REPORT OF RESEARCH FINDINGS

SUPPORT FOR FAMILIES, WHÄNAU AND SIGNIFICANT OTHERS AFFECTED BY A SUICIDE ATTEMPT

FINDINGS FROM STAKEHOLDER CONSULTATION

APRIL 2004

HEALTH INNOVATIONS MANAGEMENT SERVICES LIMITED
# Table of Contents

Table of Contents ........................................................................................................................................2

1 Executive Summary .......................................................................................................................................4

2 Acknowledgements .....................................................................................................................................5

3 Introduction ................................................................................................................................................6

  3.1 Project Scope .........................................................................................................................................6

  3.2 Focus Group Participation .......................................................................................................................7

  3.2.1 Service Provider groups ....................................................................................................................7

  3.2.2 Service user groups ...........................................................................................................................8

  3.3 Telephone Interviews ............................................................................................................................9

  3.4 Adjustments for This Phase ...................................................................................................................9

4 Methodology ................................................................................................................................................10

  4.1 Focus Group Content .............................................................................................................................10

  4.2 Interviews ..............................................................................................................................................11

5 Report of Findings ......................................................................................................................................12

  5.1 Overview ................................................................................................................................................12

  5.1.1 Proceedings .......................................................................................................................................12

  5.2 Key Issues in Supporting People Affected by a Suicide Attempt .........................................................13

  5.3 Types of People Affected .......................................................................................................................13

  5.4 Support Needs .......................................................................................................................................14

  5.4.1 Respite care .......................................................................................................................................14

  5.4.2 Financial support ...............................................................................................................................14

  5.4.3 Information .......................................................................................................................................15

  5.4.4 Support groups ..................................................................................................................................15

  5.4.5 Support for resistant family members ...............................................................................................15

  5.4.6 Professional counselling ...................................................................................................................15

  5.5 Accessing Support ................................................................................................................................15

  5.6 Services Currently Available ................................................................................................................16

  5.7 Opportunities for Improving Support ....................................................................................................17

  5.7.1 Workforce Development and Training .............................................................................................17

  5.7.2 Funding for Services ........................................................................................................................18

  5.7.3 Culturally Suitable Services ............................................................................................................18

  5.7.4 Cooperation Between Organisations ...............................................................................................18

  5.7.5 Awareness About Services Available ..............................................................................................19

  5.7.6 People Affected by a Suicide Attempt Choosing to Engage with Services .....................................19

  5.7.7 Community Awareness and Understanding .....................................................................................19

  5.7.8 Additional Issues .............................................................................................................................20

6 Conclusions ................................................................................................................................................21
1 EXECUTIVE SUMMARY

From June 2000 to May 2001, 5,060 people were admitted to hospital with injuries from intentional self harm. Fifteen percent of these people were Māori and 30% percent were youth (aged 15-24). The total figure across New Zealand is higher than this, as those not admitted to hospital were not included.

This report presents the findings from research commissioned by the Ministry of Youth Development to determine support needs of families, whānau and significant others (FWSO) affected by a suicide attempt. The findings suggest that the effects of suicide attempts on others are compounded by systemic deficiencies that currently exist within the Mental Health system in New Zealand.

The high rate of youth suicide attempt suggests that there are significant implications for parents providing care. The focus groups conducted revealed that the greatest issue facing FWSO bereaved by suicide is the need for respite from the ongoing care needs of family members who have attempted suicide. Other needs issues identified included:

- The need for understanding of the Privacy Act and consistent application of the Act as it pertains to the involvement of the family in care and treatment of a person who has attempted suicide.
- The need for a central point of contact to link people with services that are available to support them, following an attempted suicide of a family member or significant other.
- The need to be involved in the evaluation of effectiveness/usefulness of services for people who have attempted suicide.
- People affected by a suicide attempt generally want support from those who been through similar experiences. This needs to constructive support, therefore there may be training needs.

The following issues with the current situation were discussed as key to addressing needs:

- Families are often faced with being the primary care giver of a person who has attempted suicide, but without the appropriate information or training to do so.
- There is currently a respite care infrastructure in place, but it is not readily available due to limited funding.
- The inability to access services for those who have attempted suicide has significant and negative effects on families, whānau and significant others affected by the suicide attempt.
- Practical needs are entirely unmet, except perhaps if you are currently a WINZ beneficiary.
- A number of people can be affected when a suicide attempt occurs, but the need for support generally occurs in the immediate family, parents, siblings, and children.

