

Reflecting on lived experience: Suicide prevention and the importance of social work in mental health

Behiye Ali, Barbara Staniforth and Carole Adamson

Faculty of Education and Social Work, University of Auckland, New Zealand

ABSTRACT

INTRODUCTION: National suicide prevention strategies and action plans have, historically, been written without input from consumers/current users of mental health services. People who could arguably be seen as experts in this area are rarely asked for their knowledge regarding the efficacy of suicide prevention and intervention efforts. The aims of this study were to gain further insight into the effectiveness of suicide prevention intervention in Aotearoa New Zealand by asking service users “What works?” and to promote lived experience as a valid form of evidence. This article focuses on the importance of a holistic model of health and wellbeing and highlights the role played by social workers, both currently and in the future, regarding suicide prevention and intervention efforts.

METHODS: Twenty semi-structured interviews were conducted with individuals with lived experience of suicidal ideation and/or attempt.

FINDINGS: Using thematic analysis, a variety of interventions were identified which participants found effective, including exercise, addressing physical health needs, practising mindfulness, use of medications and spirituality. These interventions, and others, are presented as themes within a framework of people, body, mind and spirit.

CONCLUSIONS: It is important to view health holistically, and social workers can make an important contribution towards wellbeing through the provision of psychosocial interventions. Also, it is crucial to involve individuals with lived experience within research that informs policy and practice, and within collaborative treatment decisions.

KEYWORDS: Suicide prevention; suicide interventions; lived experience; what works; psychosocial interventions; holistic model

AOTEAROA
NEW ZEALAND SOCIAL
WORK 33(2), 6–18.

CORRESPONDENCE TO:
Behiye Ali
becky.ali@bristol.ac.uk

Suicide is among the three leading causes of death in the world and the second leading cause of death among 15–29-year-olds (World Health Organisation, 2019); in Aotearoa New Zealand, youth suicide rates are particularly high (OECD, 2019). These figures indicate that suicide rates remain at a concerning level, with an imperative for

services and policy to respond accordingly. Suicide prevention policies and action plans are often produced by national governments by and with health professionals, academic researchers, advisory groups (sometimes formed from NGO employees with professional experience) and steering groups (occasionally consisting of whānau/

family members affected by suicide). When psychological, pharmacological and/or psychosocial treatments or interventions are evaluated, the (surviving) service users themselves rarely feature in qualitative efficacy reviews of such interventions. When service users are represented, they are often shown as quantitative figures: for example, how many people had used the services and how many had gone on to re-attempt suicide.

This PhD research project (Ali, 2019) was undertaken between 2015 and 2019 by a non-Māori researcher in Aotearoa New Zealand. Between 2014 and 2019, the rate of deaths by suicide per 100,000 reached 13.93 (Coronial Services of New Zealand, 2019). Within Aotearoa New Zealand's suicide statistics, Māori are disproportionately represented. From mid-2018 to 2019, data reveal that Māori continue to have the highest suicide rate of all ethnic groups at 28.23 per 100,000 population (Coronial Services of New Zealand, 2019). Interventions targeted towards Māori (and Pacific peoples, who are also over-represented in suicide figures) focus on providing support and prevention efforts in culturally appropriate ways. This is essential, as Western models of suicide prevention interventions and mental health services often lack the dimensions, aspirations and holistic focus of Māori and Pacific peoples' models of health and wellbeing (Government Inquiry into Mental Health and Addiction, 2018). Research by Clark et al. (2011, p. 25) suggests that antiracism work is an important part of suicide prevention as "feeling uncomfortable in Pākehā [New Zealand European] social surroundings" was a risk factor among Māori youth for suicide attempts (odds ratio = 1.698, $p = 0.0040$). Clark et al. (2011) suggest this risk factor may reflect the racist environments in which many Māori youth live.

In line with social work professional values and recently developed ethical principles (ANZASW, 2019), one aim of the research was to contribute information

from service users which could influence suicide prevention interventions and policy formation. The research sought to find out what works according to the people who directly receive suicide prevention and intervention services. An over-arching aim was to contribute to existing knowledge in order to improve current treatments and services, influence those provisions in the future and reduce suicide rates.

