relation to Asian families and significant others :
  - the meanings and causes Asian families ascribe to suicide attempts, and the implications of these for supporting these families.
  - financial and material support needs of Asian families following suicide attempts.
  - accessibility of support services for Asian families following suicide attempts (including awareness of services, cost barriers, language barriers, cultural barriers and the impact of stigma).
  - the suitability of western and Asian models of counselling, therapy and support in assisting Asian families following suicide attempts.
  - the extent to which pre-existing stress or dysfunction affects Asian families' abilities to deal with suicide attempts.
  - the impacts of suicide attempts on different members of relationship groups (eg partners, parents, children, younger siblings, specific wider kin-group relationships).

2 Purpose and Scope

The Ministry of Youth Development (MYD) is the lead agency in the implementation of the National Youth Suicide Prevention Strategy and the development of a national all ages suicide prevention strategy. MYD commissioned this report as one element of the work being carried out to inform the establishment of enhanced support services and/or resources for families, whānau and significant others bereaved by suicide and serious suicide attempts.

This review of the literature on support for whānau and Pacific and Asian families and significant others who have been affected by suicide attempt is intended to sit alongside the mainstream reports on support for families affected by suicide attempt produced for this project.

An earlier report discussed support for whānau and Pacific and Asian families and significant others who have been bereaved by suicide. Some sections of this report duplicate material provided in the earlier report. It is repeated here, because it is not assumed that the reader will have read the earlier report.

3 Terminology

The definition of 'attempted suicide' and the related terms 'parasuicide' and 'suicidal behaviour' are the subject of widespread debate (see for example Peng & Tseng 1992 Bowles 1985). This report adopts the terminology used by Beautrais in her literature review on support for families, whānau and significant others affected by suicide attempts (Beautrais 2004b).

In addition, the term 'family' is used in the Pacific and Asian sections of this report to mean extended family, and may include significant others. 'Whānau' is used with a similar meaning for Māori. Where Māori and Pacific languages and phrases are used, their meanings (as used in this report) are given in the glossaries in Appendix B.

4 Methodology

In commissioning this research MYD anticipated that the quantity of literature found would be small and difficult to access through commonly used academic search methodologies. (Ministry of Youth Development 2003a).

4.1 Search Methodology

Database searches were undertaken in between November 2003 and January 2004 through the Ministry of Social Development's Information Centre. These searches looked for English language literature on the experiences and support needs of whānau, family, aiga, famili and significant others affected by suicide and suicide attempts in relation to Māori indigenous, Pacific, Asian and migrant peoples. General material on attitudes towards mental illness and how mental health services attempt to meet the needs of family and whānau was also sought in relation to these cultural groups. In addition, literature on counselling and family therapy in Māori and Pacific contexts was searched for.

The search was designed to include 'grey literature' such as unpublished theses, PowerPoint presentations and websites as well as published literature. In keeping with the spirit of the research we extended the definition of 'literature' to include sound and video recordings and works of drama.

The following databases were searched: Austrom, CareData, ChildDataDetails, Index NZ, Medline, Ministry of Social Development Information Centre database, National Bibliographic Database, Psychological Abstracts, PubMed, Social Sciences Index, Social Work Abstracts, and Sociological Abstracts.

Additional searches of the SPINZ database and Ministry of Health and Mental Health Commission's websites were undertaken. Further literature was identified by key informants and from the bibliographies of literature identified.

A hierarchical approach was used to assess the abstracts of literature found through the database searches and determine which items to review. The planned method was to review all material that directly related to the support needs for Māori, Pacific and Asian families, whānau and significant others affected by suicide attempts. In reality barely any of this material was found. Other material was selected on the basis of its robustness, age (material under ten years old was preferred) and the insight it offered to the central issue. Selected items related to cultural identity and demographics, as well as Māori and Pacific public health, mental health and counselling models were accessed. Full reviews of these areas of inquiry are, however, beyond the scope of this report.

Google searches were used to trace some specific literature. Google and the White Pages were also used to obtain contact details for key informants and relevant organisations.

4.2 Key Contacts

Over 120 key informants were approached in November 2003 – January 2004 for suggestions on sources of literature and background information for both this and the earlier report. Those initially approached comprised individuals and organisations suggested by MYD, or identified through the researchers' networks. A 'snowball' technique was then used, with key contacts suggesting the names of others to approach, although not all of the people and organisations suggested could be approached due to time constraints. The method of contacting the initial key informants was through the mail-out of a pānui followed by a phone call. As the research progressed, phone calls and e-mails became the primary means to contact informants.

Those contacted included providers of mental health and suicide prevention services, researchers, academics, policy advisors, and others with knowledge of the area. In addition youth and adult members of Te Rākau Hua o Te Wao Tapu (Foxton) gave us their personal insights into being affected by whānau members' suicide attempts when we approached them to request access to their performance script.

A number of the people we approached were very difficult to contact in the time we had available. This was in part due to trying to contact them at the end of the calendar year – a very busy time for both academics and community organisations. It was particularly difficult to contact researchers and health workers with knowledge related to Asian families affected by suicide attempts. In the end roughly 80 informants were successfully contacted. (See Appendix A for a list of those successfully contacted.)

Many informants gave us useful information verbally or by e-mail but were not able to provide us with existing written information. For grass roots organisations writing documents on areas of work for which they are not funded may not be a priority. This may be particularly so in traditionally oral cultures.

4.3 Personal Communications

In addition to suggesting sources of literature and further key contacts, a number of key contacts discussed the topic with us and offered their personal views and anecdotal information. Where this added a useful perspective not found in the literature we have chosen to include this material, referenced as 'personal communication.' At the same time, it must be noted that these comments are not part of a structured interview process. They were supplied spontaneously and were not, generally, the result of in-depth research. This means that there are limitations in the weight that can be given them, as one informant explicitly noted (Malaulau personal communication 2004).

5 Extent and Quality of the Literature

No literature was found that specifically focused on the needs of whānau or Pacific or Asian families affected by suicide attempts. What we did find was literature on suicide prevention strategies, incidence, causes of suicide and the variables that may impact on risk such as cultural, social, historical and spiritual factors. We also found related material on cultural attitudes to mental illness, cultural concepts of family, research on the dynamic nature of ethnic identities in New Zealand, Māori and Pacific models of health, well-being and counselling and disparities in access to health services. Much of the literature on suicide risk factors and prevention has a strong youth focus.

There is literature on aspects of family and whānau involvement in the mental health services and provision of mental health care from a mainstream perspective. Some of this literature includes significant reference to Māori and/or to the provision of culturally appropriate services.

In the area of models for mental health services, the literature in relation to Māori is more extensive than the other ethnic groups. For the Pacific section of this report, more research was found on issues for Samoan New Zealanders than other Pacific populations in New Zealand. This is to be expected as Samoans are by far the largest Pacific population in New Zealand. As a result, the comments made about the needs of Pacific peoples may reflect a Samoan point of view more than other island groups. There is considerable international literature on Asian issues. This includes literature on suicide in Asian countries and issues and counselling models for Asian Americans. Much of the American literature refers to Asian-Pacific-Americans (or APAs). This is somewhat

confusing as discussion under this heading includes little or no mention of New Zealand's major Pacific cultural groups. Thus literature found on Asian-Pacific-Americans was only relevant to the Asian section of this report.

Many writers note the difficulty in gaining accurate, comparable data on suicide attempts due to the fact that some attempts are never reported to hospitals where most of the data is collected, and the difficulties in establishing the intent behind an injury (see for example Booth 1999)

6 The Context

6.2 The Treaty of Waitangi, Colonisation and Demographic Change

In order to make decisions about the direction service delivery should take it is important to have a basic understanding of the cultural context of New Zealand, including the impacts of the Treaty of Waitangi, colonisation, and demographic change. A brief discussion of these issues is given below.

Government documents considering the importance of culture in New Zealand have tended to be written from a bicultural approach based on recognition of the Treaty of Waitangi as New Zealand's founding document. This literature analysis is unusual in that we have been asked to report on the needs of Māori, Pacific and Asian families, whānau and significant others in the one report. In presenting this report we are in no way seeking to minimise the central role of the Treaty of Waitangi.

The position of Māori as tangata whenua is qualitatively different to the situation of migrant minorities. Māori ties to the land and the notion of kaitiaki mean that traditional tribal maps continue to form the basis of understanding and belonging in Te Ao, even in situations where people are not living a traditional lifestyle. In an iwi-based society, notions of place are intrinsically linked with notions of whānau and dislocation. Knowledge of whākapapa, land, and cultural systems validate an individual's identity within the whānau. Within this context some, particularly those living in urban areas, may be dislocated from traditional lifestyle, values and whānau (Durie, 2001, Lawson-Te Aho, 1998).

Experiences of colonisation within a New Zealand setting are separate from experiences of immigrants who may have experienced colonisation in their homelands. Colonisation has impacted on links to land, whākapapa, and cultural identity within New Zealand, which becomes both the site of the traditional homeland and the site of a modern disempowered status (Dyall, 1997, Durie 2001, Lawson-Te Aho, 1998, Joseph, 1997). This reality means that the experiences of other indigenous peoples may at times be more relevant in illuminating issues and solutions for than the experiences of New Zealand immigrant minorities.

Immigrant minorities have traditional homelands outside New Zealand to refer to, where they may be in a dominant cultural position. Lessons learnt there and beliefs from there

may be transported here (both for the families and for the people planning services). In addition, members of these cultures may have established themselves in other new lands, lending a transnational element to these ethnic identities. As immigrant cultures Pacific Island and Asian people have had to learn to adapt to a new land. Many face language issues.

Māori, Pacific and Asian people have in common the fact that theirs are not the dominant cultures in New Zealand. They may also share some values concerning the importance the collective and the extended family as both a support mechanism and a source of obligation.

A significant proportion of New Zealanders are of mixed ethnicity, reflecting the high degree of cultural mixing within New Zealand (see for example Macpherson et al 2001). This highlights the need for flexibility and choice in service delivery.

6.3 Intention to support family, friends and whānau affected by suicide attempts

It has long been recognised that families, whānau and significant others need support to deal with suicide attempts. The Steering Group on Youth Mental Health and Suicide Prevention recommended in 1994 that a supportive environment should be provided to assist in the recovery of family and friends following a suicide attempt. The Steering Group also recommended that young people from Māori, Pacific and minority ethnic groups be provided with culturally appropriate support (Ministry of Health 1994).

In our hands Kia Piki te Ora o te Taitamariki: Strengthening Youth Wellbeing: New Zealand Youth Suicide Prevention Strategy presents a Māori perspective on suicide support services. Goal 4 of Kia Piki states the aim for postvention support services is to give effective support to those who are bereaved or affected by suicide and to reduce the potential for further suicides (Lawson-Te Aho, 1998).

The Mental Health Foundation's *Practical guide to coping with suicide* advises families affected by suicide attempts that, 'Aftercare is as much supporting those involved as the victim. You need to ensure your own support is in place to enable you to offer help.' (Coggan et al 1999). But until now, there seems not to have been any organised attempt to make such aftercare available to Māori, Pacific and Asian families.

7 Supporting Māori Whānau who have been affected by suicide attempts

7.1 Who are Māori Whānau?

Two questions of definition need to be addressed. One is who are Māori? The other is, who are the whānau? These questions are discussed below through the framework of cultural identity.

7.1.1 Cultural Identity

The effect of colonisation on Māori cultural identity has been to breakdown cultural institutions that were designed to support and modify individual and group behaviour (Lawson-Te Aho 1998a, Joseph 1997). One of the direct effects of colonisation has been to remove Māori from their traditional lands and cultural base which is the central source of Māori identity (Ministry of Health 1994c, Durie, 2001). This combined with 'the active process of assimilation,'

> rendered Māori values, traditions, practices, beliefs and world views irrelevant to the values and beliefs of the dominant culture. It creates an imposed inferiority through the denigration of Māori identity.' (Lawson-Te Aho, 1998a).

Colonisation and land loss undermined the status of Māori within social and economic structures, leading Māori to move to the cities in large numbers. In turn, urbanisation contributed to a further loss of Māori cultural identity and the undermining of Māori social structures (McFarlane-Nathan 1996, Lawson-Te Aho 1998a, Joseph, 1996). The literature suggests that acculturation is a significant cause of the high levels of depression, stress, anxiety and identity confusion among Māori and is the end result of colonisation, assimilation and urbanisation (see for example Lindforth et al, 1997, Joseph 1997, Sawrey 1991).

The process of assimilation and acculturation has also created a diversity of Māori identity (Dyall, 1997). According to the 2001 Census there were 526, 281 people (14.7% of the total population) who reported that they belonged to the Māori ethnic group. Within in this group over half identified Māori as their sole ethnicity (Department of Statistics 2001).

According to Durie there are three distinctly different groups of Māori. The first group participates fully in Māori culture and activities and probably identifies solely as Māori. The second group lives a more mainstream lifestyle and blends into society like their Pākehā neighbours but will identify strongly as Māori. The third group are those who do not participate greatly in either Māori or mainstream society and are relatively isolated (Durie 2001).

Indices have been developed to measure Māori identity by key criteria of positive self-identification and the degree of access to Māori cultural institutions such as:

- te reo Māori

- knowledge of whākapapa (ancestry)
- access to whenua tipu/Māori land
- marae participation
- whānau participation and involvement with other Māori.

(Durie 1996)

The research involved interviews with 210 households in the Manuwatu region to devise four identity profiles: secure, positive, notional and compromised. The study looked at socio-economic factors such as housing, un/employment, education and how this is inextricably linked to cultural identity. The grouping of individuals within these profiles depended on the level of participation in the key criteria. The results show 35% of the sample had a secure identity, 53% had a positive identity, 6% had a notional identity and 6% had a compromised identity. (Durie 1996).

As was noted at the Hui Ara Ahu Wakamua, the diverse nature of Māori society has significant implications for service provision:

> 'Some Māori are part of Māori society. Some Māori are part of general society. Some Māori are alienated from both.' The main point is that choice should be available for Māori clients and their whānau.
> (Durie 2001).

The diversity within Māori society implies a need for choice and flexibility when providing postvention support services to Māori whānau (Mental Health Commission, 1999). This includes services following suicide attempts. One model of Māori wellbeing may not fit with every person of Māori heritage. In fact there needs to be a range of different models available to Māori so they can chose which service best fits their needs at the time (Mental Health Commission 2003, Ministry of Health 1995a, Dyall, 1997).

7.1.2 The meaning of family and whānau

Whānau is integral to Māori identity (Metge 1995, Dyall 1997, Durie 2001, Langford, et al 1998). A fundamental distinction between Māori worldviews of identity and Western worldviews is based on the notion of self (Sawrey 1991). A traditional Māori perspective sees self as interconnected between the self (subject) and the intentional (world) whereas, Western ontology view the two as separate and independent (Joseph 1996, Love 1999, Stephens 1999). In this context the individuals' identity may not be divisible from the whānau as a whole (Metge 1995, Edwards et al 2003).

Whānau for Māori means different things depending on their environment, family links to marae and other factors. Meanings have changed over time:

> Following urbanisation, the network of rural whānau houses in close proximity to each other gave way to small units in single households. Relatives could be blocks away or even hundreds of miles. Now the term whānau was being applied to nuclear families or households, partly because the wider links did not appear to be active, and in any event were greatly reduced in terms of intensity, but also

> because there was no Māori word to describe the small family. Whamere, a transliteration of family, was sometimes used, but increasingly the tendency has been to use family and whānau as if they, were synonymous. It is a misleading practice. Members of individual households, living much of the time as a family, can also be part of a wider whānau system.
> (Durie, 1991)

Māori are more likely to live in extended family situations than non-Māori (Durie, 1996, Dept of Statistics 2001), but whānau may also be geographically dispersed (Edwards et al, 2003).

In modern usage, the term whānau may extend to include whānau as friends, neighbours, and households. Durie writes:

> Joan Metge has illustrated that point in her seminal study, *New Growth from Old*. At one end of the spectrum are whānau whose members are determined strictly according to descent, whākapapa whānau. Even spouses and adopted children (whāngai) are excluded. At the other end of the scale are groups of Māori - kaupapa whānau – who are not actually related through any ancestral link but who behave towards each other in a family-like manner, using a shared commitment. (Durie 2001).

In this sense, whānau incorporates the notion of 'significant others' (Edwards et al 2003). The use of the term whānau in this report is used in the broad sense and includes significant others and kaupapa whānau.

The concept of whānau, whether kin-based or more loosely used, is closely tied to collective responsibility to the family group and then to the individuals within the group (Metge 1995). Whānau is about mutuality, reciprocity, protection of the group, support and sharing of things in common, and aroha (love) for one another. From this base members' strengthen secure identities, and communication and behaviour is structured. (Durie, 2001).

Important whānau values include aroha (love), whānaungatanga (kinship), taha wairua (spiritual) and taha tinana (physical), tapa (sacred) and noa (free from ritual restriction), ora (energised life), tika, tikanga, pono (what is right morally, spiritually, and socially), and mana (prestige, reputation) (Metge 1995).