The following report describes the consultation undertaken, and details of the findings.
2 ACKNOWLEDGEMENTS

Health Innovations would like to express our appreciation to Meliors Simms and the team at the Ministry of Youth Affairs for their assistance in conducting this research. The guidance and assistance we have received has been invaluable to preparing this report.

We would also like to acknowledge all of the people who took time out of busy schedules to attend focus group meetings and participate in telephone interviews. Without these people, this research would not have been possible.

We are also grateful to Dr Annette Beutrais for providing case vignettes to be used as discussion points in the focus groups for this stage of the work.

In addition, the peer reviewers for this research have contributed valuable feedback throughout the research and their efforts are most appreciated.
3 INTRODUCTION

This report presents findings from the second stage of stakeholder consultation undertaken to as part of a wider study to identify and assess the types of support services needed for families, whānau and significant others (FWSO) affected by a suicide. The aim of the research is to identify best practice that will underpin a service delivery plan for New Zealand.

The initial consultation phase comprised a questionnaire that was mailed out to over 1000 people across New Zealand. During this second stage, focus groups and interviews were conducted in order to elicit more detailed information than could be obtained from the questionnaire and to promote collaboration and networking among providers.

It is important to note that the findings from this part of the research are not statistically meaningful, given the low number of participants in the focus groups. For this reason, the information provided should not be considered as conclusive, but rather as an indication of key issues that might be further explored through more extensive research.

It is also of particular significance that this research was not able to capture feedback from Māori, Pacific people, Asian or other cultures either from a service provider or service user perspective. Attempts to involve these perspectives were unsuccessful and therefore this report does not represent the needs of different cultures in a meaningful way. It is recommended that this report be read in conjunction with the literature review on Support for Māori, Pacific Island and Asian Family, Whānau, and Significant Others who have been affected by suicide attempt, in order to gain insight to the needs of these populations.

Despite the low number of participants, the findings presented here are consistent with the first part of the research that focused on support for families, whānau and significant others following a suicide attempt. In addition, the feedback received through the focus groups was consistent across groups and geographic areas.

3.1 Project Scope

Health Innovations Management Services (HIMS) contributed to the research, in accordance with the following brief for this portion of the wider research project:

- Focus groups and/or interviews with key stakeholders, to discuss support for FWSO affected by a suicide attempt.

The focus groups were to involve FWSO affected by a suicide and providers working with this population. Individual interviews were also conducted in cases where people were unable to participate in focus groups.
3.2 Focus Group Participation

Seven focus groups were conducted in the three main centres of New Zealand; Auckland (Central and South), Wellington and Christchurch. The targeted number of group participants was eight per group.

The groups were separated into service provider participants and service user participants so that the different perspectives of people in varying roles could be captured.

3.2.1 Service Provider groups

A total of 72 invitations were initially sent out to service providers. Of those, 25 people (35% of the total invited) confirmed their attendance. Nine people who had confirmed, did not attend the groups, resulting in a total of 16 participants (22% of the total invited) among the four service provider groups.

Invitations were sent out via mail and fax, with follow-up reminders via phone and fax during the following two weeks.

An additional 44 invitations were sent out ten days prior to the focus groups. Due to the short time frame, this only resulted in one additional participant.

3.2.1.1 Types of Organisations Represented

Focus group participants were selected from among the questionnaire respondents, as well as from recommendations provided by people working in the sector.

The following table provides a breakdown of the number of service providers invited to participate in the focus groups within general categories, the percentage of the total invitations for each category, the actual number of participants within those same categories, the percentage of participants within each category, and the percentage representation of the total participants for each category.