This article reflects on the research findings and discusses them in line with social work values, practices, and regarding the role of social workers within suicide prevention and intervention. The non-medical interventions described by participants provide rationale for strengths-based and recovery approaches to be used within social work. Current suicide prevention interventions, treatments and services in Aotearoa New Zealand are described using vignettes and the future of these efforts is discussed with a focus on the importance of collaboration between practitioner-experts and service-user-experts.

Promoting lived experience as evidence

The recovery movement in social work and mental health has advocated for the voice of people with lived experience of mental distress to be given choices and power in decision-making in their treatment. Consistent with this, the evidence-based practice framework as described by Drisko (2017) states that, for an evidence-based process to occur, people need to be given information about potential treatments and make choices which suit them best, not always those advocated by professionals.

In 2018, the Aotearoa New Zealand Government announced *He Ara Oranga* (Pathways to Wellness)—an Inquiry into mental health and addiction—with the aim of improving mental health services with a particular focus on equity of access. The Government intended the Inquiry to gather feedback from the mental health sector, service users and the wider community

about their experiences, expectations and the current strengths and weaknesses of the mental health system. One of the resulting recommendations from the Inquiry called for the co-design and implementation of service transformation and for the Government to “Direct the Ministry of Health, in partnership with the new Mental Health and Wellbeing Commission (or an interim establishment body) to facilitate a national co-designed service transformation process with people with lived experience of mental health and addiction challenges” (Government Inquiry into Mental Health and Addiction, 2018, p. 16). Social workers can play a crucial role in efforts to implement the Inquiry’s recommendations.

Furthermore, there has been a recent push for mental health service users to be co-creators in research regarding possible interventions (Halvorsrud et al., 2019). Conducting research with individuals with lived experience is vital to improving health and social care provision (Doughty & Tse, 2005; Mead et al., 2001). Service users must be included in suicide prevention research if we are to find out and then promote what works (Gibson et al., 2012) with the aim of better supporting people experiencing suicidal ideation and hopefully reducing suicide rates (Ward-Ciesielski & Linehan, 2014).

As evidenced by the findings of this research, service users want to have a say in the treatment they receive. As experts in their own care, they are also a source of invaluable knowledge into effective suicide prevention and intervention treatments and services, and without their active input, mental health support practices and suicide prevention interventions will risk being flawed. Drisko (2017) advocates for social workers’ active collaboration with clients, and for practitioners to be open and reflective when using evidence-based practices to explore clients’ needs and strengths, when identifying treatment options, and when deciding on a plan together.

The context of intervention and prevention

This section will outline some of the initiatives and treatments in Aotearoa New Zealand from the macro policy domain to individualised treatments.

Government policies and legislation

In response to peak suicide rates in 1998, the Aotearoa New Zealand government released a National Youth Suicide Prevention Strategy (Ministry of Health, 1998), and later, further strategies and action plans which shifted the focus to all-ages efforts. At the time of this PhD research, the Suicide Prevention Strategy (2006–2016), and the supporting Suicide Prevention Action Plan (2013–2016), provided a then-current framework for understanding how various activities within a range of sectors fit together to prevent suicide.

After analysing the feedback from the *He Ara Oranga* Inquiry, the Government later published its National Suicide Prevention Strategy *Every Life Matters – He Tapu te Oranga o ia Tangata* 2019–2029 and the linked Suicide Prevention Action Plan 2019–2024 for Aotearoa New Zealand (Ministry of Health, 2019). The Strategy and the Action Plan reflected a significant change in the ways in which service users are seen as contributors of valuable knowledge; these plans have transformed the previous suicide prevention frameworks and legislation by listening to (and acting upon) the knowledge, experience and ideas shared by people with experience of suicidal ideation and attempt. And, for the first time nationally, the Aotearoa New Zealand Government are asking people for their input and are using their responses to focus efforts on reducing suicide rates.