In addition to whānau, a wider group of hapū, iwi and significant others may be affected by a suicide attempt. Those affected may include the immediate family, grandparents, cousins, aunts, uncles, nephews, nieces, friends, school friends and neighbours (Joseph 1996, Durie 2001, Edwards et al 2003). Given the emphasis placed by Māori culture on

extended family and other relational ties it is likely that more than six whānau and significant others may be significantly affected by attempted suicide.[1]

7.2 Suicide Attempts Amongst Māori

Lawson-Te Aho notes that Māori suicide is often translated as 'whakamomori', although this term traditionally describes a psychological, spiritual and cultural state that may or may not result in death and, therefore, includes suicide attempts. Iwi may interpret the term whakamomori differently. Moreover, those in the northern part of the North Island prefer to use the term tārona (Lawson-Te Aho 1998).

In a traditional context suicide amongst Māori did exist though it occurred mainly amongst bereaved Māori women or as a result of shame caused by a harmful act (Lawson-Te Aho 1998a, Joseph 1997, Mohi 1998). Factors that contribute to suicide risk in the modern context are quite different (Coupe 2000b).

There are difficulties in establishing suicidal attempt data as the main source relies soley on national hospitalisation inpatient admissions. Data excludes those who attend Accident and Emergency departments as outpatients, or seek medical treatment from General Practioners. Data may include cases of self-harm (including motor vehicle accidents), those who were admitted more than once in the same year or died while in hospital (Wilson 1999). Research suggests that the high rate of admissions for Māori males as a result of motor vehicle accidents may in fact be hidden suicide attempts (Durie 2001, Coupe 2000a). Consequently, the true number of suicide attempts may be much higher.

Youth have the highest representation in the hospitalisation rates for intentional self-harm. Māori females had the highest hospitalisation rates for any group from 1987 – 1993 (Ministry of Health 1996, Wilson 1999). By the year 2000, the Māori rate for hospitalisation was 244.8 per 100,000 which was slightly lower than the non-Māori rate of 292.1 per 100,000. In contrast the Māori male hospitalisation rate was 10% higher than that of non-Māori males (Ministry of Health 2003).

Māori females are twice as likely to attempt suicide compared to Māori males. The hospitalisation rate for Māori females is 1.8 per 100,000 compared to 1 per 100,000 for Māori males (Ministry of Health 2003a). Females in general tend to choose less non-fatal methods such as drug overdose compared to males who will use more lethal methods like shooting (Ministry of Health 2003a, Wilson 1999). Consequently, Māori males tend to have a higher ratio of completed suicides. This is the same gender ratio as for the non-Māori population.

In 'Ethnicity issues in deliberate self-injury: A review of the literature' Wilson refers to a study in Wellington showing people are more likely to engage in suicidal behaviour if they are aged 15-24, unemployed, are sickness beneficiaries or work in the service

[1] Six family and significant others is frequently given in the international literature as the hypothetical number who are directly affected by a suicide attempt. It is recognised that it is also likely to be an underestimate of the true figure for the general population (Beautrais, 2004b).

industry, live in the inner city, or are Māori. The study relied on hospitalisation admission data only (Wilson 1999). Other risk factors may include issues around sexual orientation: lesbian, gay and transgender people may be more at risk of attempting suicide, although some authors state that this assertion has yet to be proved (Coupe 2000b).

A small South Island study looking at Māori mental health found that those at greatest risk of attempted suicide were aged 15 to 29 (Baxter et al 2002). The study suggests 1 in 3 Māori will have suicidal thoughts over a lifetime and 1 in 10 will attempt suicide (Baxter et al 2002). The rate of psychiatric disorder is high amongst the general population who attempt suicide (Baxter et al 2002, Beautrais 2004). Researchers suggest this study is limited because of the relatively low numbers of Māori included (Coupe 2000a).

7.3 Māori Experiences of Suicide Attempts by Whānau Members and Significant Others

There is very little literature found that deals specifically with the experiences of Māori affected by the suicide attempt of a whānau member or significant other. After a suicide attempt an individual maybe admitted to hospital for psychiatric evaluation or may be managed by either a mainstream or Māori mental health team (Ministry of Health 2000). Coupe notes that Māori have one of the highest rates of admissions to psychiatric care (Coupe 2000b). Māori who are admitted to hospital tend to stay for the shortest length of time of the total admissions (Wilson 1999). Moreover, the deinstutionalisation of the mental health service has driven a greater reliance on community care for those people affected by suicide (Durie 2001). These factors suggest Māori whānau in many cases are likely to provide the primary support or care to their loved one.

Staff estimated that a number of the 50-60 rangatahi who completed the Te Rākau Hua o Te Wao Tapu in Foxton in late 2003, students had either been affected by suicide attempt or completed suicide (Te Rākau staff, personal communications 2003). Several told us how they and their whānau were grappling with the effects of suicide attempts on a daily basis, as well as dealing with other life stresses (personal communications 2003). Their experiences are reflected in the autobiographical material contained in *First Hurts,* the play devised by the group:

> My Nan died, about a year after my grandfather couldn't handle it, he flushed his pills down the toilet he wanted to die. I lay with him on his death bed his last words were I love you my son and I will always be with you. A few months later my cousin went to jail. Then another cousin tried to hang himself. I know I've been brought up in the wrong way, with the wrong people at the wrong time. (Te Rākau Hua o Te Wao Tapu 2003a)

The rangatahi at Te Rākau health camp talked about a range of issues they faced when whānau members attempted suicide. Common feedback related to the lack of support and some still felt traumatised by the experience. One rangatahi told us of living in constant fear that her mother would overdose. Her mother had repeatedly attempted suicide. The strain and pressure this situation placed on the young person was enormous and had led

to her own suicidal ideation. There did not appear to be much support outside the family. Ironically a close relative is a counsellor but felt unable to counsel her for ethical reasons (Affected whānau member personal communication 2003).

Another rangatahi told how his parents' marriage broke up and there had been subsequent suicide attempts in the family. The family had been told that they would get counselling but this never eventuated. Some rangatahi indicated they would be happy to meet with a counsellor though many suggested they would prefer to discuss the matter with peers who had been through similar experiences. A possible solution may be to provide internet based chat rooms and/or peer group meetings to support young people affected by suicide attempt. This would need to be moderated or facilitated to ensure the safety of participants (Te Rākau personal communications 2003).

International literature suggests that immediately after a suicide attempt family and friends are likely to experience trauma and depression. This may result in copy cat or acting out with further suicides or suicide attempts. The authors of a report in *Aboriginal and Island Health* state that Australian Aboriginal teenagers are at greatest risk of acting out 6 months after a suicide or suicide attempt (Aboriginal & Islander Health 1995).

In relation to the South Island Māori study, Baxter et al write

> Emotional outbursts and family altercations are not uncommon as the joining around the immediate crisis breaks down.
> (Baxter et al 2002)

In medical trauma settings, reactions of fear, guilt, high anxiety and depression have been noted among patients' whānau (Blair & Harrop 1999). It may be that similar reactions occur among whānau of suicide attempters, whether or not a serious medical injury has occurred.

In addition, tensions between whānau members and the individual may have contributed to the suicide attempt and it is quite possible that the issues between whānau need to be resolved post the event. Moreover, general population research shows family dysfunction is likely to be a factor in suicide attempts (see Beautrais et al 1996 & 1997).

Māori have an increased risk of social disadvantage, high rates of poverty, unemployment and low educational achievement (Lawson-Te Aho 1998b, Durie 2001). All of these factors contribute to higher stress levels, unhappy families where violence, substance abuse and inability to communicate are common (Lawson-Te Aho 1998b). In addition, Metge points out that a number of structural issues exist between whānau members that may create tension (Metge 1995). Support services for whānau need to take into account all factors that may have a bearing on how best to support individual whānau .

Blair and Harrop suggest that whānau are likely to be receptive to outside help in the period following a trauma (Blair & Harrop 1999). The same may apply to whānau following the shock of a suicide attempt.

It is important to keep an open mind and not stigmatise or pre-judge whānau by assuming dysfunction exists. Racial stereotyping of indigenous peoples by psychologists and psychiatrists is a recognised barrier that indigenous people may face. Health professionals need to exclude this type of stereotyping as it will only hinder support services for whānau who have been affected by suicide attempt (see Fernando 1992).

Māori view the sanctity of life as paramount, particularly those who have a strong religious or spiritual conviction. (Mohi 1999, Tatz 1999). This may impact on how whānau respond to a family members suicide attempt. Those Māori with strong Christian convictions may find it difficult to reconcile their feelings around a loved ones suicide attempt (Tatz 1999).

Some affected by suicide attempt feel a need to talk about suicide but are constrained by the feeling that they shouldn't talk due to fears of copycat suicide. Some feel that this experience is not really something anyone could understand who hasn't been there (affected whānau members personal communications 2003). The fear of a repeat suicide attempt is very real for whānau.

The limited literature and anecdotal information about the feelings and responses that whānau affected by suicide suggest that there is a need for carefully planned structured support. Given the diverse nature of Māori society, a broad based approach to postvention services that is flexible and responsive to the needs of Māori is required (Ministry of Health, 1995a). A more detailed discussion about the types of mainstream and Māori support services that could provide post-attempt support occurs in a later section.

7.3.1 Attitudes towards Mental Illness

Mate Māori is a term Māori use to describe psychiatric disorder with a spiritual origin (Tatz 1999, Mohi 1999, Joseph 1997). Some Māori believe that suicide or suicide attempt is as a result of mate Māori (Mohi 1999, Tatz 1999). This may impact on how whānau respond to a family members suicide attempt.

Given that the majority of Māori who attempt suicide have a psychiatric disorder it is relevant to consider Māori mental health consumer experiences with whānau. Whānau attitudes towards family members who have a mental illness are likely to parallel similar attitudes towards suicide attempt.

In a discussion about recovery from mental health Māori whaiora (clients) talk about their relationships with whānau. Family dynamics surface particularly during times of crisis and this is when relationships are often strained or may break down (Mental Health Commission 2002). Relationships between family members who have mental health issues place stress and strain on whānau and significant others (Beautrais 2004b).

Feelings of whakama, shame and guilt are emotions experienced by some whānau who have a family member that suffers from mental health issues (Mental Health Commission

2002). There may be a range of reactions. Some whānau may criticise or feel ashamed of their loved one. Yet others may give 100% support to their loved one during the recovery process (Mental Health Commission 2002). It is likely the same range of responses will be felt by whānau who have a loved one that has made a suicide attempt. Often the focus in a mainstream treatment context is on the individual often diminishing the needs of the family or whānau (Beautrais 2004). Whereas, in a Māori context Māori Mental Health workers attempt to encourage greater whānau participation. The aim is to assist in the well being of the whānau as a whole not just the individual.

7.4 Sources of support for Whānau and Significant Others

7.4.1 Whānau

Whānau appear to provide the most significant support to Māori individuals affected by a suicide attempt. The provision of informal support is a strong focus of whānau. The ability of the whānau to provide effective support to members, however, depends on a number of factors: geographical location, whānau relationships, socio-economic, family dysfunction and other factors (personal communications 2003). The risk factors for individuals who attempt suicide include family or whānau dysfunction, which also make it more difficult for the whānau to support its members post-attempt (Durie 2001, Beautrais 2004b, Coupe 2000b).

Studies also suggest that young Māori men would prefer to talk about emotional, social and relationship issues with someone who was not part of their whānau or close community or to close in age (Dyall 1997, Edwards et al 2003). These factors tend to suggest that choices outside the family should also be given to whānau when looking at support services (Dyall 1997, Edwards et al 2003).

7.4.2 General Practitioners

According to a small study looking at obstacles to primary health care involving members of the Te Runanga o Raukawa, Māori are unlikely to use the support services of their General Practitioners (GPs). Eighty per cent of Māori interviewed said they would not wish to consult a GP about emotional or behavioural issues (Dyall, 1997). Māori who are in need of medical care or support are two times as likely not to seek help from a GP. A research study conducted by a Māori GP in Taranaki found a 30% reduction in attendance when part charges were introduced to community service card holders (Ministry of Health 2003). International literature shows that low income earners who have the greatest need for medical care are often less likely to attend because they can not afford the cost. Māori like their Pacific counterparts, have relatively low levels of GP attendance (Young,1997). This suggests that Māori whānau affected by suicide would be less likely than Pākehā to use their GP for support. Holdaway notes that 50 per cent of clients and patients who present with mental health problems go undiagnosed by their GPs (Te Rau Matatini 2003).

In the past 6 years there has been a steady increase in the number of Māori providers and services for Māori in the area of primary health care. This may have positive effects on early identification and treatment of mental health needs (Holdaway 2003).

7.4.3 Māori Mental Health Services

Twenty hospitals and sixty one non-government-organisations were providing Māori Mental Health Services in 1998 (Durie, 2001). The growing trend within the mainstream health system to offer kaupapa Māori health services is in response to poor Māori health statistics and is a recognition that mainstream health services are not always effective for Māori (Ministry of Health 1998b, Durie 2001, Dyall 1997). Māori with mental illness using mainstream services may experience barriers involving the control of entry to and exit from services; granting or denial of access to resources or services; exclusion of tikanga Māori component and the possibility of misdiagnosis. These factors reduced the likelihood of a speedy recovery (Ministry of Health 1998a).

The push for self-determination in health is also a response to the call for Māori to have greater self-determination and autonomy, and is consistent with developments among other indigenous peoples world wide (Ministry of Health 1998, Durie 2001, Dyall 1997, Raphael & Swan nd, Sellwood et al 2000).

Five key principles are set out in the 1998 Mental Health Commission Blueprint for Māori:

- Choice – need for a range of services so that options for different types of services are available;
- Relevance – Services that are culturally meaningful and able to address actual needs;
- Integration – Mental health services should not exist in isolation from other health services and intersectoral connections should be made;
- Quality – In any service, high standards of care and treatment are necessary and this should be reflected in outcomes;
- Cost effectiveness – Services must give value for money and limited resources make economies of scale important.
  (Mental Health Commission 1998)

One of the government strategies to provide quality health for Māori is the development of a Māori workforce of trained mental health professionals. Te Rau Matatini has been established and provides a national training centre for Māori mental health professionals. (Mental Health Commission 2003). A larger trained Māori mental health workforce would greatly increase the health system's ability to provide counselling and other support to whānau within the community and District Health Board setting.

The Māori Mental Health National strategic framework Tu Puawaitanga was designed for DHBs to plan and manage mental health services for Māori:

- to provide comprehensive clinical, cultural and support services to at least 3% of Māori, focussed on those who have the greatest mental health needs
- to ensure that active participation by Māori in the planning and delivery of mental health services reflects Māori models of health and Māori measures of mental health outcomes
- to ensure that 50% of Māori adult tangata whaiora will have a choice of mainstream or kaupapa Māori community mental health service

- to increase the number of Māori mental health workers, including clinicians by 50% over 1998 levels
- to maximise opportunities for intra- and intersectoral co-operation

(Holdaway 2003)

With the increase of Māori service providers there is a greater need to improve liaison between mental health services and Māori providers. Individuals with mental illness will need access to the most appropriate service and the transition from one service to the next should be seamless (Holdaway 2003, Ministry of Health 1995b). Holdaway states that new mental health specialist roles need to be developed for early intervention. These may be of great benefit to the individual and the whānau members affected by suicide attempt.

When mental health consumers were asked who were the most helpful in their recovery they suggested that Mental Health workers were the most helpful followed by GPs, Psychiatrists and Psychologists. Māori spoke of the value they gained from learning about the Māori culture which helped strengthen their identity and build self esteem for some it was a spiritual connection to Te Ao Māori (Mental Health Commission 2002). In addition, Māori commented that they valued Māori Mental Health workers and traditional healers who used cultural models that made a big difference to their recovery. One client commented that it was just another Māori face which helped him calm down and help in his recovery (Mental Health Commission 2002). Culturally appropriate models and frameworks are likely to provide the best support to Māori mental health consumers. Māori mental health services and models of wellbeing are likely to provide the best support for whānau affected by a loved one's suicide attempt.

The Ministry of Health has funded family strategies that encourage whānau involvement and participation in the decision making process and evaluation of mental health services. Family advisory services are designed to provide peer support and education to families and advisory services within the DHBs. This raises the question how many Māori family advisors are part of this scheme? And how do whānau access this service? (Mental Health Commission 2003a). Moreover, DHBs have a mandate under the Mental Health Act 1999 to actively involve families in the care of their loved ones yet most DHBs fail to offer support services to whānau under stress (Mental Health Commission 2003a). This gap needs to be closed in relation to whānau affected by suicide attempt.

7.4.3.1 Narrative Therapy

A report exists of the narrative therapy provided by one Māori health provider, Te Whare Marie (part of Capital Coast Health, located in Porirua) to the whānau of a boy who had attempted suicide. Narrative therapy based on Māori mythology uses the stories of the atua (gods) to discuss and debate similarities between the challenges, trials and tribulations the atua face and the challenges and tribulations the clients face. The process acknowledges the spiritual foundation of Māori whānau and utilises meaningful Māori metaphors. (Laing et al 2002, Cherrington 1999). Such metaphors may provide useful tools for some whānau to address emotions arising from suicide attempt.