Table 3: Focus group participants*

<table>
<thead>
<tr>
<th>Type of Organisation</th>
<th>Invited Participants</th>
<th>% Of Total Invited</th>
<th>Actual Number of Participants</th>
<th>Actual Participants as % of Invited Participants in this Category</th>
<th>Actual Participants as % of Total Participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Educational Institution/MOE</td>
<td>14</td>
<td>19%</td>
<td>2</td>
<td>14%</td>
<td>13%</td>
</tr>
<tr>
<td>Māori</td>
<td>6</td>
<td>8%</td>
<td>1</td>
<td>17%</td>
<td>6%</td>
</tr>
<tr>
<td>DHB</td>
<td>15</td>
<td>21%</td>
<td>2</td>
<td>13%</td>
<td>13%</td>
</tr>
</tbody>
</table>
3.2.1.2 **Roles of Participants**

The roles of the focus group participants did not feature as a factor in the feedback provided. While people in different roles contributed different perspectives on a theme, the individual roles did not impact on dissent or consensus among role types or within groups.

The following respondent types were focus group participants:

<table>
<thead>
<tr>
<th>Table 4: Roles of service provider focus group participants</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental Health Provider</td>
</tr>
<tr>
<td>Administration/Management</td>
</tr>
<tr>
<td>Medical</td>
</tr>
<tr>
<td>Educator</td>
</tr>
<tr>
<td>Other</td>
</tr>
</tbody>
</table>

3.2.2 **Service user groups**

In addition to the service provider focus groups, service user focus groups were also held in Central Auckland, Wellington and Christchurch. Advertisements were placed in the local papers to invite participants to attend the focus groups. Meetings were scheduled for evening hours to enable people to participate outside of working hours.

A total of 15 people who responded to the advertisements, confirmed that they could attend the focus groups. Seven people who confirmed, did not attend the groups, resulting in a total of eight participants among the three groups.

3.2.2.1 **Relationships**

The relationship to the person attempting suicide was the main reason for the participants attending the focus groups. It is important to note that three of the eight participants had also been affected by a suicide attempt or a completed suicide by another member/s of the family.

<table>
<thead>
<tr>
<th>Table 5: Relationship of service user group participants to the person who attempted suicide</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mother</td>
</tr>
<tr>
<td>Father</td>
</tr>
<tr>
<td>Sister</td>
</tr>
</tbody>
</table>
3.3 Telephone Interviews

Interviews were conducted via telephone to supplement the information gathered through the service user focus groups. An additional three people agreed to do an individual interview.

Findings from the telephone interviews were consistent with those of the focus groups.

3.4 Adjustments for This Phase

The following adjustments were made in an attempt to increase participation in the focus groups:

- **Increasing involvement of FWSO bereaved by suicide** – advertising was placed in regional newspapers to invite people affected by a suicide attempt to attend a focus group to discuss support services.

- **Ensuring additional lead time for focus group participation** – additional time was built in to enable extra initiations to be sent out, if the response rate was low. This did not result in additional participants attending the focus groups.

- **Increasing participation of Māori providers and FWSO bereaved by suicide** – Twenty five percent of the participants in the service user focus groups were Māori. Seventeen percent of the participants invited to the service provider focus groups were from Māori organisations, but only 6% attended.

- **Shorter focus group sessions** – it was decided to reduce the time in the focus group from three hours to two. The three hour time frame meant participants were having to give up a half day to attend.
4 METHODOLOGY

The stakeholder consultation was undertaken by conducting two separate types of focus groups, as follows:

1. **Focus Groups – Service Providers**

   Face-to-face meetings were conducted with service providers, in the form of focus groups, to gather more detailed information on support services for FWSO affected by a suicide attempt. Invitations were sent to those who attended the last round of focus groups, and others who expressed interest in participating in the focus groups, but were unable to attend the focus groups held last year to discuss support needs of FWSO bereaved by suicide.

2. **Focus Groups – Service Users**

   Face-to-face meetings and individual interviews were held with family, whanau and significant others who had been affected by a suicide attempt. These participants self-identified from adverts placed in regional newspapers. The adverts were chosen as the preferred method of identifying participants, as many provider organisations were reluctant to be involved in recruiting participants from among their own client lists or other contacts.

   Where participants were unable to attend the focus groups, individual interviews were scheduled.

   In order to ensure that participants in these focus groups were appropriately supported and that the meetings were conducted with adherence to a professional code of ethics, the groups were facilitated by a PhD level psychologist.