The role of medication

Fawcett and Busch (2014) argue that pharmacologic treatments are an important part of suicide prevention, whereas other researchers state that medications, prescribed to address feelings of major depression

and suicidal ideation, may in fact increase risk factors for suicide (Hammad et al., 2006). Separately, it could be argued that medications aimed at broader mental health challenges could potentially (indirectly) prevent suicide and therefore could be prescribed alongside other interventions such as psychological treatment and/or psychosocial support.

However, by recognising the social experiences and contributing factors of mental distress (including trauma, loss and abuse, and experiences in childhood and adolescence), the domain of social work brings a different perspective to the medical treatment of mental health. Allen (2014) states these determinants are often missed in purely medical, illness-based approaches and argues these approaches and the medical model of health can in fact “get in the way of recovery and change through focus on the illness rather than the person as a whole – their fundamental human potential and the opportunities they could access to bring about change” (p. 11).

The executive summary of the *He Ara Oranga* Inquiry echoed this critique of medically dominated mental health systems where medication may often be used as an intervention of first choice: “We can’t medicate or treat our way out of the epidemic of mental distress and addiction ... People may be offered medication, but not other appropriate support and therapies to recover.” (Government Inquiry into Mental Health and Addiction, 2018, pp. 10–11).

Psychological interventions

Interventions offered by clinical social workers are underpinned by recovery approaches, strengths-based models, systemic models, indigenous models and therapies including cognitive behavioural therapy (CBT) and dialectical behavioural therapy (DBT) (Appleby et al., 2020).

Moving away from a medical model of health, clinical social workers also promote

person-based approaches within clinical settings, for example, through the co-design of assessment and goal setting thus aiming to reduce the power inequality between practitioners and service users (Booyesen, 2017).

DBT is a cognitive-behavioural approach that enables a person to link body, mind and emotional responses to stress and several participants in this research project described finding DBT helpful. DBT has been shown to be effective in reducing suicidal behaviours by up to 50% during treatment and follow-up phases (typically at least one year each) in seven randomised controlled trials when compared to treatment as usual (Linehan et al., 2015; McMain et al., 2009). In Aotearoa New Zealand, Cooper and Parsons (2010) found their social work background aids their understanding and delivery of DBT. The authors argue, that once trained, social workers are highly skilled DBT practitioners as the therapy aligns well with social work values.

A systematic review and meta-analysis by TARRIER et al. (2008) discussed significant effects of CBT in reducing suicidal behaviour. CBT has also been adapted for use with Māori in Aotearoa New Zealand (Bennett et al., 2014). A 12-session programme, organised into five progressive treatment phases, was developed by the authors and their colleagues and was informed by dimensions of Māori culture.

There is strong evidence in support of acceptance and commitment therapy (ACT) as a way to dismantle negative, anxious or violent thoughts (Ruiz, 2010); but it is worth noting that ACT is a therapy with quite specific characteristics, and it is seldom used to respond to severe depression and suicidal ideation (Flaxman et al., 2010).

Psychosocial interventions

Outside of therapy models, there exist several psychosocial interventions that address the personal, social and vocational

problems associated with mental health disorders (Cramer & Kapusta, 2017). Consistent with social work practice, psychosocial interventions discussed by participants in this study included: support groups, exercise, religious support, whānau/family, social and cultural support systems and telephone helplines. Linked to these is research into social inclusion (Silver, 2010) and family connectedness (Matlin et al., 2011) as effective suicide interventions.

Culturally focused interventions

According to the *Kia Piki te Ora* Suicide Prevention Programme Evaluation final report (Ministry of Health, 2015), a *Kia Piki te Ora* (Māori Suicide Prevention Service) operates in nine District Health Board regions and is one part of the health and social care sector's longer-term goals to reduce suicides and suicidal behaviours in Māori communities. The service works towards these goals by promoting mental health and wellbeing for Māori; by reducing access to means of suicide for Māori; by increasing the safe reporting of suicide by the media and by contributing to improved mental health services for Māori (Ministry of Health, 2015). The evaluation report stated that, generally, stakeholders felt that *Kia Piki te Ora*'s contributions to Māori suicide prevention were good when providers engaged with the community, but that stakeholders were also often unclear on the role and responsibility of the service.