In the article *Narrative Therapy: The interface of Tikanga Māori and Clinical Psychology Workshop* psychologist Lisa Cherrington discusses the effective use of narrative therapy using Māori mythology with a 10 year old Māori boy who had attempted suicide. Therapy involved bringing the parents and their son together (Cherrington 1999). There were multiple issues the parents had previously separated and a consequence was that the boy saw less of his father and had difficulty making friends at school. Cherrington used narrative therapy to discuss and debate similarities between the challenges, trials and tribulations the atua face and the challenges and tribulations the boy faced. A video of the performance was made by the boy's father and the video was considered a family taonga (treasure). The mother gave permission to share the story of her son's recovery particularly, if it could help other young Māori tamariki and rangatahi (Cherrington 1999).

7.4.5 Other sources of support

Most of the focus in suicide support services is on prevention rather than support after attempts. The literature suggests services offering post attempt are few and fragmented. Community development groups that are part of the national Kia Piki te Ora o te Taitamariki Youth Suicide Prevention Strategy may include post attempt support for whānau in an ad hoc way in response to need, but do not appear to have a formal mandate or funding to do this work yet (Department of Internal Affairs 2003).

We are aware of two other services that provide support for whānau as part of a wider kaupapa: Te Mauri o Ueneku (a community group) and Te Rākau Hua o Te Wao Tapu (a marae based camp for rangatahi). As far as we know no evaluations have taken place.

7.4.5.1 Te Mauri o Ueneku – Rainbow of Life

Te Mauri o Ueneku has been established by people who have been affected by suicide and is based in Gisborne. Its kaupapa includes provide education, information, support to whānau affected by suicide. Underpinning the vision of Te Mauri o Uenuku are the 4 key Māori components of wellbeing: wairua – spiritual; mauri – physical; hinengaro – mental & emotional and allow family/whānau to encircle you with aroha – relationships, love & support. Te Mauri o Ueneku attempts to refer individuals and whānau to appropriate professional services if required, but does not offer these services itself **(**Te Mauri o Uenuku 2003).

7.4.5.2 Te Rākau Hua o Te Wao Tapu

Part of the literature review involved meeting with the staff and students at Te Rākau Hua o Te Wao Tapu (Te Rākau) health camp in Foxton. Te Rākau is managed by Jim Moriarty who has extensive experience in theatre marae, and working with youth at risk. The main concept behind theatre marae is to use historical and contemporary performance methods and practices of both Māori and Pākehā to draw together a common kaupapa (Te Rākau, 2003b).

Participants have faced multiple traumas or difficulties, including being affected by suicide attempt. Some expressed the view that facilitated peer support groups such as those provided as part of Te Rākau were helpful in resolving various issues, suggesting

that holistic initiatives such as Te Rākau may also provide support for some of those affected by suicide. (personal communications, 2003, see also Edwards et al, 2003). Such a programme, and the follow up provided to participants should, however, be subject to evaluation.

7.4.6 Coordination

Currently coordination of services exists at a District Health Board (DHB) level in some areas. Social workers and counsellors aim to work as a dedicated team to facilitate links between clinical services and community groups. Social workers work closely with clinicians (psychologists, psychiatrists) mainly in the area of family support (Taufua, personal communication, 2003). This type of coordination has limited usefulness for those whānau who are not already in contact with DHB services.

In a personal communication with social worker Ben Taufua we were told of the gaps within the volunteer service. For example, the aunt of a young rangatahi who had attempted suicide telephoned Youthline for advice and support. The response from Youthline staff was 'you will just have to cope with the situation' which was far from satisfactory (Ben Taufua personal communication 2003). This highlights the difficulties whānau members may face when trying to find practical support from volunteer services. Appropriate training and quality accreditation may improve the quality of crisis response for organisations like Youthline in this situation. In addition, postal information packs which contain directions for practical support or advice may also be worth considering.

7.5 Directions for providing support for Whānau affected by suicide attempt

Māori whānau need to have access to types of support services that can facilitate the healing process and well being of the group. Support to assist their loved one and maintain their wellbeing is needed.

Durie suggests that the way forward for Māori health is a two pronged approach the first is the enhancement of whānau potential and the second is the conversion of whānau dysfunction into less harmful patterns. There are 4 patterns of whānau dysfunction:

(1) Whānau tu kino (unsafe families)
(2) Whānau wewete (laissez-faire families)
(3) Whānau pohara (marginalised families)
(4) Whānau tu – mokemoke (isolated families)

The solution is a whānau healing framework employing Māori methodologies and models of well being which are discussed later in this paper. These frameworks have been applied in some household settings where violence, alcohol & drug, physical and sexual abuse have occurred. While the framework is not a panacea for all mental health problems it has delivered positive outcomes for a number of households (Durie 2001).

Access to mainstream services may be the preferred option for some whānau members affected by suicide attempts but is unlikely to offer effective and acceptable support to

all. Some Māori have a strong preference for kaupapa Māori services (Ministry of Health 1995a, Durie, 2001).

7.5.1 Māori Models of Well-being

Both mainstream and kaupapa Māori services need to take account of Māori models of wellbeing. Māori view wellbeing broadly and take the holistic view that the physical, emotional, physical, spiritual and mental aspects of a person are interconnected and related. Māori advocate that the World Health Organisation (WHO) take a much broader view of health and recognise the value of spirituality/wairua and whānau (Dyall 1997).

Developments in Māori health services, particularly in Māori mental health and community development, provide frameworks and directions within which support services for Māori whānau affected by suicide might be developed (Raphael & Swan, nd).

Four widely adopted models of health have been developed over the past 15 years as a result of hui and consultation with Māori. They are interrelated, and illustrate holistic Māori worldviews of health in simple metaphorical forms. All emphasis the importance of whānau and, therefore, provide useful frameworks for offering services to both an individual who has attempted suicide and their whānau. This holistic approach is appropriate. A brief description follows.

7.5.1.1 Te Whare Tapa Wha

This model was developed by Mason Durie in consultation with Māori. The whare represents the four walls of a house which symbolise strength and balance. Each wall represents a different dimension of health taha wairua (spiritual wellbeing), taha tinana (physical wellbeing), taha hinengaro (mental wellbeing), and taha whānau (family well being) (Durie 1998, Ministry of Health 1995b, Dyall 1997).

7.5.1.2 Ngā Pou Mana

Ngā Pou Mana works on the proposition that for a group of people to be healthy they rely upon appropriate social and economic policies being in place (Dyall, 1997). Policy needs to acknowledge the importance of whānaungatanga (extended family), taonga tuku iho (cultural heritage), te au tūroa (physical environment) and turangawaewae (land base/source of identity). The foundation for Māori identity is grounded in the knowledge of the atua. (Love, 1999, Durie, 2001). This model could be taken to imply that those with a knowledge of atua (gods) (who are likely to be suitable Māori health workers) may be the people best placed to support whānau by suicide.

7.5.1.3 Te Wheke – Rose Pere's Model

Developed by Rose Pere, Te Wheke uses the symbol of the octopus with eight tentacles. The head of the octopus is whānau, iwi and hapū. Each tentacle represents an element of healthy selfhood and suckers on each tentacle represent various elements, overlapping and intertwined. Woven together the dimensions provide strength, support, cultural and social framework. The eight dimensions are wairuatanga (spirituality), mana ake (unique identity), mauri (life force), whānaungatanga (extended family), tinana (physical

wellbeing), hinengaro (mental wellbeing), whatumanawa (emotions), and ha a koro mā kui mā (inherited strengths) (Love, 1999, Dyall, 1997).

Individual healthy selfhood intertwines with and is inseparable from the health of the whānau and conversely, so that each permeates through the other to hapū and iwi. Wairua is the source of life and has the potential to sustain well being and counteract evil. Sustenance at all levels is required for health and wellbeing (Love, 1999, Durie, 2001, Dyall, 1997).

7.5.1.4 Model from Te Ara Ahu Whakamua hui

A fourth model was developed at the Te Ara Ahu Whakamua hui and builds on the above three models. In this model Māori health exists when Māori have a strong sense of identity, self esteem, and control over their destiny, knowledge of te reo Māori and tikanga, economic and whānau security and a voice that is heard (Dyall, 1997).

7.5.1.5 Poutama

Not all Māori who attempt suicide will be hospitalised. Those who are may have contact with social workers who may play a key role in facilitating the recovery of both the patient, and their whānau (Watts, Anson and Battistel 1997). A review of the work undertaken with the Māori social work teams at Auckland Hospital highlights the successful integration of Māori traditional models within existing social work practice: Poutama a traditional Māori process is used with existing social work practice to help rehabilitate trauma patients in an acute hospital setting (Blair and Harrop 1999). This model could have application within the context of providing support to whānau post suicide attempt.

The theme of respect and responsibility to whānau is an overriding principle in the development of the service. This principle forms the basis of the relationship between social worker the patient and whānau (Blair & Harrop 1999). The role of the social worker is to reduce the impact of the psychological and social trauma brought about by the injury and intervene where necessary by identification of post-trauma and reduce the risk.

Poutama is based on Māori spiritual and cultural beliefs using a 7 step framework:

1. Karakai (prayer to recognise the spiritual aspect of the patient and whānau)
2. Mihi (establishes the relationship between patient, family & social worker)
3. Whakapuaki (to uncover emotional issues that may need to be normalised)
4. Whakatangi (whānau taking responsibility/control for daily or practical issues)
5. Whakaratarata (identify short or long term implications of the trauma encourages positivity)
6. Whakaora (emotional, physical healing between family and patient & discharge plans).
7. Whakaaoti (signals the completion and discharge of patient, family and liaison with community support services.

(Blair & Harrop 1999).

The recovery and well-being of patients and whānau involves a journey that balances the needs of whānau, patient and the hospital. Social workers have developed 5 outcomes to ensure that when a patient and whānau leave hospital they are:

- grounded in reality
- remember the journey
- have realistic plans for the future
- understand trauma responses
- resourced for the future

(Blair & Harrop 1999).

Social work interventions may include assessment of previous trauma history, assessing the family's coping ability and ability to take in information, and obtaining and providing information about the patient. The literature suggests that the family is an important part of the patient's recovery and it is important to support whānau and ensure whānau needs are addressed (Blair & Harrop 1999).

7.5.2 Effective health services for Māori

He Aha Ngā Ratonga Hauora Whai Mana provides a useful and unique framework to describe effective health services for Māori, from a Māori consumer perspective. It proposes a model with three key elements (1) technical or clinical safety and monitoring; (2) structural and systemic responsiveness and; (3) consumer satisfaction (Ministry of Health, 1995a). A detailed checklist for implementing this framework is discussed in *He Taura Tīeke – Measuring Effective Health Services For Māori* (Ministry of Health 1995b).

7.5.3 Information resources for Māori

Whānau may benefit from having information about suicide attempts, risk factors and prevention. *Kia Whai Te Maramatanga – The Effectiveness of health messages for Māori* provides a useful guidance for developing information resources for Māori (Ministry of Health, 1994).

7.5.4 Mainstream Counselling Approaches

Mainstream counselling services may be useful to some whānau members. In relation to psychotherapy, Durie notes that since the discipline's origins are European, 'the more acculturated a client is in term of middle class Western values, the more comfortable the therapeutic relationship is going to be' (Durie 2001). This is likely to hold true for other forms of mainstream counselling as well.

Mainstream counselling services have increasingly attempted to be responsive to Māori. Some include bicultural approaches (the coming together of two worlds both Māori and Pākehā and blending the two systems into one). There are, however, risks that bicultural counselling therapy may marginalise Māori as power relationships between client and practitioner are out of balance, services may remain eurocentric in view and links between Māori concepts may be blurred (Durie 2001).

In recent years some mainstream services have acknowledged Māori models of wellbeing in tangible ways, such as incorporating Māori kaupapa health initiatives or by working closely with external kaupapa Māori services (Ministry of Health 1998, Mental Health Commission 1998).

7.5.5 Kaupapa Māori Counselling Approaches

Kaupapa Māori counselling approaches provide an alternative mainstream approaches, and may be more acceptable to some Māori whānau members. Proponents of Kaupapa Māori counselling approaches argue that Māori counsellors are able to make connections with Māori clients that won't be achieved by non-Māori (Mahoney, 1998). The rationale is that that mainstream counselling does not match the needs of Māori and often misses the clues and subtext of the individual's mental health. Moreover Māori mental health tends to manifest differently than non-Māori, and because of this mental health issues may not be detected easily or identified. (Love 1999, Hope 1998, Donovan 1997, Durie 2001, Mohi, 1999).

Māori counsellors can draw on networks and communities with local knowledge of the whānau and of the historical or contextual issues that have a direct bearing on the wellbeing of a whānau or individual. This approach is adopted in suicide prevention work in prison where links and networks will be built with an inmate to support and protect them (Love 1999, Durie 2001).

Love identifies three essential concepts underpinning Māori counselling models: (1) Whānaungatanga (extended family), (2) Whakamānawa (encouragement) and (3) Mauri (spirit). Because the emphasis on whānaungatanga, this approach may offer more to whānau of the suicidal person than counselling approaches focussing solely on that individual. These therapies are sometimes called kaupapa Māori psychology (Love 1999).

Within the framework of kaupapa Māori counselling a number of therapies have been developed. Mauri therapy is a broad term to describe different types of Māori healing. Often the therapy may include the use of narrative and cultural traditions to instil a sense of identity and belonging (Durie 2001).

Paiheretia is a way of facilitating access to wairua, hinengaro, tinana and whānau through Māori institutions and culture. The process includes gaining knowledge, valuing healthy living and establishing greater contact and liaison with whānau. It also addresses conflict resolution (Durie 2001). Some of these issues may be relevant to some whānau members affected by suicide attempt.

While there does not appear to be formal evaluation of the effectiveness of these kaupapa Māori counselling methods this may be because the approaches are still in their infancy. Proponents of kaupapa Māori counselling argue that it is worth pursuing based on its strong theoretical foundations in Māori kaupapa and because it offers an alternative to the mainstream services that are not working for many Māori (Durie 2001).

7.5.6 Tohunga

Tohunga (healers) are now attached to some District Health Boards and provide traditional massage and natural herbal remedies which may reduce stress and increase well being. They have been widely used by Māori inmates in prison (Department of Corrections 1996a). Durie states that Tohunga are able to bring a spiritual dimension to healing seldom evident in conventional therapies (Durie 2001).

The option of seeing a tohunga acknowledges Māori and Pākehā different world views and the need to provide access to Māori traditional therapies to maintain well being (Love, 1999). The literature suggests mainstream clinicians need to work with Tohunga or Māori therapists to provide a range of services (Mental Health Commission, 1998).

7.5.7 Canadian Native American Models

Suicide postvention programmes for Native Americans have been developed in Canada since the 1980s (Leenaars 2000). The Anne Edmunds program, run in association with the Canadian Mental Health Association, now works with communities and on a national level to support families by running educational programs (Leenaars 2000). It appears that this programme provides postvention services as an addition to existing community based suicide prevention work.

It would be possible for a similar model to be adopted in New Zealand by adding postvention services to existing suicide prevention services. As noted above, some of these services may be offering some ad hoc postvention support already, although, with the exception of Pacific World they have never been contracted to do so.

7.5.8 Respite Care

Respite care for whānau and significant others affected by suicide attempt should be considered particularly in cases where there is a high risk of further suicide attempt. Respite care must be culturally appropriate as whānau will not experience respite if they are uncomfortable with the care their loved one is receiving.

7.6 Conclusions

There was no literature found on Māori whānau experiences of suicide attempts.

Whānau are likely to be living in stressful situations post suicide attempt, yet very little is currently available to them. On-going support is currently only available on an ad hoc basis. Organisations like Pacific World, Te Mauri o Ueneku (a community group) and Te Rākau Hua o Te Wao Tapu are only available to a very few.

Whānau and community appear to provide the most important source of support to whānau affected by suicide attempt. Cultural beliefs about whākapapa and atua and appropriate kawa remain important to many Māori whānau. To provide effective support, mental health workers and care givers should be aware of these values. They need an awareness of how whākapapa whānau and kaupapa whānau function in order to understand who the affected people are. Access to local kaumātua, tohunga and Māori

cultural advisors may also be useful to facilitate coordination of support for those whānau who wish to follow traditional protocols.

Effective coordination is essential if on-going support for whānau is to be provided. Although some whānau may access support and information through GPs, this is likely to be a less effective means of access than for mainstream families and significant others. Social workers or mental health workers involved in the care of the individual may be better placed to offer support of the whānau, or direct them to appropriate support. Where the attempter is under mental health care, assessment of initial whānau needs could be done by that team.

Resources exist at a District Health Board through Kaupapa Māori services yet the uptake of resources by whānau for support services relating to suicide attempt is hard to measure. Information packs and promotion of these resources would help raise general awareness amongst whānau and the general population. Issues around access are not only culturally defined but they are also linked to availability of information and education.