It was anticipated that by keeping the groups separate, service users would have an opportunity to more freely express their views about their experiences of and needs for support services.

4.1 **Focus Group Content**

The focus groups enabled further investigation into support services currently available to FWSO affected by a suicide attempt.

Service provider participants were asked to review a series of three case vignettes to identify the types of people affected by a suicide attempt, what their support needs might be, how they might access this support, and whether it is currently available. Participants were invited to provide input based on their knowledge and experiences.
Service user participants were asked to think about their situation and to identify people who were affected by the suicide attempt, what their support needs were and factors involved in accessing support.

During the second part of the focus groups, participants were asked to prioritise areas of need for support services for FWSO affected by a suicide attempt. The rating scale used was 1 for high priority through 5 being lowest priority.

Feedback was gathered from participants using standardised forms for data capture to indicate written responses. Verbal responses were captured by the group facilitators, according to topic areas.

### 4.2 Interviews

Individual telephone and face-to-face interviews were conducted to supplement the information obtained through the focus groups. Questions were similar to those presented in the focus groups. Interviewees were self selected based on their inability to attend the focus groups.

Responses were recorded by interviewers using a standardised form so that feedback could be reviewed by topic category in the same manner as for the focus groups.
5 REPORT OF FINDINGS

5.1 Overview

Overall, the findings from the service provider focus groups were consistent with those of the service user focus groups. This is notable, given that the participants in each of the groups were not provided with information about feedback from the other groups.

A variety of organisations were represented among the service provider focus group participants, including:

- Guidance counsellors
- Counsellors
- Lifeline
- District Health Boards (DHB)
- SPINZ
- Private Psychologists
- NZ Aids Foundation
- Van Asch Deaf Education Centre
- Hillmorton Hospital

5.1.1 Proceedings

The group facilitators introduced themselves, and gave a brief introduction of Health Innovations and their involvement with the Ministry of Youth Development on this research project. Participants were then advised of the purpose of the stakeholder consultation.

The group participants were then asked to introduce themselves. For service providers, this meant describing the organisation they came from and their role within that organisation.

Service users were asked to introduce themselves and to talk about how they had been affected by a suicide attempt. Some participants were FWSO bereaved by suicide, who were bringing forward their views of support needs prior to the suicide, when there had been multiple attempts at suicide.
5.2 Key Issues in Supporting People Affected by a Suicide Attempt

Participants were asked to write down the single greatest issue that they believed currently exists in relation to support for people affected by a suicide attempt. The main issues that were highlighted by participants were:

- There is a lack of awareness of services available to support people affected by a suicide attempt.
- Families are often not made aware of suicide attempts because of the Privacy Act, and therefore cannot provide valuable history.
- Feelings of guilt, anger and blame can be disabling for family members.
- Service providers are often not made aware of suicide attempts by their patients, i.e. when they’ve been seen by A&E.
- Support in rural communities is very limited.
- Families do not know where to go for assistance, as Mental Health Services (MHS) and crisis services through the DHBs are not generally available to families.
- Families are being referred to inappropriate services, and are not asked to provide feedback.
- GPs are generally the only health professional in a rural community, and they are not usually trained in mental health issues.
- People affected by a suicide attempt cannot go directly to MHS, and often cannot afford the cost of a GP visit to get a referral.
- Good psychologists are expensive to access.
- Service users wanted somewhere to go to share their experiences with others who understand what they have been through.
- There are no support services available for siblings.
- The quality of service providers allocated by CAFS is variable.

5.3 Types of People Affected

Group participants were asked to identify the types of people who, in their personal experience, had been affected by a suicide attempt, or to use the case vignettes as an example. The main groups of people identified were:

- Parents
- Partner, husband or wife
- Siblings
- Children
- Health professionals
- Friends
  - Of the family
  - Of the attempter
- Work colleagues
- Distant relations
- Other (i.e., parole officers, lawyers, drug dealers)

It was felt that support was often identified for parents, in the case of an adolescent attempting, and partners, in the case of adults attempting, but siblings and children are often the ones who are left out.