Te Au is the National Māori Suicide Prevention Centre of Aotearoa which focusses on promoting hauora (health and wellbeing) within Māori whānau, hapū and iwi; the organisation provides several suicide prevention initiatives through a Māori-centred approach. There exists an ongoing demand for suicide prevention interventions provided 'by Māori for Māori' (Lawson-Te Aho & McClintock, 2020), likewise from Pasifika communities (Tiatia-Seath, 2014). Le Va for example, an organisation which supports Pasifika families and communities to access the best possible

health and wellbeing outcomes provides *FLO Talanoa*—a suicide prevention education programme (Le Va, 2020).

Within the emerging field of computer-based technology aimed towards mental health support, people in Aotearoa New Zealand are able to access an increasing number of websites, applications and programs. Some are focussed towards young people, whilst others may make it easier for users of any age to ask for help without having to present themselves in person to a practitioner. For example, thelowdown.co.nz is a website which helps young people to recognise and understand depression and anxiety. Similarly, commonground.org.nz provides support and advice for whānau/family and friends to help the young people in their lives enjoy positive mental health and wellbeing. Finally, sparx.org.nz helps young people with mild to moderate depression, stress and/or anxiety by guiding users through CBT techniques and problem-solving strategies.

Methodology

Theoretical orientation

Using a constructionist epistemology, the intention for this study was to generate or inductively interpret and structure meanings (Creswell, 2009) regarding *what works* for service users, with regard to their mental health wellness following suicidal ideation/attempt. Ethical concerns for sensitivity guided this research, as did a qualitative descriptive methodology (Bradshaw et al., 2017).

Recruitment

Following approval from the Health and Disability Ethics Committee (HDEC), the research was advertised through local mental health charities, non-Government organisations and District Health Board services. Posters were displayed and letters were sent by service providers to service users (past and present) who met the criteria

of being over 18, not currently experiencing suicidal crisis (and to not have experienced crisis for at least the past six months) and who were able to discuss their mental wellness in a healthy way.

Method

Face-to-face, semi-structured interviews were chosen as the method most appropriate for discussing extremely personal experiences in detail. During the interview, participants were asked questions about 'what works/had worked' for them, including questions of what had contributed to their wellness and what had been effective for them with regard to their recovery. Participants were asked about the interventions, treatments and/or services they had accessed and what about them they found beneficial.

Sample

All 20 participants had been users of mental health services at some point and many were still accessing services. The sample was ethnically diverse (as shown in Table 1) and participants were aged between 18 and 70 with the majority identifying as female ($n = 16$).

Limitations

As a British researcher with no Māori affiliation and a limited awareness regarding cultural understandings of suicide, it was

essential to seek guidance from relevant Māori advisors in order to conduct the research in a culturally appropriate manner. Subsequently, a research reference group consisting of service users, peer support workers, academics and health professionals with key expertise regarding Māori culture, Pasifika culture and clinical psychology, was established.

Ethical considerations

At the time of applying for ethics consent, no similar research had been conducted in Aotearoa New Zealand. The HDEC were concerned that this population was too vulnerable to participate in research discussing suicide and that any discussion of their experiences could lead them to self-harm. Efforts to safeguard against this concern were put in place including: inviting participants to bring a supportive individual to the interview; the researcher contacting participants following the interview to debrief and providing participants with the contact details of helplines and support networks, including a psychotherapist specialising in suicidal ideation.

(The 20 participants who took part in this research reported a positive change in wellbeing following their interview and stated that being heard had had a beneficial effect.)

The ethics application process was extensive, lasting 10 months before approval. Advertising and recruiting processes were guided by the HDEC's recommendations.