Māori whānau may need respite care support services following a suicide attempt by a loved one. A small-scale research project could be carried out on this topic. Possible needs include culturally appropriate counselling, peer support, financial assistance, and access to culturally appropriate respite care.

The stigma associated with mental illness is likely to be a source of stress for whānau affected by suicide attempts. Liaison between Māori mental health workers and the whānau may help to reduce stress levels and increase understanding.

Mainstream and kaupapa Māori counselling models both offer potential approaches for supporting whānau affected by suicide attempt. Some writers strongly advocate the use of kaupapa Māori approaches, and these may be more acceptable and relevant to many whānau. The diversity of modern whānau, however, means that a choice of service types is preferred. Close liaison between kaupapa Māori and mainstream services is required to ensure that services are coordinated and that whānau are aware of the choices available to them.

In order to provide effective support to whānau, trained Māori counsellors with specialist skills in mental health issues are required. The current Māori mental health workforce development plan may address this issue. In addition, mainstream support services need training in Māori issues and access to on-going support from appropriate kaumātua or Māori advisors. There will be whānau who will not necessarily want counselling per se the important factor is to provide choice.

District Health Boards need to be more responsive to the needs of whānau in both the initial assessment and support post suicide attempt. District Health Boards or mental health specialists should be involved in the initial assessment and the wellbeing of their whānau..

All services providing support to whānau affected by suicide attempt should receive on-going evaluation. In addition, given the lack of literature on the experiences and support needs of whānau affected by suicide attempt it would be helpful to commission field research on this topic.

8 Supporting Pacific Families and Significant Others who have been Affected by Suicide Attempts

8.1 Who are Pacific Families and Significant Others?

Two questions of definition need to be addressed. One is who are Pacific peoples? The other is, who are the families and significant others affected by suicide attempts?

8.1.2 Cultural Identity

It has frequently been noted that 'Pacific people' and related terms (such as Pacific Islanders, Pacific Islands peoples) are labels of convenience that have been developed by agencies, primarily in New Zealand, for the purposes of administrative simplicity. The terms are not ones traditionally used in the islands of the Pacific. Many older Pacific people object to the term Pacific Islanders, in particular, because of the negative connotations it has historically carried in New Zealand and because distinct island identities are lost within it. Younger, New Zealand born Pacific people are more likely to self-identify with the term Pacific Islander (or with the abbreviated label 'PI,') or 'Polynesian' although island group differences (and sometimes differences within island groups) continue (Bathgate & Pulotu-Endemann 1997, Anae 2001).

In this report, the term 'Pacific people' is used for statements that appear to be generic across most island groups. Examples for specific islands groups are given under separate subheadings (expect where the examples are too brief to warrant a separate heading).

Half of the Pacific people living in New Zealand identify as Samoan. The next biggest groups are Cook Islands Māori, Tongan, Niuean, Fijian and Tokelaun. The majority of Pacific people in New Zealand were born in New Zealand (Macpherson et al 2001).

A significant proportion of New Zealand-born Pacific people identify with more than one ethnicity, particularly with more than one Pacific ethnicity, with mixed Pacific-Māori ethnicity (1 in 5 new-born Pacific babies is also Māori), or with mixed Pacific-European ethnicity. Mixed ethnicity is also a factor for some island-born people. This may include Chinese ethnicity as well as multi-island group or European ethnicity. Many writers note that younger Pacific people identify closely with their Māori associates (Macpherson et al 2001, Anae 2001).

These factors highlight the complexity of discussing the support needs of Pacific peoples and the importance of not imposing rigidly classified solutions. Any support services should be designed to meet the needs of this diverse population and allow for flexibility and choice.

It also needs to be noted that Fijian Indians are classified as 'Asian' in New Zealand census data (Macpherson et al 2001) and so come under the 'Asian' section of this report.

Religion is integral to most Pacific people's way of life. For example in the 1996 census, 89% of Pacific people stated that they belonged to a religious group, compared to 72% of the total population (Macpherson 2001 et al). The church, the minister and the church

organisational hierarchy are a central pole on which identity is built. Belief in God and the power of prayer are essential parts of life for most Pacific people (Tofi 1996). Nevertheless, there are individual and island group variations in religiosity. For example Malo found that the Cook Islands Māori mental health consumers he spoke to did not feel as strongly linked to the church and Christianity as the Samoans (Malo 2000).

8.1.3 The meaning of Family

The extended family is an essential building block of most Pacific societies and is integral to the identity of most Pacific people in New Zealand (see for example, Mental Health Commission 2001). Malo writes:

> With the important role of the extended family in the lives of Pacific Islanders, cousins become their friends, the elders become their leaders, and the extended family as a whole, becomes the community. Pacific Islands cultures are different from almost every other culture in New Zealand because the extended family plays such an important role in their lives. (Malo 2000)

Terms for family include aiga (Samoan), famili (Tongan) and kōpū tangata (Cook Island Māori). The idea of family incorporates concepts of genealogy and lineage which are very important in most Pacific cultures. These concepts link people together and also link them to particular places (Tamasese et al 1997, Mitaera 1997).

It is likely that the collective extended family identity means that the number of families and significant others who are intimately affected by a suicide attempt may be significantly higher than the hypothetical 6 suggested by mainstream researchers (Beautrais 2004a & 2004b).[2]

In New Zealand, institutions such as the church and cultural organisations may be important in fulfilling some of the functions of the extended family and village in the home islands (Tavalia 1997).

In recent times, cheap airfares and the development of the internet have allowed families to develop a transnational, corporate character, offering continuing links between branches of the family that remain in the home island and those that have migrated to New Zealand and other countries (see for example, Anae et al 2002). Support for families may have to address transnational issues as the individual who attempted suicide and concerned family members may not live in the same country.

Interactions in Pacific cultures tend to be governed by relational rules (see for example, Tamasese et al 1997). The cultural definitions of relationships will affect both the impact of a suicide attempt on different members of the family and the way support can best be provided to the family. As well as support for individual family members, support for the family as an entity may be important (Bathgate & Pulotu-Endemann 1997).

[2] Beautrais notes that 6 is likely to be an underestimate for the general population. It may be even more of an underestimate for Pacific people.

8.1.3.1 Samoan

The relational being is essential to Samoan identity:

> 'I cannot say that I am a person, just me; (because) then I will be nothing without my other connections'
> (Samoan man quoted in Tamasese et al 1997)

In Samoan communities relational rules govern the interactions between parents and children, brothers and sisters, and matai and untitled people:

> The Samoan self is described as reliant on relationships that are occurring in the va, or "space between"—between the self and parents, siblings, grandparents, aunts and uncles, other extended aiga (extended family members) in New Zealand, the homeland and abroad, church/neighbourhood communities, friends, peers, and wider New Zealand society.
> (Anae et al 2002)

Tiatia et al describe the core values of aiga as:

> Fa'aaloalo (respect);
> Loto alofa (love, compassion);
> Fealofani (harmonious relations);
> Tautua (service);
> To'aga i le lotu (commitment to Christian life and the church).
> (Tiatia et al 2002).

8.1.3.2 Tongan

Foliaki writes that in Tongan communities,

> The basic social unit is the 'famili' or extended family made up of grandparents, parents, children, and aunts, unmarried cousins from both sides of the family. The nuclear family has no equivalent in the Tongan world.
> (Foliaki 1999)

Eighty six percent of Tongans live in family units compared to 73% of the rest of the population (Foliaki 1999). Relationships within the extended family are traditionally highly structured:

> The extended family structure is ranked, and in this ranking the women were ranked higher than their brothers' and their brothers' children. The father's eldest sister had the highest status within the family and was accorded 'fahu' status. The fahu was defined as the person with unlimited authority over others within her blood kin. This meant in social terms that this woman and her children had the right to ask and expect goods and services from her brothers' and mother's brothers.
> (Foliaki 1999)

Nevertheless, there is diversity among Tongan households in New Zealand. For example, there has been a recent rise in the number of single parent Tongan households, outside the extended family structure (Foliaki 1999). The specific needs of the individual family should be considered in service provision.

8.2 Suicide Attempts Amongst Pacific Peoples

8.2.1 Suicide Attempts in Pacific Island Countries

Suicide has traditionally existed in many Pacific cultures although the nature of suicide risk factors and the meanings attributed to it have changed significantly in some (Rubinstein & White 1985, Macpherson & Macpherson 1985). Although there is some data on suicide attempts, it is limited and not particularly robust (see for example Bowles 1985, Vivili et al 1999).

Suggested reasons for suicidality among Pacific youth include the belief that there is no-one with whom to discuss emotions, the stress of social change, and pressures from peer, study, family, culture and religion (Bourke 2001).

In most Pacific countries more females attempt suicide than male, but this is not the case in Western Samoa (Aghanwa 2000, Booth 1998, Booth 1999).

8.2.1.1 Samoa

According to Bowles, in the 1980s there were close parallels between completed suicides and attempted suicides in Western Samoa. This contrasts with Western European cultures where they appear to be more distinct populations in terms of social and psychological profiles (Bowles, 1985). In the early 1980s the number of completed suicides in Western Samoa was nearly identical to the number of suicide attempts. Self-poisoning, which is usually a feature of attempted suicide, is the dominant method of completed suicide in Samoa. Paraquat, the particular agent often used in Samoa is highly fatal, thus it is possible that some people die by suicide who might survive if a different agent was used (Bowles 1985).

In contrast with most other countries, in Western Samoa females were less likely to attempt suicide than males. But the high fatality of the method used meant that Western Samoan females had a relatively high suicide rate. In 1988-91, 46% of youth suicidal acts were female, which a nearly identical proportion of youth suicides being female (Booth 1998, 9, Booth 1999)

Several writers have commented on reports of a young person being ‘musu’ towards a parent prior committing suicide (White 1985, Macpherson & Macpherson 1985). White describes musu as

> a culturally defined way of feeling and acting in response to conflict with someone in authority, especially parents, toward whom one owes love and respect and should not express anger. (White, 1985)

It expresses a reluctance to do what is asked of one and involves withdrawal. White notes that,

> Labeling a child *musu* may lead a parent to lessen demands or criticism, thus keeping the level of conflict low. According to Freeman, Samoans themselves recognize that suicide is a potential outcome of extreme *musu*, which is another reason that the attribution of serious *musu* may evoke attempts at minimizing or resolving the conflict. (White, 1985, 6)

It is not clear if musu is also a factor in suicide attempts. But if it is, the family may react with particular culturally prescribed responses. According to Macpherson and Macpherson, people around will try to heal the rift, but will do so in a way that makes the adult appear generous and not in retreat. This, they argue, may not be sufficient to meet the young person's expectations (Macpherson & Macpherson 1985).

One Western Samoan suicide prevention programme sought to reduce suicide through changing power structures. The programme showed a greater reduction in suicidal behaviour for females than males, and the reduction for females was mainly due to improved communication (Booth 1999). The literature did not detail the response of families to these changes in power structures. It may be that families need support to accept such change.

The importance of offering counselling for family members affected by attempted suicide has, however, been recognised in Samoa and is available through the Mental Health unit at the National Hospital and from the Community Health Nurse Service (Bourke 2001). The exact nature of these services and their effectiveness is not clear.

8.2.1.2 Fiji

A study of suicide attempters admitted to the main general hospital in Fiji found that over 60% had social problems and/or mental illness. They tended to be young, and over fifty percent had a strong intention to die. Over thirty percent were ethnically Fijian. The majority were female (Aghanwa 2000).

8.2.2 Suicide attempts among Pacific people in New Zealand

Suicide was the second leading cause of injury for Pacific people in New Zealand in 1996-98. Suicide attempts ranked as the third leading cause of hospitalisation among young people between 1993 and 1998 (Tiatia et al 2003). Hospitalisation data for attempted suicides by Pacific peoples in the 1996/97 year showed there were 93 in-patient and day-patient hospitalisations for self-inflicted injury in the Auckland region. The majority were female and the highest rates occurred for females aged 15-19 years. Hospitalisation data is, however, of limited usefulness as it does not include those who presented to Emergency Departments, general practitioners, traditional healers, private accident and emergency clinics, or those who did not seek any treatment. Moreover, some misclassifications of ethnicity are also likely to have occurred (Tiatia & Coggan 2001).

According to Bathgate and Pulotu-Endemann suicide by Pacific people appears to,

> centre around unresolved family conflicts, inability to meet family and social obligations, shame resulting from misdeeds, sexuality and sexual conduct, failure to meet unrealistic expectations, low self-esteem, abuse, conflict between traditional ways and adopted new ways and constraints or demands placed by the church. (Bathgate & Pulotu-Endemann 1997)

Tiatia et al have carried out in-depth research into young Pacific people who presented at Auckland public hospital emergency departments following suicide attempts (Tiatia & Coggan 2001, Tiatia et al 2002, Tiatia et al 2003, Tiatia et al nd) Health Research Council nd). In a study of 56 Pacific people they found that 71% were female, just over half identified as Samoan (roughly in line with the population distribution), and 43% were employed (Tiatia & Coggan 2001). Fifty-six percent of the attempters lived with aiga (Tiatia et al 2003). The research indicated that 'aiga may be a young person's only unit of support, even if it may be a damaging environment' and that emotional repression, embedded in cultural codes of conduct, imposes a negative impact on these young people (Tiatia et al 2003).

The great majority of people in the general population who make serious suicide attempts have a recognisable psychiatric disorder at the time of the attempt (Beautrais 1998 & 2000). Following a suicide attempt, they have high rates of admission to psychiatric hospitals, high up-take of social welfare benefits, high levels of reported relationship problems and high levels of legal problems and criminality. They also have elevated risks of making further attempts, and of dying from suicide or other causes. (Beautrais 1998 & 2000). No comparable studies were found assessing outcomes for Pacific people who have attempted suicide, so we do not know how applicable these findings are to that population. If a significant proportion of Pacific people who make suicide attempts do have a psychiatric disorder, it is likely that the families will face the strains in dealing with this.

According to Tiatia and Coggan it appears that, in contrast to the general population, Pacific people who are employed may be more at risk of suicide attempts that those who are unemployed. This, she argues, may be because of the commitments employed Pacific people have to family, church and community through fa'alavelave. Being the eldest in the family also appears to increase the risk of suicide attempt (Tiatia & Coggan 2001, Health Research Council nd)

8.2.2.1 Samoan

Tiatia et al analysed medical records 27 Samoan young people who had attempted suicide and interviewed 20 of them, looking specifically at the role of aiga in their suicide attempts. Notes from Tiatia's Powerpoint presentation to SPINZ indicate that aiga play significant roles both in terms of placing these young people under intolerable pressure, and offering positive associations that provide reasons for young people to live. The

researchers identify key themes of, the importance of aiga, obligation, duty, communication, and intergenerational misunderstandings (Tiatia et al 2002).

Pressures cited by informants as precipitating suicide attempts include: responsibility placed on the eldest child to care for the family, failure to live up to family expectations in academic or sporting life, a belief that they are letting the family name down, inability to communicate with parents and lack of parental attention due to parents' work commitments (Tiatia et al 2002)

One informant stated,

> Family is really important, without them you're nothing and they're always there for you at the end of the day, but man! Can't they just give us a break! ... In the end I couldn't balance everything at once, so I just did what I did – just kill myself or basically just wanting to escape.
> (cited in Tiatia et al 2002)

Several writers have noted that young Samoans striving for success in the Palagi world face particular stresses in meeting their cultural obligations to their extended family. Taule'ale'ausumai states that credit for career success is ascribed by Samoan culture to the parents and not the individual. He writes,

> How can one pay a mortgage and still contribute a substantial amount of money to the church and the extended family commitments (*fa'alavelave*)? Samoan philosophy often expects the individual to pay up today and worry about tomorrow when it comes...
> What can eventuate is that the individual is confronted with a choice of fulfilling either extended family obligations or personal commitments. Every choice will result in conflict with a higher authority. To choose to fulfil personal commitments may result in alienation from the family for the interim or even a permanent period of time.
> (Taule'ale'ausumai 1997)

8.3 Pacific Peoples Experiences of Suicide Attempts by Family Members and Significant Others

No research was found that focused specifically on the experiences of Pacific people affected by the suicide attempt of a family member or significant other. But inferences can be drawn from related literature. Tiatia and Coggan note that 'in some communities, discussing suicidal behaviour can be considered taboo' and associated with shame, guilt and stigmatisation (Tiatia & Coggan 2001). This would place stress on families following a suicide attempt and may make it difficult for them to access support.

It is likely that some of the issues identified in literature relating to other cultures (mainstream New Zealand and international) may also affect Pacific families. For example, the literature suggests families do not know what to do if they fear that an individual who has previously attempted suicide might do it again (Beautrais 2004).

Given Pacific people's lower levels of access to general practitioners (GPs), unease about the mental health system and lower awareness of what services are available this could be a significant issue for Pacific families (Tofi 1996, Young 1997, Toafa et al 1999, Crawley et al 1995). Research is needed to see if this is in fact the case.