5.4 Support Needs

The following support needs were highlighted as the key types of assistance that FWSO would find valuable:

- Respite care
- Financial support
- Information
- Support groups
- Support for resistant family members
- Professional counselling

5.4.1 Respite care

The greatest support need identified for immediate families was respite care. Adolescent and young adult attempters are generally released into the family’s care when they are still ‘at risk’ or even suicidal. This puts pressure on the family to ensure someone is always on watch for changes in behaviour that may lead to another suicide attempt. This is particularly difficult for solo parents, who have no family support, but can also be difficult for nuclear families, as one parent is always on watch, which puts pressure on their marriage/relationship.

Another component of a respite care service that families would find beneficial is to have a buddy support system in place. This would be someone you could call upon when you are struggling to stay awake during the night when you’re on watch, or just someone to talk to when the circumstances feel overwhelming.

5.4.2 Financial support

Financial support was also identified as a strong need for immediate or extended families. Parents, partners and/or grandparents, often have to take time off work to care for family members who have attempted suicide, and/or to attend family meetings regarding care plans. In some cases solo income earners cannot afford time off work, as it means no money coming into the household.

There may also be additional expenses for travel, babysitters, or feeding/clothing other people who may now be living in the household. During the immediate stage following a suicide
attempt some families required support in the home for daily tasks that become neglected, i.e. cooking, washing and cleaning.

5.4.3 Information

There were several areas of information needs identified. Information for FWSO on how the Privacy Act works, and when Health Professionals can and should be overriding this to involve families in care/treatment plans. Families also wanted practical information on what to expect, how to handle it and how to ensure their family members safety. Information is available on how to manage diabetes and asthma, but information on managing suicide risk is not readily available or accessible.

5.4.4 Support groups

Family members who attended the focus groups expressed a need to talk to people who have experienced what they are going through. No one had managed to find a support group of people they could meet with. It was recognised that these support groups should be run by a trained facilitator, but should be someone who has been affected by suicide or a suicide attempt who has received formal training as a facilitator.

The majority of participants said that the focus groups were the first time they had spoken to anyone in a similar situation to them, and felt much better after the experience. Participants expressed appreciation for hearing others talking about similar feelings struggles that they had experienced.

5.4.5 Support for resistant family members

Support for resistant family members affected by a suicide attempt was also identified as a need. How to engage resistant family members to accept support, when it is perceived that assistance is needed, is often a major issue. Compassionate Friends is a youth group set up for siblings affected by cancer, but there is nothing similar for siblings affected by suicide attempt.

5.4.6 Professional counselling

Trained counsellors who can provide individual and family therapy on an as needed basis, was also identified as a need. This is sometimes provided through DHB CAF Services, but is inconsistent and not evaluated for effectiveness. The main purpose of this therapy is to provide emotional support to the family, but does not assist with any practical needs that may arise.

5.5 Accessing Support

Work and Income were identified as a possible source of financial assistance, but this level of support is income tested and it was recognised that it can take a long time to receive assistance if you are not currently a beneficiary.
There was general consensus that people requiring support when affected by a suicide attempt do not know where to go for assistance. Group participants thought there should be a liaison service where those affected could find out what is available in their area. It was recommended that this service could be accessed through an 0800 number and that telephone operators had access to a database of services available in the caller’s area. Some participants also felt that the service should be available 24hrs a day, seven days a week.

It was also recommended that information materials be readily available in public places, such as GP surgeries, library’s, hospitals (A&E), Alcohol and Drug services, community centres and churches. It was thought though that church ministers and priests might need education about suicide and suicide attempts.

5.6 Services Currently Available

The Mental Health Foundation was recognised as an organisation producing very good informational brochures. Lifeline, Raeburn House, SPINZ and Auckland City Council have directories of community support services available in specific areas. These directories were not specifically targeted to support services for people affected by a suicide attempt, but were mentioned as examples of community directories to explore.

The Salvation Army was recognised as a free service that is currently helping people who are experiencing difficult times in their lives, to get back on their feet. Citizens Advice Bureau was mentioned as a place to obtain information on support services available.

In some parts of New Zealand support groups are operating, but these groups are struggling to obtain funding for training facilitators to ensure the groups are run effectively and are of benefit to participants.

Supporting Families in Mental Illness NZ (SFNZ) was also identified as an organisation providing practical and emotional support to families of people with serious mental illness.