Analysis

The interviews were audio-recorded, transcribed and verified by participants, some of whom chose to use pseudonyms while others preferred their real names to be used. Braun and Clarke's (2006) model of thematic analysis was used as a method for identifying, analysing and reporting patterns within the data. Aided by the software NVIVO, the analysis process identified initial codes, key themes and concepts. The (de-identified)

Table 1. Participants' Ethnicity

Ethnicity	Number of participants (out of 20)
Māori	4
NZ European	4
Pacific Peoples	2
Asian	1
NZ other	5
Other	2
Preferred not to disclose	2

transcripts and initial codes were then shared with the research reference group; some codes were redefined following the discussions.

Findings

The data were grouped into four themes and developed through the lens of Te Whare Tapa Whā model of health established by Mason Durie (1994) as there are similarities between Durie's model and the holistic view of health and wellbeing identified from this research. Durie's (1994) model puts the individual at the centre—as an expert with knowledge about their own hauora (health and wellbeing). According to Cherrington (2009), Te Whare Tapa Whā model is beneficial for Māori *and* non-Māori alike.

The four interrelated data themes are discussed in the following section as: people, body, mind and spirit.

People

People-centred points of support ranged from formal crisis and professional mental health teams through to care provided by whānau/family. The support provided by crisis assessment teams (CATs), community mental health teams (CMHTs), community support groups, community drop-in centres and whānau/family members was influenced by *who* was providing that support. In Aotearoa New Zealand, social workers could be members of any of these teams.

Crisis teams

Four participants described concerning experiences of CATs which left them feeling frustrated, isolated and, for Anita, with an increased risk of attempting suicide:

I don't have any respect whatsoever for the CAT team...They didn't want to listen to my family, my support network or anything. They are not interested in anything they have to say...To me it actually put me in more danger of doing something than not.

Anita's experience highlights the importance for CAT teams, and other service providers, to include whānau/family members when responding to crises. Two participants, however, reported only positive experiences, with Carol stating how her CAT had led to her accessing other services: "I think it was when the crisis team got involved then they would say go to respite because I said 'please don't put me into hospital'."

Community mental health teams

Some participants discussed their CMHTs as having been helpful to them and their wellness. In most community mental health services, case management is provided by keyworkers who come from various disciplines, including social work. Participants described the range of services provided via multi-disciplinary teams as "a massive part" of their recovery including psychosocial interventions such as effective whānau/family meetings, support to do exercise and giving advice for getting back into employment.

When discussing how CMHTs could continue to work well (or how they could improve), one participant stated that validation is the most important skill which CMHT staff can possess. Consistent with social work's emphasis on empathy (Loughran, 2018), recognising someone's feelings, acknowledging them as important and in some cases repeating back what they have said are ways in which service providers can validate a person's feelings of distress.

Other supports

Highlighting the importance of community inclusion and social wellbeing, five participants described the ways in which a local support group had been key to their wellness. One participant, Bob, emphasised how attending Narcotics Anonymous and Alcoholics Anonymous meetings "massively contributed" to his recovery by providing mutual support from his peers, leading to

voluntary work and later to a career as an addiction counsellor. Three participants stated that whānau/family support had played a vital role in their wellness, and that this was an ongoing source of care unmatched by health practitioners.

Body

Medication

All 20 participants had used medications relating to their mental health at some point, with many still doing so. Nine participants reported positive effects from medication, including Anita: "I'm happy with that because honestly it keeps me stable, and I need to be stable." Five participants believed the medication was having a positive effect on their mental health and wellbeing but noted there were negative side-effects. Six participants disliked the medication they were taking either because of the side-effects or because they felt it was not having a positive effect. One participant became so addicted to diazepam that she needed to attend a drug rehabilitation programme, whilst others felt their medication was prescribed to control them: "in many ways I often feel I just take this stuff just so that they won't think I'm being stubborn or something. I take it to please them" (Ralph).