Moreover, Beautrais notes that one study found that the families that were worst affected by suicide attempts were those that had compounding problems such as financial stresses. Given the low economic status of most Pacific families, they may well fall into this category (Tofi 1996, McCarthy 2001, Foliaki 1999).

8.3.1 The Centrality of the Family

In situations where relational factors precipitated the suicide attempt, families and significant others, as well as the individual who attempted suicide, may be left with unresolved issues relating to the precipitating event. This is also likely to be the case where family dysfunction is present (see Beautrais 1998, Beautrais et al 1996 & 1997). To support these families it may be necessary to address these issues. It is important, however, for support services not to stigmatise affected families and significant others by assuming family dysfunction.

Given the significance of family and relationships as both precipitating factors in suicide attempt and as factors young Pacific attempters identify as offering reasons to live, it would be useful to investigate how families experience the same issues attempters talk about. For example, if young people see their failure to meet family obligations and expectations as factors triggering a suicide attempt, are families forced to reassess their expectations following an attempt, and do they experience disappointment associated with this? If intergenerational conflict and emotional repression are seen by the young person to be issues, how do their elders respond?

Complicating this picture is that fact that suicide attempters in the general population are likely to have fewer family and social supports than non-suicide attempters. This analysis does not appear to have been broken down for ethnicity. It has, however, been suggested that a breakdown in family and the culture that sustains it is a stress factor for Pacific peoples as well as Māori and refugees (Bridgman 1993). The implication is that this very breakdown may decrease mental health, and it is a possible factor in suicide attempts. To support families affected by suicide attempts may involve addressing these bigger issues, as well as the immediate response to the event. This is in line with the *Guidance Notes for Involving Families in the care of mental health consumers* which state that 'the task may be one of re-building family'(Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists 2000, 5). Family members who are unable to effectively support the person who attempted suicide due to estrangement may nevertheless need support themselves.

Other's in need of support, while may include children connected to the attempter. *.A Review of the Evidence: In Our Hands* recommends early intervention programmes with very high risk families as a suicide prevention strategy (Beautrais 1998). It is not clear what impact intervening to address risk factors in families where a suicide attempt has

been made would have, although arguably this may improve long-term outcomes for children within the family.

8.3.1.1 Samoan

Tiatia's research indicates that the aiga and roles within it are of central importance to young Samoans who attempt suicide. Issues identified by Tiatia may also have an impact on families. These include cultural obligations, parent-child communication (particularly the withholding of private experiences and emotion) and roles such as the position of the eldest child and the significance of feagaiga (the brother-sister covenant) (Tiatia 2002). For example, the feagaiga relationship that exists between brother and sister requires a brother to always protect his sister. It may be that a suicide attempt by one party to this relationship may have a particular impact on the opposite sex sibling.

8.3.1.2 Tongan

Foliaki states:

> Within Tongan society suicide is viewed as one of the most traumatic life events that could possibly occur. It is the ultimate rejection of ones family who are left with the stigma that Tongan society confers upon their failure to adequately care and support the victim.
> (Foliaki 1999)

This implies that there may also be considerable distress and feelings of rejection for the family in cases of suicide attempt.

8.3.2 Attitudes towards Mental Illness

In situations where the suicide attempts is associated with a diagnosis of mental illness, cultural attitudes to mental illness may have an impact on how the family deals with the situations.

The literature relating to Pacific conceptions of health, wellness and unwellness, indicates that mental unwellness is often seen as having a spiritual basis, or a basis in an infringement of tapu. Spirits of the deceased are seen as being able to impact upon the living (Bathgate & Pulotu-Endemann 1997). Such spiritual illness could arise from a break down in social relationships (Crawley et al 1995). For example Bathgate and Pulotu-Endemann describe how:

> An illness known as fa'anoanoa ... can occur when there is disruption to, or disharmony within, the family... Fa'anoanoa, or unhappiness is caused by a death or serious illness in the family, by shame, or a feeling of injustice. When a person is fa'anoanoa they are moved by the belief that no one loves them, and they feel compelled to isolate themselves, seldom talking and perhaps becoming unkempt. In its extreme form, fa'anoanoa evokes bad thoughts that are manifested in undirected violence, murder or suicide. (Bathgate & Pulotu-Endemann 1997).

It is unclear to what extent these traditional concepts continue to shape the world views and responses of young and New Zealand born Pacific people. For some they may have little relevance. It would be useful to investigate this and to investigate whether suicide attempts are themselves seen as disrupting harmony and infringing tapu, and whether family members feel themselves to be vulnerable to spiritual ramifications from this.

Bathgate and Pulotu-Endemann write that there Pacific people tend to conceal a family member's mental illness or use traditional methods or assistance from clergy to deal with the matter. Many families feel ashamed, especially if they believe the illness is a result of spiritual factors or social disharmony (Bathgate & Pulotu-Endemann 1997).

Stigma and discrimination are significant issues (Malo 2000, Esera 2001). But families generally continue to support the mentally ill person and struggle to understand what is going on (Malo 2000). One Pacific mental health consumers comments:

> 'The family is actually part of the healing process. Pacific Island parents always like to have contact, they always like to know what's going on and what's happening'
> (cited in Malo 2000)

Nevertheless, there is a lack of knowledge about mental health issues within Pacific communities, and many family members find it very difficult to understand mental health consumers' situations, particularly in relation to clinical diagnosis and medication (Malo 2000).

Parents may continue to expect mentally ill young people to meet their high expectations of success and behaviour (Malo 2000)

8.3.2.1 Samoan

Esera uses 'ma'i aitu' as a term 'for most ailments pertaining to the mind or psyche' (Esera 2001). Mental illness may be seen to result from a curse levelled at an ancestor due to their breach of tapu and sa. In other words, the symptoms may not necessarily be seen until generations after the cause. In these instances, the illness is viewed as having come from the bloodline of the family (Tamasese et al 1997).

In Samoan culture relational arrangements are governed by the concepts of sa (sacred) and tapu. Human beings and the relationships between them are sacred. Tamasese et al write '*Tapu* within relationships between people ensures that the human condition remains in a state of well being' (Tamasese et al 1997) A family member's actions can have negative effects on the health and wellbeing of other family members (Tamasese et al 1997, Esera 2001).

In the case of mental illness, Esera writes:

> As Samoan pride is based on family genealogies, and the bloodlines, imagine the social disgrace and damage to the family name if a family member is being

> diagnosed with a mental disorder that is genetically transmitted! Basically, it means that the whole extended family suffers from it too, as it "runs in the family".
> (Esera 2001)

Esera argues that this belief continues to the present day (Esera 2001).

8.3.2.2 Tongan

Foliaki provides a useful overview of attitudes towards mental illness in Tongan culture. He writes that mental illness is traditionally seen stemming from a breach of tapu, usually through an offence against family, superiors or a sacred symbol or place. He notes that these attitudes may be diluted among young New Zealand Tongans, but are still strongly held by those in the forty-plus age group. In addition, Foliaki states that there is severe stigma associated with mental illness, which may make Tongan families attempt to conceal mentally ill members. (Foliaki 1999)

Despite this spiritual emphasis, Foliaki also offers another Tongan definition of mental illness as being '"the feeling one gets when one does not meet ones social obligations"' (Foliaki 1999). This definition highlights the way in which family and cultural obligations impact on mental wellbeing. Arguably, families may be at risk of this kind of mental illness following a loved ones suicide attempt, due to the sense of rejection and a feeling that they have failed that individual.

8.4 Sources of support for Families and Significant Others after a Suicide Attempt

Taule'ale'ausumai writes of Samoan culture,

> "Who does the caring in an unofficial way?" The answer is everyone – clergy, laity, male and female.
> (Taule'ale'ausumai 1997b)

8.4.1 Family and significant others

Family members may support each other following a suicide attempt. The research by Tiatia et al indicate that young Pacific suicide attempters view family as being of great significance in their lives (Tiatia et al 2003, nd, 2002). It is likely that other family members also see the family in this way. Other writers also note that parents, grandparents and extended family may be turned to for support in dealing with major life events, in preference to health services (discussed in Tofi 1996). Culturally prescribed roles within the family may define who supports whom.

8.4.1.1 Samoan

Tiatia et al's research indicates that it is important to look at role and relationships in terms of support for suicide attempters (Tiatia et al 2002). The same is likely to be the case for other family members. For example the bond between brother and sister may be especially supportive, and the eldest child may take more responsibility for caring for

others (Tiatia et al 2002). On the other hand, formalised roles can limit the type of support sought from whom. For example parent-child communication is seen as a one-way process in Samoan aiga so it may not be appropriate for a child to express anger towards a parent (Taule'ale'ausami 1997a).

Samoan families are likely to use prayers as a means to deal with problems in a general sense and this may include dealing with a family member's suicide attempt (Pacific Health Worker personal communication 2003). The process of prayer may assist the family to communicate. Taule'ale'ausumai writes,

Often prayer may be the only time that provides families with an opportunity to share their concerns on directly with each other, in that by praying publicly to God, others are made aware of needs and concerns of the individual, which would seldom by shared at other times.
(Taule'ale'ausumai 1997b)

Support may be provided in non-verbal ways. For example, Bathgate and Pulotu-Endemann note that Samoan massage is used in cases of illness (including mental or emotional illness) to rebalance life essence that has been disrupted by wrong behaviour. It is often the first step in a healing process and usually performed by a taulasea or older family member, thereby functioning as a coping mechanism and to increase family solidarity (Bathgate & Pulotu-Endemann 1997, Malaulau 2004).

8.4.2 Church

The church is another major source of support. Much has been written about the significance of the church in Pacific culture and families (Tamasese et al 1997, Finau 1999, Culbertson 1997). The minister may be turned to in time of crisis (Tofi 1996). For example Tavalia writes that Niuean pastors in New Zealand take on additional responsibilities as:

> A social worker, an insurance broker, a real estate agent, an interpreter and translator, a friend in court and many other roles ... Sometimes financial support is needed; if the minister has some money he gives it freely and confidentially.
> (Tavalia 1997)

Some writers, however, question the effectiveness of the support some traditional churches provide. The extent of support may be undermined if families feel the need to make offerings whenever the minister visits, or if the hierarchical relationship between minister and the family impedes communication (see for example Taule'ale'ausami 1997b). Furthermore a belief that suicide is condemned by the Bible may limit some ministers ability to provide support for families of suicide attempters.

Many ministers are aware that issues of status, financial obligation and fear of condemnation can interfere with the ability of churches to support families under stress fully. A number have worked extensively to make their ministry relevant to Pacific peoples' modern realities and have been instrumental in addressing delicate issues in

Pacific communities. They are making increasing use of pastoral counselling models to support their parishioners (Culbertson 1997, Finau 1999, Taule'ale'ausami 1997b).

Others within the church may play major roles in supporting families in difficult times. In particular ministers' wives (sometimes referred to as 'lady ministers') and the 'women's fellowships' have roles in supporting the female members of the congregation and dealing with sensitive family issues (Tavalia 1997). But some families find that the church congregation is a place were people gossip and stigmatise them for having a mentally ill member (Malo 2000).

8.4.3 Traditional healers

Many Pacific people make use of traditional healers, although they may deny that they believe in spiritual illnesses out of a desire not to appear 'uncivilised', or because of Christian views (Toafa et al 1999, Esera 2001). The literature describes different types of healers as being responsible for various aspects of mental and spiritual healing (Bathgate & Pulotu-Endemann 1997, Foliaki 1999, Tamasese et al 1997). Healers may be turned to for mental health issues (Esera 2001)

It would be useful to investigate whether families feel empowered if they are able to turn to traditional healers to support the individual who attempted suicide, or for their own wellbeing.

8.4.3.1 Samoan

Traditional healing centres around the re-establishment of relational arrangements as a way of restoring wholeness (Tamasese et al 1997). Samoan families may use traditional healers, such as taulaitu, to address spiritual and mental illness. (Taule'ale'ausumai 1997b, Esera 2001).

Esera describes Samoans as 'a traditional people who simply believe that the only cure for mental disturbance is in locating and eventual exorcism of the bad spirits responsible' (Esera 2001). A taula aitu or a faipele may perform this (Esera 2001)

The healers' skills are passed down through the generations and are seen as a gift from God. Although healers did not traditionally accept payment for their services, the culture of reciprocity means that gifts are now accepted (Esera 2001). According to Esera, in Samoa faipele (card operators) are usually the first people to be consulted in cases of mental disorders. Their services tend to be costly (Esera 2001).

8.4.3.2 Tongan

Foliaki writes that a traditional healer is the first person consulted in the majority of cases of mental unwellness (Foliaki 1999). Thus it is possible that a traditional healer may be consulted before or after a suicide attempt linked to mental illness.

Traditional Tongan healers are given the responsibility of carrying on the healing lineage by their families. They provide their services free. According to Toafa et al, many are very uncertain about their status as healers within the New Zealand context and may feel

the need to be secretive about their work; 'They felt that if one mistake was made by a healer then the whole system would be condemned forever' (Toafa et al 1999). Toafa et al quote one healer who was afraid of being arrested because she thought her work was not legal in New Zealand (Toafa et al 1999).

Toafa et al further argue that trust and faith in traditional healing and the healer are intrinsic to the success of the healing. Analytical explanation, as promoted by Western medicine, is in their view 'in danger of eroding the very heart of the faito'o' and is, they argue, antithetical to Tongan healing (Toafa et al 1999). Traditional treatments are conceptualised as removing the offending substance from the ill persons body, and can involve exorcism to lure out harmful spirits (Foliaki 1999).

8.4.4 General Practitioners (GPs)

Young argues that Pacific families, like their Māori counterparts, have relatively low levels of GP attendance (Young 1997). Furthermore, there are indications that psychological wellbeing and distress do not predict use of health services by Pacific people, suggesting that Pacific people tend not to view psychological distress as a problem for which medical help should be sought (Tofi 1996). These factors may limit the usefulness of GPS as a source of support to Pacific families affected by suicide attempts.

8.4.4.1 Tongan

Toafa et al's research illustrates that for Tongans there is frequently apprehension about visiting a GP. Cost, difficulty attending appointments, language difficulties and different world views all impinge on the ability of many Tongans to access GP services effectively. It is notable that the researchers found that, while most Tongans consulted traditional healers, few Tongans told their GPs that they did so. Tongan patients did not usually tell their doctors what had been prescribed for them by their traditional healers (Toafa 1999). Tongans were also likely to tell their GPs what they believed the GPs wanted to hear (Toafa et al 1999).

The researchers reported that some GPs were trusted by their Tongan patients, but that this very much related to the characteristics of the individual GP. Those GPs who were trusted by their Tongan patients were fluent in Tongan, encouraged their patients to drop in without an appointment, and rang their patients to discuss test results. They found that:

> Through time and trust an ongoing relationship can be developed where the Tongan person will feel sufficiently comfortable to discuss what is really going on in their life.
> (Toafa et al 1999).

8.4.5 Mental Health Services

An individual who has attempted suicide may be admitted to a psychiatric ward or put under the care of a mainstream of Pacific community mental health team. Historically there has been a shortage of residential psychiatric care operating from a Pacific perspective. Deinstitutionalisation and community care mean that it is likely that many

Pacific people who have attempted suicide will receive on-going care for mental health issues within the context of their family. (Lealaialoto 1996). Moreover some suicide attempts may not come to the attention of health professionals.

Ideally mental health services would offer care and treatment to the individuals and support to their families and significant others (Community Liaison Committee of the Royal Australian and New Zealand College of Psychiatrists 2000). In fact the strain on mental health services in some areas and the crisis situation created by a suicide attempt may mean that the most pressing needs of the individual patient are focussed on, and the needs of the wider family are not (Cassie 2003, Beautrais 2004).

There is a broad consensus in the literature that many Pacific people find mainstream mental health services difficult to access, culturally unsafe and ineffective in meeting their needs and may delay or avoid seeking treatment for these reasons. The lack of acknowledgement on the roles of family and significant others (such as community members and ministers) when dealing with Pacific clients is one of the prime concerns. Mainstream counselling services tend to be individual and medical model focused, in contrast to Pacific models of health. Mainstream health professionals unawareness of their Pacific patients cultures and values, and the unfamiliarity of western treatment paradigms for Pacific peoples are also issues (Crawley et al 1995, Pulotu-Endemann, 1994/95, Bridgman 1993, Tukuitonga & Finau 1997, Anae et al 2002, Malo 2000, Mental Health Commission 2001).

According to Esera, the DSM-IV classification system does not recognise cultural factors or values which may be important in the diagnostic process for some cases of traditional mental illness (Esera 2001).

Practitioners who are not conversant with Pacific cultures are at risk of not understanding what is being conveyed to them either verbally or through body language (Tamasese et al 1997, Esera 2001). Interpreters can assist in these situations, although some Pacific people are concerned that the interpreter might tell others about their problems (Toafa et al 1999).