Rural families usually have access to an emergency fund to assist with travel costs when accessing health services outside of their community. However, this is usually a reimbursement rather than an up-front payment, which causes difficulties from some families.

It was also recognised that there are a number of very good private therapists in the community who would be available to provide therapy, but cost was seen as a major barrier to accessing these services. The quality of therapists available through the public mental health services is extremely variable, and there are often long two to three-month waiting lists.

Service users felt that if they knew the right questions to ask, they could access services through the public health system, but it was generally after a battle.

The hospice structure was identified as an excellent model of care. Families are provided with assistance for practical activities such as grocery shopping, baby sitting and transport.
5.7 Opportunities for Improving Support

Group participants were asked to think about prioritising support needs, under the following key headings:

- Workforce Development and Training
- Funding for Services
- Culturally Suitable Services
- Cooperation Between Organisations
- Awareness About Services Available Among Those Affected by a Suicide Attempt
- People Affected by Suicide Choosing to Engage with Services
- Community Awareness and Understanding

Each topic was given a ranking of one to five, depending on how important immediate implementation was to the participant. As there were seven topics, some were given equal rankings. Participants were also asked to comment on why they gave the ranking they did, and any ideas for implementing the solutions.

The graph below shows the number of participants who ranked each category as a high priority, i.e. one or two.

![Graph showing the number of participants who ranked each category as a high priority](image)

5.7.1 Workforce Development and Training

Slightly over half the participants indicated that this was an immediate priority. The main areas to address were providing funding so volunteer organisations could operate more efficiently and provide adequate training to their staff (both volunteers and paid staff). Service users felt funding for training should be directed to those people who have been affected by a suicide attempt, so that they can become effective counsellors/support people.
A number of participants would also like to see funding spent on training GPs to better deal with mental health issues, to prevent more suicide attempts. It was felt that there are enough adequately trained clinicians to provide support to FWSO affected by a suicide attempt, but some practical training of risk management interventions for families would be useful in their role. Providers could then run group training sessions for families to disseminate this information in a practical way.

5.7.2 **Funding for Services**

Slightly over half the participants felt that this was a priority. Some service providers felt that clients can often devalue ‘free’ services, and they tend to be more focussed in treatment when they are contributing to the cost. It was recommended that a similar system to Employee Assistance Programmes be implemented, where there is a finite limit on the funding available, and after that the individual is responsible for meeting some or all of the cost.

Service users felt that funding of respite care was a higher priority than funding of clinical services or counselling. There are a number of volunteer organisations that operate on very limited funds, but with training and service access facilitation, they could be assisting more people.

It was acknowledged that, in some cases, if families, whānau and significant others knew about effective services, they would have found the funds to pay for treatment themselves.

5.7.3 **Culturally Suitable Services**

Approximately one quarter of participants felt that this was an immediate priority. Group participants felt that awareness and access to services was the first step. Once services are identified and established, then there would be a natural progression of ensuring cultural appropriateness.

As well as identifying services that were appropriate for people from different ethnic backgrounds, there is a need to ensure services are available for all age groups.

FWSO all need to have a choice regarding accessing mainstream or culturally specific services. In some cases, culturally specific services may not be appropriate.

5.7.4 **Cooperation Between Organisations**

Almost three quarters of the group participants saw this as an area of immediate focus. There is a perception that a number of organisations are providing duplicate services, with funding from different revenue sources.

Cooperation between organisations in rural communities was identified as working well, with a number of small agencies sharing buildings and reception areas.

Private and NGO organisations reported having difficulty working with public organisations. For example, if a patient who is seeing a private therapist is treated at A&E after a suicide
attempt, their current therapist is not notified. To ensure effective treatment for the patient, communication between agencies is essential.

Service providers and service users perceive that Government funded services are hard to access. This includes DHB Mental Services, Work and Income, ACC, Accident and Emergency Services, and Crises Intervention Services.

5.7.5 Awareness About Services Available

This was clearly the highest priority for group participants, with nearly 90% of attendees rating this as an immediate priority.

Participants reported that those people affected by a suicide attempt don’t know where to turn for support. Support services have been identified, but in the majority of cases families don’t know about them.