Physical activity

Of the 20 participants, nine felt that keeping physically active was essential to staying well mentally, with participants, including Claire T, acknowledging the social benefits of exercise:

Gymnastics, running, yoga they are all like important parts of my wellness and also kind of group exercise like doing it with my sister. She is really into her sport or like doing gymnastics with other people that I know, like there is a social element to it.

Carol described how bike riding was incredibly important for her recovery

and ongoing wellness, as it led to many unanticipated positive outcomes: "I started going every day and that made such a difference because then it helped with my physical as well as my mental [health] ... I started sleeping better; I noticed my mood was improving."

Physical health

Several participants made links between good physical and mental health. Bob described how keeping hydrated, eating a balanced diet, exercising often and sleeping well were the "little, but very important, things that kept me well."

Another participant discussed the link between a (previously undiagnosed) autoimmune disease and their feelings of depression and suicidal ideation, advocating for early health screening when people first present with mental health distress.

Mind

Talking therapies

All 20 participants described talking therapies as one of the main components in their recovery. Treatments including ACT, DBT and CBT were provided by either a psychotherapist or a social worker. One participant described moving from feeling like a victim of her own thoughts to feeling in control of her emotions and to having an ability to challenge her own thinking. Participants described these talking therapies as an extremely valuable way to understand the meaning of their experiences, thoughts and behaviours and to make changes to become more satisfied in their lives.

Helplines

Five participants had used phone and text helplines such as those provided by Lifeline, Warmline and Youthline as well as the 1737 phone and text service launched by the Ministry of Health in June 2017. Experiences such as Delia's were largely

positive: “I mean it was a helpline that, you know, ultimately helped me ... and that was the start of getting assistance,” with two other participants reporting how essential helplines were to them as a way of being listened to and taken seriously, without having to physically see a practitioner face-to-face.

Mindfulness and meditation

Several participants used mindfulness and meditation to regulate their emotions and others used the practices in their daily routine to help them feel focussed and less anxious. Practising mindfulness and meditation led Tamara towards her own personal research into a gratitude practice. Carol used mindful colouring-in-pictures to occupy her hands in order to focus her emotions as it “takes away all the horrible thoughts” whereas Michael and Paula discussed their uses of mindfulness and meditation as a form of spirituality.

Spirit

This theme is broad in its scope and includes those faiths, spiritual beliefs, systems of support and places which offered a sense of purpose and connection. Participants experienced spirituality in different ways. For example, after trying many treatments for severe psychotic episodes, Amy stated that her newfound belief in God was the intervention which contributed to her continuing wellness, whilst Michael discussed the ways in which Buddhism had taught him a new way to focus on happiness and how powerful this had been after his own suicide attempt. Both Amy and Michael discussed how effective spirituality could be as an anti-suicide intervention and as a continuing source of mental health support, and they advocated for spirituality to be “taken more seriously by doctors.”

Two other participants, Ghost and Frances, discussed the ways in which local community drop-in centres provided them with a sense of purpose and connection.

Their recovery was positively impacted by these connections and the effects they had on their spirit, as in, their internal, socially constructed understanding of what and who else they belong to: “I reckon having places that me as a mental health consumer can go to and like be treated non-judgementally like here ... because if this place wasn’t here I literally would be six feet under” (Ghost). Frances reflected on the positive impact her local community drop-in centre had previously had on her wellbeing:

You can go and hang out for the morning and just have a cup of coffee, chat with people. It gives people I think a purpose and with mental health something to look forward to, to think “Monday oh I’m going to meet so and so, game of pool, catch up with old mates.”

Sadly, this centre had recently been closed due to a lack of funding.

Towards a holistic model of health and wellbeing

Powerful stories of recovery and self-determination were shared during this project, uncovering a wealth of data about what works regarding participants’ experiences of treatments, services and other interventions. Similarities can be drawn between the themes of the data and the four dimensions of Durie’s (1994) Te Whare Tapa Whā model of health: Taha Whānau (Family and Social Wellbeing), Taha Tinana (Physical Health and Wellbeing), Taha Hinengaro (Mental and Emotional Wellbeing) and Taha Wairua (Spiritual Wellbeing).