If the attempter receives in-patient care the resulting separation from their family may cause considerable stress. (Bathgate & Pulotu-Endemann 1997). One Pacific mental health consumer comments:

> ‘Some of the hospital staff had told my family to stay away for a while because they felt like that was hindering my recovery. But to be able to see my family actually made me feel for just a little while like I wasn’t in hospital, and I enjoyed getting visits from them.’
> (cited in Malo 2000)

It is likely that some families and significant others of a person going through the mental health system as a result of a suicide attempt may feel confusion or anxiety about the treatment that person is receiving. It is possible that they may be unsure if the treatment is

helping yet also unsure about how to get better help for their loved one. Some may also find mainstream counselling services ineffective at meeting their own needs, even if these services are offered (Taule'ale'ausumai, 1997a).

There are indications that the mental health system is becoming more responsive to Pacific consumers, and presumably also their families (Malo 2000).'

Moreover some DHBs now have Pacific mental health units. Their services may include elements of traditional and Christian belief as well as clinical treatment (Pacific health worker personal communication 2003). An example is Wellington DHBs Health Pacifica service, which is based on the fonofale model and is complementary to the mainstream service. It captures both the clinical and cultural components of mental health care (Esera 2001).

8.4.5.1 Samoan

The western division of the self into mental, physical and spiritual components, each of which can be treated separately, is seen as wrong to many Samoans who state that this makes it difficult to heal the unwell person (Tamasese et al 1997). There is also concern that mainstream practitioners may not understand the important relationships that govern interactions. For example, in a group setting, there are not only rules about what can be said in front of someone of the opposite sex, 'relational tapu' also governs interactions within a single sex group (Tamasese et al 1997)

Moreover racial stereotypes and prejudices are believed to negatively influence the treatment Samoans receive in mainstream mental health services. For example Tamasese et al found evidence of stereotypes relating to the view that Samoans are poor and therefore their needs are not a priority, as well as cultural stereotypes (Tamasese et al 1997).

8.4.5 Other sources of support

8.4.5.1 Suicide Prevention Services

It is not clear to what extent youth suicide prevention services actively provide support to Pacific families affected by suicide attempt, although it appears from the logic models being used to evaluate Pacific World that this is one of their goals (Department of Internal Affairs 2003).

8.4.5.2 Pacific Community Groups

The Ministry of Youth Affairs' publication Helping troubled young people: A Guide for Parents (1998c) suggests Pacific community groups may be a source of assistance in dealing with youth issues. There are a wide range of these organisations, many of which have a long history in New Zealand (Taule'ale'ausumai 1997b). Some have dealt with families of people who have attempted suicide but they are not necessarily trained in this area (Tafua Personal Communication 2003).

8.5 Directions for providing support to Pacific families affected by suicide

8.5.1 Pacific Models of Health

Support for Pacific families needs to take account of holistic Pacific models of health (Crawley et al 1995). Anae et al argue that the Fonofale model for Pacific health and the Fa'afaletui model of Pacific health research together represent the optimal conditions for mental health (Anae et al 2002).

The Fonofale model of health was proposed by Pulotu-Endemann in1984 and has since been further developed (Mental Health Commission 2001). It is based on the model of a fale (house) and incorporates the values and beliefs of members of the major New Zealand Pacific cultures. 'In particular, these groups all stated that the most important things for them included family, culture and spirituality' (Mental Health Commission 2001).

The roof represents culture (including NZ-born culture), the foundation represents the family, and the pou (posts) represent the spiritual, physical, mental and 'other' dimensions which are continuous, connect the culture and the family, and interact with each other. The fale is encapsulated in a cocoon that contains the dimensions of the physical environment, time and context (Mental Health Commission 2001, Anae et al 2002).

Tamasese et al propose the fa'afaletui model as a basis for Pacific health research. It is also based on a house and represents the critical process of weaving (tui) together all the different levels of knowledge from within the 'houses' of collective representation to enhance the Samoan world view (Tamasese et al 1997).

Anae et al write,

> From these frameworks, the importance of mental health promotion for Samoan people lies in the strengthening of spirituality and the relational arrangements within the family, in recognition that the family is the first place of relational harmony, belonging and identity.
> (Anae et al 2002).

They note that these relational arrangements flow outwards into the community, particularly to the church and to the wider community of New Zealanders (Anae et al 2002).

This appears to be a particularly appropriate model for support services to families and significant others affected by suicide attempts as it allows the needs of the family as a whole to be considered along with the needs of the suicide attempter (Esera 2001). A holistic model that has regard for environmental factors as well as medical factors acknowledges the diversity of factors that are perceived to cause suicide attempts.

8.5.2 Pacific Mental Health Service Provision

The Mental Health Commission describes a Pacific service as one that is run 'by Pacific people for Pacific people' and has the following elements:

- Service delivery is culturally appropriate for Pacific people
- The services provided are for Pacific users, but non-Pacific people may access the service
- The philosophy of the service is based on Pacific values and beliefs
- The service is based on Pacific models of health or models of health that encompass Pacific beliefs and values
- Pacific people are involved in the governance and management of the service
- Pacific people provide a significant number of the staff and health professionals

(Mental Health Commission 2001)

Recent moves to develop the Pacific mental health workforce are likely to offer greater opportunities for Pacific people to receive counselling and support from professionals of their own cultures (Mental Health Commission 2001).

A number of DHBs have established Pacific Mental Health Units in recent years (Esera 2001). It would be useful to evaluate whether they are able to provide better support to families than mainstream services.

8.5.3 Mainstream Counselling and Support Services

Many Pacific people are not comfortable seeking support in mainstream health settings, but it is difficult to provide ethno-specific services in many areas. Therefore it is vital that mainstream providers adapt to meet the cultural needs of Pacific people. For older, island born people the language and specific cultural practices of their island group are particularly important (Bathgate & Pulotu-Endemann 1997, Tukuitonga & Finau 1997, Mental Health Commission 2001).

Pacific people have emphasised that they wish to see health services oriented in a more culturally appropriate way, including:

- A focus on the family group rather than the individual
- Clinicians to be aware of cultural belief and family-based decision making process
- More trained Pacific people involved in mental health work

(Bathgate & Pulotu-Endemann 1997).

In relation to family involvement in mental health services, Foliaki argues that education of consumers' families is needed, but,

> Challenging strongly held traditional beliefs is not necessary. Fostering open, honest relationships is the key. Providing Pacific consumers and their families with the necessary information and allowing them to make choices is empowering.
> (Foliaki 1998)

Acting on workforce issues is a long term process as New Zealand has almost no Pacific psychiatrists and few Pacific clinical psychologists or trained counsellors. A blueprint of Pacific Mental Health Services and Workforce has been developed to address the situation (Mental Health Commission 2001)

Where there are not suitably trained Pacific staff or the Pacific population is too small to support a stand alone Pacific mental health service, the use of Pacific advisers or advocates in a mainstream setting is seen as a positive move forward in meeting the needs of Pacific people (Crawley et al 1995, Tamasese et al 1997). Mental health consumers have suggested their families may be better able to understand their diagnosis and situation if the information is provided by someone of their own ethnicity who also speaks their language (Malo 2000). Some mental health services make use of, or work with, traditional healers which is also viewed positively (Tamasese et al 1997).

The Mental Health Commission states that mainstream services need knowledge and understanding about the following points in order to provide culturally responsive services to Pacific people:

- Diversity within different Pacific cultures, with regard to language, customs, traditions and rules of conduct
- The central importance of language, family, religion, and traditions in Pacific cultures
- Differences between island-born and New Zealand-born Pacific peoples
- The importance of involving Pacific communities, families and service users in both individual and service planning and treatment processes
- The need to treat Pacific peoples with compassions, respect and equality
- Service users' right to access traditional healing and conventional medical treatments at the same time
- Barriers, such as lack of transport or information, that make it difficult for some Pacific service users to access the treatment they need
- Discrimination that Pacific people can experience as Pacific people and as people with mental illness

(Mental Health Commission 2001)

8.5.4 Just Therapy Approach

The Lower Hutt Family Centre has developed an approach to counselling known as Just Therapy, which acknowledges and addresses the impacts of external forces such as cultural alienation, colonisation, racism and unemployment on clients (Waldegrave & Tamasese 1993). This may be useful in providing support to families and significant others who perceive that these factors may have contributed to their loved one's suicide attempt, or who are struggling to deal with multiple stressors of which a family member's suicide attempt is one.

8.5.5 Pastoral counselling

Tiatia's research stresses the importance of spirituality in providing reasons for young Pacific suicide attempters to live (Health Research Council nd). Other writers have highlighted the role that churches play in the lives of Pacific people and argued that pastoral counselling for Pacific people dealing with difficult, traumatic or sensitive issues provides helpful avenues to explore (see for example Culbertson 1997, Taule'ale'ausumai 1997b, Halapua 1997). Sensitive support from ministers may be a culturally acceptable way to support families and significant others affected by suicide attempts. It would be important that this support did not create undue financial or other obligations on the affected family.

8.5.6 Community Care

Lealaiauloto, discussing her findings from networking with Pacific mental health consumers and their families, draws attention to the needs of families who care for mentally ill people to have the finance and capability to do an effective job:

> Pacific Island families effectively caring for and supporting a relative who suffers from a mental disorder must be adequately funded and trained for the job. (Lealaiauloto, 1996)

It may be that this kind of support is what would assist Pacific families most.

8.5.7 Education and Resources

The consultation process undertaken to produce the 1995 *Strategic Directions for Mental Health Services for Pacific Islands People* revealed a clear desire for family education on suicide prevention for Pacific families, delivered by health professionals and cultural advocates (Crawley et al 1995). We are not aware if this has occurred on any large scale basis, but it is likely Pacific families who have been affected by a suicide attempt and are fearful of it re-occurring would find appropriately presented education of the subject beneficial. *Pacific People's Health Education Guidelines* provides guidance on how to go about developing resources for Pacific people (Ministry of Health and Health Funding Authority 1999).

8.6 Conclusions

Pacific families in New Zealand are a diverse population. Cultural identities are shaped by origins in different island groups and status as island-born or New Zealand born. Many young Pacific people are of mixed ethnicity.

No literature was found on the subject of Pacific families' experiences of suicide attempts. Possible support needs have been drawn from related literature on the experiences of Pacific suicide attempters, cultural attitudes towards mental illness, and the mental health system.

It appears that existing support services for Pacific families and significant others who have been affected by suicide attempts are non-existent or minimal. Family, community and the church are likely to be the main existing sources of support for Pacific families.

The stigma associated with mental illness is likely to be one a significant source of stress for Pacific families affected by suicide attempts. This includes stigma resulting from cultural beliefs about mental illness being caused by curses or spirits, possibly generations in the past.

From the limited anecdotal evidence available it appears that Pacific families tend to be very concerned about mentally ill family members and try to support them in any way possible. At the same time, they may have difficulty understanding clinical diagnoses and treatments and may experience mainstream mental health services as culturally unsafe and inaccessible.

Pacific people have specifically asked for education on what to do if they fear a young person may be suicidal. Families of people who have attempted suicide are likely to be very fearful of a re-occurrence, and education about risk factors and prevention should be provided to them in culturally appropriate ways. The Ministry of Health publication on education resources for Pacific people provides a useful guide on how to do this.

Providing information about on-going support through GPs may be less effective for Pacific families than for mainstream families and significant others. Other sources of information provision such as churches and community organisations should be considered.

Choice and provision of a range of services will be required to meet the on-going support needs of Pacific families who have been affected by suicide attempts.

Pacific models of health provide a framework for delivering support to Pacific families affected by suicide attempts alongside support for the attempter. Significantly, these models recognise relational values, spirituality and the social and economic environment within which the family exists. As such, these models should be used in both mainstream and Pacific mental health settings.

Pacific Mental Health Services and Workforce: Moving on the Blueprint provides guidelines for making mainstream services culturally responsive to Pacific people. These emphasise family involvement and cultural factors (Mental Health Commission 2001). It is likely that implementing these guideline in relation to the care of suicide attempters would greatly assist their families by ensuring they were included and creating a culturally safe setting.

Pacific mental health services tend to be based on Pacific models of health which include a strong emphasis on family. It would be helpful for an evaluation or research project to be done to see if this results in family members and significant others being better supported, and to see what additional support families with loved ones being cared for through these services require.

It is not clear what services Pacific family members may need for their own respite and support following a suicide attempt by a loved one. A small-scale research project could be carried out on this topic. Possible needs include culturally appropriate counselling, peer support, financial assistance, and access to culturally appropriate respite care.

All services providing support to Pacific families affected by suicide attempts should receive on-going evaluation of their effectiveness. This should include an assessment of how well they are implementing Pacific models of health.

9 Supporting Asian Families and Significant Others Affected by Suicide Attempts

9.1 Who are Asian Families and Significant Others?

9.1.1 New Zealand's Asian Population

Asians make up 6.4% of New Zealand's population. They are the second largest ethnic group in the Auckland region (after Europeans) and the third largest ethnic group nationally (after European and Māori). They are also the fastest-growing ethnic group in the country. Eighty-seven percent of Asians live in the five main urban areas of Auckland, Hamilton, Wellington, Christchurch and Dunedin compared with 54% of all New Zealanders (Ho et al 2002, Asian Public Health Project Team 2003).

People of Chinese ethnicity make up New Zealand's largest Asian ethnic group. The next most populous ethnic groups are: in order, Indian, Korean, Cambodian and Vietnamese. People of these ethnicities do not necessarily come from the country their ethnicity is named after (Walker et al 1998). Most notably, 38% of Indian immigrants were born in Fiji. A substantial proportion of ethnically Chinese immigrants come from Hong Kong, Taiwan and Malaysia as well as mainland China (Friesen & Ip 1997).

Asians in New Zealand are more likely to have educational qualifications than the general population, but do not have high incomes. They have higher unemployment but are less likely to receive income support (Walker et al 1998, Friesen & Ip 1997).

Many Asians are recent immigrants. This is most strikingly the case for Koreans who are the fastest growing segment of the Asian population in New Zealand. Ninety two percent of Koreans in New Zealand arrived here in the last ten years (Ho et al 2002).

As well as diversity of ethnic background, the Asian population is characterised by a diversity of background circumstances. Many Cambodians and Vietnamese came to New Zealand as refugees from the late 1970s to early 1990s (Ho et al 2002, Kizito 2001). There have recently been increasing numbers of refugees from Burma.[3] Forty percent of refugees are estimated to have experienced severe trauma (Kizito 2001). Refugees' reasons for coming to New Zealand contrast with more recent business migrants. There are also about 50,000 Asian fee paying students in New Zealand (Ho et al 2002). In addition, the New Zealand Asian population includes New Zealand born Asians.

Asian communities are also characterised by a diversity of religious affiliation:

> In 2001, half of the Chinese people said they had no religions, one-quarter were Christians and nearly 1 in 7 were Buddhists. Within the Indian population,

[3] Refugees have particular health needs. While in the past many refugees came from Asian, in recent years the majority of refugees have come from the Horn of Africa, with others coming mainly from the Middle East, Afghanistan and Bosnia-Herzegovina (Kizito 2001)

> Hinduism is the most common religion (53%), followed by Christianity and Muslim. Only 6% have no religion.
> (Ho et al 2002).

Most Koreans are Christians, whereas most Cambodians and nearly half of the Vietnamese are Buddhists (Ho et al 2002).

This diversity means that the concept of 'Asian people' has limited use:

> It is difficult to view ... the great variety of peoples of the different countries of Asia as Asians. There is no substantial and easily definable Asianness that is represented by them. Together they all do not constitute a collectivity. Asia is too large and diverse to be able to develop much beyond an essentially geographical entity.
> (Vasil & Yoon cited in Ho et al 2002).

Nevertheless, the proportion of recent migrants among the Asian population means that language issues are common to many. One in seven adult Asians cannot speak English or Māori (Ho et al 2002). Others may not be fluent. Language difficulties are a major impediment for recent immigrants living and accessing services in New Zealand. They are also a major factor in the difficulties Asian students experience in adjusting to life in New Zealand (Ho et al 2002). The experience of racism may also be a common factor for many Asians (Ho et al 2002).

9.1.2 Asian Families and Significant Others

Given the diversity of backgrounds of Asians within New Zealand, it is not possible to generalise about family structure or significance for all Asians. The international literature suggests that those cultures influenced by Confucianism (including Chinese, Korean and Japanese) stress the importance of family and the social structure. Collective values and the good of the group are emphasised. Filial piety is the basis of duty to the family and 'embodies the concept of mutual care for members of the family' (Kok & Tseng 1992, Mingzhao et al 1992)

In many Asian cultures the extended family was the primary unit of social organisation until very recently, but this is now breaking down in some (Wai-Hoi 1992). Moreover Sun-Hwan Chu states that the nuclear family is emphasised in Korean culture (Sun-Hwan Chu 1999). Migration to New Zealand is likely to further break down extended family structures as effective units for every day functioning. One study of Chinese migrants showed that only six percent of migrants had siblings in New Zealand. More siblings were located in the USA and Canada and nearly as many were in Australia, while 60% of siblings were located in the country of origin (Friesen & Ip 1997). Moreover there is a significant phenomenon of 'astronaut families' in which the father returns to the country of origin to wok while the rest of the family remains in New Zealand (Ho et al 1997). There are indications that these 'split families' experience high levels of strain (Ho et al 2002). Thus Asians in New Zealand may be affected by a suicide attempt elsewhere in

the world, and if an attempt occurs within New Zealand, the affected family may be widely dispersed around the globe.