Several participants thought it would be ideal to have a central point of contact where FWSO can find out about the services available to meet their immediate, short term and long term needs. In a time of trauma, people often need assistance to establish what their needs are and how to meet them. This need can arise at any time of the day or week as well.

Information on this central point of contact could be given to families by their GP, at A&E, by Mental Health Services, and/or advertised in the front of phone book with other Health services.

5.7.6 People Affected by a Suicide Attempt Choosing to Engage with Services

Group participants rated this as the lowest priority. Most participants reported that this was beyond anyone’s control, and would be the individual’s responsibility. The priority was to ensure that those people effected by a suicide attempt knew where to go to find out what services are available to assist them.

It was also agreed that if services were appropriate, then the people affected by suicide would be more inclined to access them.

It was acknowledged that in some cases FWSO don’t know what they need, and it would help to have a social worker or support person assigned to families to help define what support was required, and to ensure that those displaying symptoms of not coping, were engaging in appropriate treatment.

5.7.7 Community Awareness and Understanding

Once again, slightly over half the participants felt that community awareness and understanding was a high priority.

Education campaigns regarding Mental Health conditions have helped to increase awareness and reduce stigma. It was suggested that the campaigns need to include information on where to get help if you are affected. More education from SPINZ and the Mental Health
Foundation is needed. Some service users were not aware of SPINZ and the information currently available from them.

Most participants agreed that public education campaigns should be around supporting suicide prevention and early detection, as prevention is better than a cure. Participants also commented that the stigma associated with suicide is slowing disappearing, but there is still silence and people do not know how to talk about it.

5.7.8 Additional Issues

There were several additional issues that were raised during the groups. These included the following:

- Whether the community at large understands the difference between a suicide attempt and self-harming.
- Family history of completed suicides and suicide attempts is often not investigated by GPs and Mental Health Services.
- There is no real measure of service effectiveness at the time of service provision, nor is there any standardised process for reporting outcomes for individuals receiving care. Families do not feel that they are given an opportunity to provide feedback about services and the care that family members have received.
- The prevalence of Drug and Alcohol addiction amongst those people attempting suicide. Families wanted more information on the correlation between suicidal tendencies and drug and alcohol addictions.
6 CONCLUSIONS

A recurrent theme throughout the focus groups was the frustration that FWSO experience with obtaining assistance for family members at the time of a suicide attempt and in the aftermath of the attempt. This issue is so significant that it was difficult to elicit information from FWSO about support needs beyond this. Therefore, efforts to provide better support for FWSO affected by suicide attempts will need to address the challenges and barriers for FWSO resulting from the deficiencies present in the current Mental Health service.

People at risk of suicide meet the criteria for receiving care through the public health system. Unfortunately, challenges with appropriate resourcing and funding allocation that currently exist within the Mental Health system mean that people are being denied access to care. FWSO report that this often results in people at risk of suicide being unable to access care or discharged from inpatient care, before it is safe to do so. Families are then left to cope with the burden and stress of caring for people who are at severe risk of suicide, without having the capability to do administer care appropriately.

The support needs of FWSO affected by a suicide attempt are compounded by the need for support to cope with the inadequacies of the Mental Health system. In addition to emotional support such as counselling and peer support, practical support, including useful information and resources, will be necessary outside of the mental health system to supplement or counteract the barriers to care and implications of that for FWSO. These circumstances and needs should be considered in developing strategies for improving support for FWSO affected by a suicide attempt.
APPENDIX A – FOCUS GROUP EVALUATIONS

All participants in the focus groups were asked to complete an evaluation of the focus group they attended. Participant’s responses are collated below:

Was the style of the focus group appropriate to the topic?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
</tr>
<tr>
<td>Yes, very good</td>
<td>1</td>
</tr>
<tr>
<td>Yes, excellent</td>
<td>1</td>
</tr>
<tr>
<td>Yes, very passionate group</td>
<td>1</td>
</tr>
<tr>
<td>Ok</td>
<td>1</td>
</tr>
</tbody>
</table>

Did you feel that your input was valued and heard?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>17</td>
</tr>
<tr>
<td>I feel good, I was heard</td>
<td>1</td>
</tr>
<tr>
<td>Yes, definitely</td>
<td>1</td>
</tr>
<tr>
<td>Yes – very good</td>
<td>1</td>
</tr>
<tr>
<td>Yes, often</td>
<td>1</td>
</tr>
<tr>
<td>Yes, everybody was included</td>
<td>1</td>
</tr>
</tbody>
</table>

Was the focus group organised and conducted in a way that was easy to understand?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>20</td>
</tr>
<tr>
<td>Great</td>
<td>1</td>
</tr>
<tr>
<td>Fairly</td>
<td>1</td>
</tr>
</tbody>
</table>
Was there too much or too little time given to different topics?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>5</td>
</tr>
<tr>
<td>It was easy to understand</td>
<td>1</td>
</tr>
<tr>
<td>Could talk for long periods</td>
<td>1</td>
</tr>
<tr>
<td>Start and finish on time, flowed all the time</td>
<td>1</td>
</tr>
<tr>
<td>All OK</td>
<td>1</td>
</tr>
<tr>
<td>About right</td>
<td>1</td>
</tr>
<tr>
<td>Great</td>
<td>1</td>
</tr>
<tr>
<td>Well timed</td>
<td>1</td>
</tr>
<tr>
<td>Just right</td>
<td>1</td>
</tr>
<tr>
<td>About right</td>
<td>1</td>
</tr>
<tr>
<td>Very efficient</td>
<td>1</td>
</tr>
<tr>
<td>Enough time</td>
<td>1</td>
</tr>
<tr>
<td>Fine</td>
<td>2</td>
</tr>
<tr>
<td>More time would have been valued</td>
<td>1</td>
</tr>
<tr>
<td>Scenario 1 had sufficient time – rest rushed, unable to write responses on form</td>
<td>1</td>
</tr>
<tr>
<td>No, the meeting facilitator kept to the plan which meant the meeting was well done</td>
<td>1</td>
</tr>
</tbody>
</table>

Were the topics discussed useful and meaningful?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td>Yes, very</td>
<td>2</td>
</tr>
<tr>
<td>Not sure about vignettes, especially 3!!!</td>
<td>1</td>
</tr>
<tr>
<td>Yes, except been in discussion groups like this since 1990 when I was in the field – will they have results?</td>
<td>1</td>
</tr>
<tr>
<td>OK</td>
<td>1</td>
</tr>
<tr>
<td>Yes, the general consensus was evident</td>
<td>1</td>
</tr>
</tbody>
</table>

Did the focus group cover enough of the relevant points that needed discussion?

<table>
<thead>
<tr>
<th>Response</th>
<th>Number responding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Yes</td>
<td>15</td>
</tr>
<tr>
<td>Nearly</td>
<td>1</td>
</tr>
<tr>
<td>No</td>
<td>1</td>
</tr>
</tbody>
</table>
Ideas for Improvement

- Nil – Well conducted and professional
- More people
- None, all OK
- More participants
- Maybe some questions to think about before we come to the meeting. Info about what other countries do (?)
- How did people get invited to participate?? I think a portion of the community may not have been aware
- More people at group – more ideas
- Clarify identified person and significant to others – maintain clarity and maintain focus
- More
- More information about the direction you sought
- More time for discussion of stigma and discrimination, i.e. Reasons why services don't get used
- One person involved in a support group had lots of personal info as opposed to professional info to share. It is hard to stop someone who talks about a son's suicide. But was a different perspective from others.
- Info on relevant services in area of work would be helpful

Additional Comments

- This has been the biggest discussion since my sisters passing – it was very touching.
- Very well run – pleasant to participate in.
- They listened and understood
- Talk to some young people!! Really important
- Very good
- How about asking Deaf Association to attend?
- Well run and organised. Great hosts!
- Excellent, well lead, a valuable use of my limited spare time. Our views were valued
- Let me know outcome
- Thanks and good wishes for your much needed goals
- Could have immediate response from DHB if able to be coordinated
- Enjoyable and very easy to contribute to discussion. Good idea to have us write down our ideas / ratings first and then discuss them – prevented group from being influenced by one or other individuals.
- Looking forward to outcomes!! Great to see positive research underway