On average, Asian families have a higher proportion of adolescents than the general population and have larger household size (Walker et al 1998). Studies of Asians in Auckland show family, employment and health are considered the most important things in life (Walker et al 1998). Communication with children and relationships with parents and grandparents were seen by the majority of respondents as having a positive effect on their lives. Social support systems rely heavily on family relationships and friends from their own culture (Ngai et al 2001)

Many Indo-Chinese refugee families experienced traumatic separation in the process of flight and resettlement (Ho et al 2002). Family members may remain in the home country or be dispersed around the globe. A number of families have been reunited in New Zealand through a family reunification scheme.

International students do not usually have any family in New Zealand. For them, significant others in New Zealand would be 'their home stay families,' teachers and classmates (Ho et al 2002). In cases of suicide attempt by international students, it is likely that issues would arise of bringing family members to New Zealand and/or organising support for the student either in New Zealand or their home country.

9.2 Suicide Attempts Amongst Asian Peoples

9.2.1 Suicide Attempts In Asian Countries

Comparisons of suicide attempt data between nations are difficult due to differences in definition, reporting mechanism and varying degrees of cultural reluctance to report suicide attempts. (Kok & Tseng 1992). It appears, however, that females generally outnumber males in attempted suicides by a ratio of 2 or 3 to 1 (Kok & Tseng 1992).

Patterns of suicide attempt in a cultural group's homeland are not necessarily transposed on migration. For example, Hawaii's large Japanese population does not appear to have produced the family homicide-suicides that are seen in Japan (Tseng et al 1992).

9.2.1.1 Hong Kong

In 1985 the prevalence of attempted suicide was estimated to be about 46.9 per 100,000 (Wai-Ho 19992).

A random study of 1107 high school students found that 22% believed that one or more of their peers had seriously considered suicide (Tse & Bagley 2002). This suggests that peers may have an awareness of a forthcoming suicide attempt and may be particularly affected by it. Another study found that 11% of Hong Kong students had engaged in deliberate self-harm or a suicidal gesture (Tse &Bagley 2002). A further study indicates that 25% of adolescents experienced suicidal ideation, with 2% of male and 5% of females indicating a serious immediate intent to commit suicide (Tse & Bagley 2002).

Studies found a 2-3 to1 female to male ratio among suicide attempters (Tse & Bagley 2002, Wai-Hoi 1992).

Attempted suicide is much more common in teenagers and young adults. According to Wai-Hoi this is characterised by impulsive acting out, with family or romantic problems among females of low socio-economic backgrounds who have 'immature' personalities being commonly found (Wai-Hoi 1992). Unemployment, job disappointments and financial difficulties are major precipitating factors in only 12.1% of cases, although loss of face for high achievers whose occupational status is lowered is a significant precipitator (Wai-Hoi 1992).

Separated and divorced people are significantly over-represented among suicide attempters (Wai-Ho 1992). Historically, cohabitation and being a concubine were found to be precipitating factors for suicidal behaviour, but the significance of these factors appears to be diminishing (Wai-Hoi 1992).

There is evidence that a parent's suicide attempts have an impact on the likelihood of their offspring attempting suicide. Tse, Bagley and Hoi-Wah report on a 1998 study by Ho and Hung that showed about 25% of suicide attempters have a parent who has engaged in deliberate self-harm. In a related finding, up to half of adolescent attempters have a close relative with a diagnosed mental illness (Tse, Bagley & Hoi-Wah 2002).

Mental illness is believed to be less of an important cause for attempters than for completed suicides (Wai-Hoi 1992). About one percent of attempters commit suicide within a year, and the long term risk of suicide is about 10% (Wai-Ho 1992).

One study found that 70 percent of suicide attempters had relatives who were supportive of them following the attempt. On the hand 16 percent were resentful (cited in Wai-Ho 1992).

9.2.1.2 Malaysia

In 1986 the rate of self-injury in Kuala Lumpur was estimated to be 12.7 per 100,000. This is thought to have been an underestimate. Moreover, rates are believed to have increased since that time. Rates of suicide attempt are not evenly distributed between ethnicities. Indians are significantly overrepresented and Chinese slightly overrepresented while Malays are under represented. Battered wives make up 1.1% of attempters (Ong & Leng 1992).

9.2.1.3 China

The data on suicide attempts is not good. High rates of suicidal behaviour have been associated with the Cultural Revolution (Mingzhao, Jueiji 1992). It is unclear whether this is also the case for refugees and other migrants from China.

9.2.1.4 Taiwan

The data on suicide attempts is not good, but it appears that females have a four times greater rate than males. Financial losses from gambling and illicit loans are increasingly important as precipitating factors (Chong et al 1992).

9.2.1.5 Korea

In 1981 Korea's suicide rate of 22.6/100,000 was the sixth highest in the world. It is believed that attempted suicide is ten to twenty times more common than completed suicide, with females 1.6 times more likely than males to make an attempt. Unemployment and unstable work history co-relate with suicide attempts (Suk 1992).

Historically families have been reluctant to acknowledge suicide attempts. A 1969 study showed,

> Half of the families of suicide attempters denied their suicidal intention, and in general displayed a negative attitude to the staff. The was probably due to worry about the financial problems the families were facing, and the psychiatric illnesses of the patients.
> (Suk 1992)

The majority of families were only interested in physical treatment for their loved one, rather than methods of prevention. The majority of attempters received no psychiatric treatment (Suk 1992).

9.2.1.6 Singapore

The attempted suicide rate is estimated to be 92 per 100,000 with a female to male ratio of 1.6 to 1. The most common factor associated with suicide attempts is relationship problems, including problems with spouses, partners, parents, siblings and in-laws. One study indicates that attempters have significantly less social support than control groups. There is considerable variation in suicide rates between different ethnic groups. It is not clear if this is also the case for suicide attempts (Kok 1992).

9.2.1.7 Philippines

Attempters who have been followed up stated that the biggest source of improvement in their wellbeing was relief at improved relationships and emotional interactions within their families. Families used religious rituals and spiritual involvement to cope with the suicide attempt. Although most are Catholic they do not feel morally censured following a family members suicide attempt, but rather see their survival as a manifestation of faith (Ladrigo-Ignacio & Gensaya 1992).

9.2.3 Suicide Attempts Amongst Asians in New Zealand

We were unable to find data on Asian suicide attempts in New Zealand. The Ministry of Health's Suicide Facts: Provisional 2000 Statistics show 21 Asian people died by suicide in 2000. Numbers of Asian suicide deaths are not shown for previous years (Ministry of Health 2000)

The great majority of people in the general population who make serious suicide attempts have a recognisable psychiatric disorder at the time of the attempt (Beautrais 1998 & 2000). Following a suicide attempt they have high rates of admission to psychiatric hospitals, high up-take of social welfare benefits, high levels of reported relationship problems and high levels of legal problems and criminality. They also have elevated risks of making further attempts and of dying from suicide or other causes. (Beautrais 1998 & 2000). No comparable studies were found assessing outcomes for Asian people who have attempted suicide in New Zealand, so we do not know how applicable these findings are to that population. If a significant proportion of Asian people who make suicide attempts do have a psychiatric disorder, it is likely that the families will face strain in dealing with this.

It has been noted that refugees are at significant risk of mental health problems. Asylum seekers may be particularly vulnerable due to their uncertain status in New Zealand (Kizito 2001). It is not clear if this translates into being at greater risk of making suicide attempts.

9.3 Asian Families and Significant Others' experiences of being affected by suicide attempts

Hinduism and many forms of Buddhism do not appear to contain strong condemnation of suicide. In contrast Christianity and Islam strictly prohibit suicide (Peng & Tseng 1992). These religious differences suggest there may be different reactions to suicide attempts for Asian families and significant others of different religious or philosophical backgrounds.

Writing about China, Mingzhao et al state that 'suicidal behaviour is viewed culturally as disgraceful behaviour if it happens to a family member' (Mingzhao et al 1992).

Refugees who are affected by suicide attempts may experience added difficulties due to already being at high risk of depression and post-traumatic stress disorder (PTSD) resulting from pre-migration events and the post-migration stressors of adapting to life in a new culture (Ho et al 2002). A study of the mental health of adult Khmer refugees in Dunedin showed experiencing a major life event during the past year was a risk factor for PTSD and other mental disorders (Abbott 1997). Providers of support need to be sensitive to the fact that a family members' suicide attempt may cause a resurfacing of the effects of earlier trauma.

New Zealand Asians may be affected by a non-Asian person's suicide attempt and may find seeking support within the mental health system culturally unacceptable. Young reports a case study of a Cambodian girl whose New Zealand boyfriend attempted suicide when she said she did not want to see him again. After the attempt the boy's mother blamed the girl and prevented her from speaking to her ex-boyfriend. As a result, the girl threatened to kill herself. Concerned teachers attempted to get her admitted to a psychiatric unit, but before this happened a counselling session was held with a member of the Cambodian community. At the session,

> The girl said she did not mean what she had said, she just wanted to show that she's desperate, but that she really would commit suicide if she was admitted to that clinic as it's a shameful thing to the whole family who will lose face with all their friends and relatives.
> (Young 1989)

9.3.1 Attitudes towards mental illness

Asians tend to strongly stigmatise mental illness. Cultural values equating hospitalisation for emotional problems with shame on the family name contribute to under-utilisation of mental health services by Chinese people (Ngai 2001).

A denial of the experience and expression of emotions in Confucian cultures is believed to 'make it more acceptable for psychological distress to be expressed through the body rather than the mind' (US Department of Health and Human Services, quoted in Ho et al 2002, Sun-Hwan Chu 1999, Ngai et al 2001). Thus support services for Asian families affected by suicide attempts may need to address somatisation (the physical expression of psychological distress).

Buddhism, Confucianism and Taoism 'teach that order and harmony are maintained through perseverance and a stoic acceptance of suffering'(Sun-Hwan Chu 1999). Many Asians feel self-restraint in relationships is necessary to avoid loss of face. For example Sun-Hwan Chu notes that Japanese Americans see mental illness as a 'sign of personal and family weakness' and believe that endurance, loyalty and sacrifice for the good of the whole family are required. There is a reluctance to seek help outside the family. Similar reluctance to go outside the family for help, difficulty expressing emotional needs and somatisation exists among American Indo-Chinese families (Sun-Hwan Chu 1999).

There may also be a tendency to blame external circumstances, such as someone else or society in general, for one's mental illness because 'real personal dysfunction is largely seen as a punishment for or direct result of immoral actions, pursuits, or behaviour'(Kirby & Daya 1999).

One health professional in the study done by Ngai et al commented that a suicide attempt may by the first time a family recognises a member's mental health problem (Ngai et al 2001). The same has been noted among Indo-Chinese families in the USA (Sun-Hwan Chu 1999).

9.4 Sources of Support for Families Affected by Suicide Attempts

9.4.1 Family and Friends

There are different views about the amount of support members of Asian families are able to provide their members. Despite the strong emphasis given to family in most Asian cultures, some of the literature suggests that in families from Confucian backgrounds members may find it difficult to offer each other emotional support because

> The influence of the teachings and philosophies of a Confucian, collectivist tradition discourages open displays of emotions, in order to maintain social and family harmony.
> (US Department of Health and Human Services quoted in Ho et al 2002).

On the other hand Ngai et al quote reports showing that Asians tend to rely on family members, close relatives and friends, rather than mental health providers to solve psychological problems (Ngai et al 2001).

Some New Zealand Asians do not have strong family and social support networks in their geographical vicinity due to their recent settlement, or for students, the temporary nature of their stay here (Ho et al 2002). Weak social supports have been found to be a risk factor for mental illness among refugees in New Zealand (Abbott 1997). Following a friend or family member's suicide attempt individuals who do not have strong networks of family or significant others may be in particular need of appropriate support services.

9.4.2 General Practitioners

Ngai et al found that two-thirds of Asians thought it was important to have a GP who spoke their language (Ngai et al 2001). Although Asians are concerned about their health and seek early intervention for a range of health problems most do not have a regular GP. This may be, in part, due to a lack of understanding about how the New Zealand health system operates (Walker et al 1998).

One study found most Asians do not report stress and depression to their doctor (Walker et al 1998). In many Asian cultures it is unacceptable to complain to a doctor about emotional problems, so patients may instead concentrate on physical symptoms (Ho et al 2002). If doctors are not aware of this they may miss the underlying issues and misdiagnoses or fail to offer optimum assistance (Ho et al 2002). Nevertheless a survey of doctors with Asian patients found that Asians did seek early treatment for a range of illnesses including stress and depression (Walker et al 1998).

Health professionals report that they face difficulties in dealing with Asian patients with mental health problems and psychiatric issues due to language barriers and having to rely on family members to translate sensitive information (Ngai et al 2001). The burden of acting as interpreter may be difficult for family members who are already under stress. To get an interpreter for a GP consultation the patient is supposed to pay, possibly putting this service out of reach to many low-income Asian families (Ngai et al 2001).

The perceived unfriendliness and relative youth of some general practitioners, and discomfort with the style of providing information can also create difficulties for Asians (Ho et al 2002).

9.4.3 Mental Health Services

Asians face major sociocultural barriers to accessing health care in New Zealand. Lack of English proficiency is the most significant barrier. Asians may not be aware of the

existence of services because they do not have the English language skills needed to access the information (Ngai et al 2001, Walker et al 1998, Ho et al 2002).

Problems of access and suitability are particularly acute in the mental health arena. Ho et al note:

> problems such as inability to explain their emotions and personal problems in English, ... create significant stress and confusion for people for whom English is a second language.
> (Ho et al 2002)

A lack of appropriate interpreter services compounds the difficulties (Ho et al 2002).

Twenty one percent of respondents in the study by Ngai et al indicated that they had experienced depression, emotional problems or mental health problems in the last three years. But only seven percent had used mental health services. Others appear to have approached private psychiatrists, received support from friends or been treated by a GP for physical symptoms caused by depression (Ngai et al 2001).

Ho et al write,

> Research on help seeking pathways for emotional problems among Asians reveals that Asian people are less likely than other ethnic groups to request outside help for their difficulties.
> (Ho et al 2002).

Once Asian patients are in the system, they may drop out again. Ngai notes, 'Asians can easily be lost in the follow-up system, possibly due to language barriers and lack of understanding of the health service system.' (Ngai et al 2001).

Moreover Ho et al note that a there is a widely held belief that Asians are extremely well-adjusted and experience extraordinary well-being and mental health (Ho et al 2002). The belief that Asians represent a 'model minority' has also been noted in the United States (Sandhu 1999). This may decrease the support available to Asians who are experiencing traumatic situations such a family members' suicide attempt.

Ngai et al found that all the mental health professionals in their study expressed difficulties in assessing and treating Asian clients due to cultural differences, and 94.4% reported difficulties in providing a culturally sensitive service (Ngai et al 2001).

Internationally, it has been noted that Western mental health services may be poorly suited to treating Asian patients. Assessment models make very limited acknowledgment of culturally specific types of mental illness (Leva & Wickes 1999, Kwan 1999). Moreover, Western counsellors may misread Asian communication styles and may lack understanding of family structures (Sun-Hwan Chu 1999). In New Zealand, Abbott notes

that the diverse needs of immigrant and refugee communities are not adequately met by existing monocultural and bicultural services (Abbott 1997).

9.6.3 Traditional Medicine

Asian cultures make considerable use of non-western systems of medicine. Chinese medicine is widely used in a number of Asian countries. In addition, some Asian cultures utilise traditional folk medicines (Ho et al 2002). No literature was found on the use of traditional medicines in relation to suicide attempts, but it is noted that many Asians consider Chinese medicine to be superior to Western medicine for health promotion and the treatment of chronic conditions (Ho et al 2002). It may be that some family members turn to traditional medicine to support either themselves or the person who attempted suicide.

9.4.4 Asian Health Support Services

The Waitemata DHB has a volunteer Asian health workers service based at hospitals. Research indicates that these support workers are seen as 'fundamental' in bridging gaps between patients and staff (Ngai et al 2001). It is not clear whether this service is offered in the mental health area. There are risks associated with having support for families affected by suicide attempts provided by volunteers. On the other hand, if these people are appropriately trained and supervised, they may provide culturally and linguistically specific support that otherwise would not exist.

Asian Health Support Services have also produced information pamphlets on health services in three Asian languages as well as a booklet on cultural perspectives in Asian patients' care. They are also involved in training, liaison, and health information, and in 2001 were planning to establish a Helpline (Ngai et al 2001).

9.4.5 Refugees as Survivors Centres

Refugees as Survivors Centres provide specialist assistance to people from refugee backgrounds (Kizito 2001). It is not clear if they assist families affected by suicide attempts.

9.5 Directions for providing support to Asian families affected by suicide

9.5.1 Mental Health Services

Culturally appropriate mental health services for Asians have begun to be developed in North America including ethno-specific services, increased numbers of bilingual and bicultural staff, greater communication and innovative programmes. Chinese immigrants, in particular, have been found to have a preference for consulting Chinese therapists due to 'mutual sympathy, common language, and flexible appointment schedules' (Ho et al 2002).

In New Zealand, Asian community representatives have been urging the government to take action to provide better access to health services that cater to their needs (Asian

Public Health Project Team 2003). New Zealand health care workers have suggested that the availability of interpreters is the number one priority in order to better meet the needs of Asian clients (Ngai et al 2001). Pamphlets printed in Asian languages, an Asian helpline service, Asian health support workers, more Asian health professionals and culturally sensitive healthcare services are also suggested (Ngai et al 2001, Ho et al 2002). These recommendations are all relevant to the provision of support services to Asian families and significant others who are affected by suicide attempts.

Health professionals rated the need for more Asian social workers and counsellors higher than the need for more Asian general health professionals, indicating a particular concern for Asian patients' cultural and psychosocial needs (Ngai et al 2001).

Refugee families may have specific difficulties dealing with a family member's suicide attempt, due to past trauma. Kizito's *Refugee Care: A Handbook for Professionals* provides useful guidance on communicating with refugees in a consultation (Kizito 2001). Kizito recommends that health professionals consider referral to a Refugees As Survivors Centre or other mental health service if persistent signs of trauma are present. Particular sensitivities exist in understanding the needs and responses of refugees, managing disclosures, and deciding if counselling is appropriate (Kizito 2001)

International students are a particular sub-group who may have difficulty accessing support if they are affected by a suicide attempt (Butcher et al 2002). In situations where an international student attempts suicide it is likely that New Zealand health services will have a role to play in contacting family members and supporting them if they come to New Zealand following the attempt.

Racism has been identified as a serious problem facing immigrants and their mental health (Ho et al 2002). It is essential that any service provided is free of racism and discrimination.

9.5.2 Models of Counselling for Asians

Considerable literature exists about counselling and psychotherapy for Asians in America (see for example Sandhu 1999). Given the lack of New Zealand literature, this material should be accessed by professionals working with Asian families in New Zealand. For example, Fong and Chung provide and extended analysis of the use of Confucian role approach in Yin-Yang theory in relation to south-East-Asian refugee families (Fong & Chung 1999).

9.5.3 Education and Resources

The majority of respondents in a survey of health needs among Asians in North and West Auckland believed that pamphlets on health issues printed in their own languages would be helpful (Ngai et al 2001). Resources dealing with mental health and family and parenting issues were specifically requested, as well as resources explaining the New Zealand health care system (Ngai et al 2001). It is likely that Asian language resources dealing with suicide attempts would be helpful to families.

9.5.4 Asian Specific Health Services

The study by Ngai et al revealed 40% of health professionals supported the idea of an Asian mental health team (Ngai et al 2001).

9.5.5 Home Support and Respite Care

Research into the healthcare needs of Asians in Auckland has shown that Asian caregivers may feel exhausted by the repeated intrusion into their homes by health and support people attending to an ill person's needs, especially if they are having to translate for the ill person. A lack of culturally appropriate respite care for disabled and elderly people has also been noted (Ngai et al 2001). This is likely to also be the case for mentally ill family members who have attempted suicide. Where community care workers visit suicide attempters in their homes, it is necessary that they speak the attempters language or have an interpreter with them, rather than relying on family members to translate. Efforts should be made to provide culturally appropriate respite care.

9.6 Conclusions

The Asian population of New Zealand is very diverse. A majority are recent immigrants. Lack of fluency in the English language is a major factor in many Asians ability to access services and support.

The diversity of the population makes generalisation impossible. It does, however, appear that the centrality of family in Confucian societies does not necessarily mean that family members are able to offer effective support to each other.

Little New Zealand material exists on health issues for Asians in this country. Despite Asians being New Zealand's third largest ethnic group, Asian models of health and Asian government-funded health service providers are only in the initial stages of development.

Addressing language issues through providing access to interpreters is likely to be the most significant factor in making support services accessible to and effective for Asian families and significant others affected by suicide attempts.

All those involved in supporting Asian families and significant others should be trained in the use of interpreters, and have access to them. The services also require networks within Asian communities and access to community leaders or advisors in order to provide effective services. DHBs in the five main metropolitan areas should have either Asian mental health services or at least, Asian cultural advisers attached to their mainstream services. This may also be appropriate in other areas.

All services should receive on-going evaluation of their effectiveness in meeting the support needs of Asian families. In addition, given the lack of literature on the experiences and support needs of Asian families who have been affected by suicide attempts, it would be helpful to commission field research on this topic.

10 Summary of Support Needs

Based on findings from the literature by population group. Given the lack of research, the findings are not definitive.

	Māori	**Pacific**	**Asian**
Over-arching issues	Diversity of Māori means choice and adaptability of services are required. High value placed on the collective identity of whānau may necessitate support service approaches that differ from mainstream individualistic models. Preference for kaupapa Māori services by some Māori. These services exist in related areas, offering both models for and a possible expectation of their development in the area of bereavement support. Cultural attitudes towards mental illness may shape reactions to varying degrees. Mainstream services need an awareness of these attitudes. Need to access cultural advice and have networks to Māori resource people and organisations. Coordination within and between services is required.	Diversity of Pacific peoples means choice and adaptability of services are required. High value placed on collective identity may necessitate support service approaches that differ from mainstream individualistic models. Preference for Pacific (ideally, island group specific) services by some Pacific people. Cultural attitudes towards mental illness may shape reactions to varying degrees. Mainstream services need an awareness of these attitudes. Need to access cultural advice and have networks to Pacific resource people and organisations. Coordination within and between services is required. Some Pacific people lack of fluency in English. Need Pacific language services or interpreters and Pacific resource materials. Possibility that family in New Zealand may be affected by an attempt overseas.	Diversity of Asian peoples means choice and adaptability of services are required. High value placed on collective identity may necessitate support service approaches that differ from mainstream individualistic models. Cultural attitudes towards mental illness may shape reactions. Mainstream services need to be aware of these attitudes. Need to access cultural advice and have networks to Asian resource people and organisations. Coordination within and between services is required. Many Asian people lack of fluency in English. Address through Asian language services or interpreters and Asian language materials. Family in New Zealand may be affected by an attempt overseas.

If Attempter is Hospitalised	Whānau may not feel mainstream hospital is effective or culturally appropriate for their loved one. Whānau may feel excluded due to individualistic attention on the attempter and/or hospital's interpretation of privacy requirements. Address through creating whānau focus as well as individual focus in hospital setting.	Family may experience distress at separation. Family may not feel mainstream hospital is effective or culturally appropriate for their loved one Family may feel excluded due to individualistic attention on the attempter and/or hospital's interpretation of privacy requirements. Address through creating family focus as well as individual focus in hospital setting May have difficulties understanding medical diagnosis and reasons for any medication.	May be considered shameful to family. Family may have added anxiety due to not understanding the New Zealand health system. Address through Asian support workers and/or pamphlets in Asian languages explaining relevant aspects of the health system. Support to arrange for close family members (eg young person's parents) to travel to New Zealand may be required.
When Attempter is in community (eg living with family)	Fear of reoccurrence may be exacerbated if whānau do not feel loved one is receiving culturally appropriate care. Issues that precipitated attempt may re-emerge	Community has a desire for education on suicide issues – may be particular need for families affected by suicide attempts. Fear of reoccurrence may be exacerbated if family do not feel loved one is receiving culturally appropriate care Issues that precipitated attempt may re-emerge	Community has desire for education on mental health and family issues – may be particular need for families affected by suicide attempts. May experience strain from having to interpret for the attempter's visiting health and support workers. Need to provide linguistically matched workers or interpreters.
Longer Term	For some there maybe ongoing issues relating to the dealing with the suicide attempts. May be less likely to see a GP than non-Māori. Other avenues of referral for support needed.	For some there maybe ongoing issues relating to the dealing with the suicide attempts. May be less likely to see a GP than mainstream. Other avenues of referral for support needed.	For some there maybe ongoing issues relating to the dealing with the suicide attempts. May be less unlikely to discuss emotional difficulties with a GP. GP awareness or other avenues of

	May have a strong preference for kaupapa Māori support services. Māori mental health service and counselling models provide starting points from which to develop Māori-specific counselling on suicide issues. Mainstream counselling services need to be aware of issues of power and colonisation as well as cultural dynamics. Tohunga and kaumatua may be useful in providing support in a kaupapa Māori or mainstream health setting.	Other stresses, such as poverty, may make it harder to recover from a family member's suicide attempt. Many would prefer Pacific- support services. Some may opt for a kaupapa Māori service. Ideally support would be offered in Pacific languages. Church leaders likely to be turned to for support. May also receive support and assistance form traditional healers. If these people are given accurate information or education about suicide attempt and mental illness it may assist them to provide support. Counselling services need to be aware of culturally specific ways of communicating, including the relational rules that govern interactions.	referral for support needed. Lack of fluency in English and racism may be barriers to accessing both formal and informal support. Innovative means of promoting access to support services are required. Ideally support would be offered in Asian languages.
Evaluation and Research	All support services need to be evaluated for their accessibility and effectiveness for Māori. Research into the experiences and support needs of whānau affected by suicide attempt is required.	All support services in areas with significant Pacific populations need to be evaluated for their accessibility and effectiveness for Pacific people. Research into the experiences and support needs of Pacific families affected by suicide attempt is required.	All support services in areas with a significant Asian populations need to be evaluated for their accessibility and effectiveness for Asian people. Research into the experiences and support needs of Asian families affected by suicide attempt is required.

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Appendix A – Key Informants

The following key informants were successfully contacted.

1. Lanuola Asiasiga, Shore Whairiki, Massey University
2. Brice Awan, Skylight
3. Annette Beautrais, Christchurch School of Medicine
4. Suzanne Bidwell, Librarian, NZHTA, Christchurch School of Medicine
5. Sheryl Billet, Ministry of Health
6. Chris Bowden, SPINZ
7. Shelley Bowser, A & D Rongoana Res Care,
8. Marilyn Brewin, University of Auckland, Injury Prevention Centre
9. Heather Campbell, Turanga Health
10. Taima Campbell, Auckland Area Health Board
11. Lisa Cherrington, Victoria University
12. Terryann Clark, Minesota, USA.
13. Maria Cotter, Ministry of Health
14. Nicole Coupe, Toimaiora, Department of Māori & Pacific Health, Auckland University
15. Chris Cunningham, Associate Professor and Director Health Research, School of Māori Studies, Massey University, Wellington Campus
16. Paul Diamond, Radio New Zealand
17. Moira Douthet
18. Lorna Dyall, Department of Māori and Pacific Health, Auckland University
19. Shane Edwards, Shore Whairiki, Massey University
20. Fiva Fa'alau, Shore Whairiki, Massey University
21. Family Centre, Lower Hutt
22. Jann Fielden, thesis author
23. Molly Fiso, Pacific Island Women's Project
24. Michiko Furuya, Writer on issues for Japanese youth
25. Pauline Gardiner, WellTrust
26. Alex Handiside, Mental Health Commission
27. Tanya Heke, formerly of Taki Rua
28. Bob Henare, Mental Health Commissioner
29. Wendy Henwood, Shore Whairiki, Massey University
30. Tamiaho Herandi-Serrancke, Hapai te Hauora Tapui
31. Leon Ho, Soka Gakkai International Victory Over Violence Project
32. Bessie Kingi, Niu Developments
33. Georgina Kupa, Manukau Hospital, Māori Unit
34. Keri Lawson-Te Aho, Te Aho Associates
35. Laura Looi, Soka Gakkai International Victory Over Violence Project
36. Rachel Lord, Replay Radio
37. Michelle Mako, Ministry of Health
38. Mana Magazine
39. Materoa Mar, Yesterday, Today, Tomorrow
40. Kirsty Maxwell, Te Rau Matatini, Massey University

41. Ministry of Education National Office
42. Ministry of Māori Development, Te Puni Kōkiri, Whangarei
43. Moewaka-Barnes, Shore Whairiki, Massey University
44. Jim Moriarty, Te Rākau Hua o Te Wau Tapu
45. Tafa Mulitalo, School of Social & Cultural Studies, Massey University, Albany Campus
46. David Mullholland, Department of Internal Affairs, Community Development Group
47. Shymala Nada-Raja, Toimaiora - Otago University Injury Prevention Research Unit
48. National Māori Council of Nurses
49. Saliti Ngan-Woo
50. Frank Ngatai, Te Puni Kōkiri
51. Puti Nicholls
52. Arawhetu Peretini, Manager, Mental Health Māori, Ministry of Health
53. Carmel Petreu, Pacific Health Unit, Ministry of Health
54. Jessica Phuang, Asian Liaison Officer, Auckland Police
55. Keith Pitman, Yellow Ribbon Campaign
56. Theresa Pomeroy, Huia Communications
57. Fuimaono Karl, Pulotu-Endermann
58. Faiela Rawson, Pacific Care Trust
59. Dr Paparangi Redi, Te Rōpū Rangahau Hauora a Eru Pomare
60. Lewis Rivers, Skylight
61. Heker Robertson, Ministy of Pacific Affairs
62. Iritani Rudolph, Hapai te Hauora Tapui
63. Debbie Ryan, Advisor, Pacific Health, Ministry of Health
64. Kathleen Samu
65. Manu Sione, Pacific Trust
66. Harold Soe, Pacific World
67. Margaret Southwick, Pacific Health Research Centre, Whitireia Polytechnic
68. Merryn Statham, SPINZ
69. Tahu Stirling, Hauora Maturaka
70. Sailau Sua Uli'i
71. Ika Tameifuna
72. Ben Taufua, Middlemore Hospital
73. Jemaima Tiatia
74. John Tovey, Te Rōpū Te Roopu Taniwhaniwha
75. Alan Va'a, Manakau Youth Centre
76. Moira Wairama, Playwright
77. Louisa Wall, Health Research Council
78. Clayton Wikira, Hokianga Health Enterprise Trust
79. Noho Williams, Ministry of Health, Christchurch

Appendix B – Glossaries

B.1 Māori

aroha the usual translation love is not an exact equivalent for aroha. Its primary reference is caring, compassionate love for others, especially love for relatives. It is also used to convey: sympathy for those in sorrow or trouble; gratitude; and approval. It is not properly used for sexual love.

atua spirit, god, spirits.

hapū a middle-range socio-political grouping defined by descent from a named ancestor through both male and female links, generally associated with a local district and community, commonly regarded as a subdivision of an iwi.

hui generic term for a Māori gathering, typically held on a marae and organised according to a nga tikanga o te marae.

hingengaro mental and emotional state.

kaupapa basic idea, topic, plan, principle.

kaupapa-based whānau whānau formed to address particular issues, principles or purposes.

kawa protocol or ritual

iwi a people, as in te iwi Māori (the Māori people); a large-scale socio-political grouping defined by descent from a named ancestor and usually transcribed as tribe; bone.

marae enclosed space in front of a village or house.

mauri life principle of both human beings and other aspects of nature: material object representing the life principle of someone of something.

noa free of religious restriction; ordinary; relaxed; the complement and antidote of tapu.

rangatahi young leader; young person.

tapu in a state of religious restriction, which may be translated as sacred or polluting according to context; n. the rule prohibiting access to something tapu.

tinana physical environment

taonga treasure

te the

tikanga rule, plan or method, normal, usual, reason, correct, right.

tipu grow, increase

turangawaewae place to stand

tūroa established of long standing, physical environment

tupu grow, increase

tuku iho cultural heritage

utu return for something received, whether good or bad; reciprocity, compensation, price.

wairua spirit; the incorporeal aspect of the person.

whākapapa descent line(s) tracing the connection between ancestors and their descendants; the recital and study of descent lines and associated kinship linkages.

whakamā used to describe a range of feelings from shyness through embarrassment to shame and behaviour involving varying degrees of withdrawal and unresponsiveness.

whānau family.

whānaungatanga relationships.

whāngai feed; nourish, bring up. Used by eastern and southern iwi as an adjective to describe adoptive relationships and as a noun to describe adopted children.

whenua land, country

B.2 Samoan

aiga family

Fa'aaloalo respect

fa'anoanoa an emotional unwellness caused by family disruption or disharmony

faipele card operators

fale house

feagaiga brother –sister covenant

Fealofani harmonious relations

Loto alofa love, compassion

ma'i aitu a term for most ailments pertaining to the mind or psyche, or a spiritual illness

matai head of a family / chief

pou post

sa forbidden, prohibited, sacred, holy

tapu to make sacred, to place under restriction

taulasea healer who uses massage to rebalance the life essence

taulaitu (taula aitu) healer of the mind and spirit

Tautua service

To'aga i le lotu commitment to Christian life and the church

va space between

B.3 Tongan

fahu the status given to the father's eldest sister, defined as the person with unlimited authority over others within her blood kin

faito'o medicine, Tongan doctor, treatment

Famili family

kau faito'o fakamahaki a particular type of spiritual healer

B.4 Cook Island Māori

Kōpū extended family