Te Whare Tapa Whā model of health encapsulates the concept of hauora (health and wellbeing). The model sees family and social wellbeing as having equal importance to mental and emotional wellbeing, and so, if treatment procedures are designed to address an ongoing mental health issue such as suicidal ideation, but the issues of limited access to education, or inadequate housing are not addressed, then the holistic

wellness of an individual will continue to falter. Similarly, data from this project, such as Bob's experience of Narcotics Anonymous and Alcoholics Anonymous meetings, or the social element to Claire T's exercising, showed links between different dimensions of health and wellbeing. The importance of focusing on health and wellbeing holistically was perhaps best summarised by Michael's experience:

They gave me medications to take and I thought "great, this will work and everything will be fine now" but then I'd go back to my mildew apartment, my diabetes and my asthma, my debt, my unemployment and arguments with my girlfriend. No job meant I couldn't afford to eat healthy and a damp apartment would flare up my asthma. Everything would fall apart but it would just be numbed by my meds, but it would all still get so bad that I'd attempt suicide again.

Further implications that can be drawn from the data include the need for caring and respectful, person-centred support as advocated by social work theory (Washburn & Grossman, 2017). The interventions discussed worked best when the service provider was interested in the individual and was informed regarding that person's history, state of wellness and the importance of their whānau/family members. Other participants stated the sense of belonging and social inclusion provided by whānau/family members, community support groups and/or community drop-in centres were sources of crucial support which differed greatly from the medical-focused treatment provided by practitioners.

Participants generally accepted that, while medication played an important role in their wellness, it was unlikely to be the main answer to their difficulties. Other changes needed to happen and medication was one way to support these changes. Pattoni (2012) argued that the individual must be at the centre of these changes, not necessarily as the only person responsible for making them

happen, but as the driving force behind deciding what needs to change and how.

According to the Mental Health Foundation (2018), regular exercise can have a profoundly positive impact on depression and anxiety by relieving stress, helping with sleep and improving overall mood. These benefits were reported by the nine participants who discussed physical health including Carol, whose experience of bike riding improved her physical, mental and emotional health as well as her social wellbeing.

The New Zealand Suicide Prevention Strategy (Ministry of Health, 2019) acknowledges poor physical health as a risk factor for suicidal behaviours and outlines the importance of enabling individuals, their whānau/families and friends to encourage each other to participate in activities that can improve physical wellbeing. Linked to this is a recommendation for the increase of GPs' resources, funding and the allocated time for appointments which could support physical screening when individuals first present with mental distress. For example, diagnosing and treating an autoimmune disease (which can cause brain inflammation and potentially a mood disorder) with diet, exercise and/or medication focussed on treating the disease could dramatically reduce an individual's chances of later developing a mood disorder (Benros et al., 2013). Typically, GP appointment times in Aotearoa New Zealand are set for 15-minute time slots, although some practices might have quick 'acute' clinics for one problem only and may be shorter (Royal New Zealand College of General Practitioners, 2018). As part of a multidisciplinary team within GP practices, social workers can play an important role in early intervention and can provide a range of support services, case management and advocacy with non-medically oriented client needs.

Research by Dobl et al. (2017) evidenced the successful integration of social workers into primary healthcare practices in Aotearoa New

Zealand with benefits including increased engagement with communities, a strengthened workforce and an enhanced access of populations to coordinated care. The authors within that study advocate for the model to be used more widely in public health services affected by health and social inequalities.

The interventions and treatments presented within the 'mind' theme each had a positive effect on the participants' ways of thinking including the way in which phone and text helplines provide support without the (socially anxious) individual having to physically visit a practitioner. Talking therapies had been accessed by, and were beneficial for, all 20 participants in varying ways, with some finding a particular therapy to be effective only after trying others. It is hoped that the range of therapies discussed in this research highlights the benefits of practitioners, including clinical social workers (Appleby et al., 2020), offering a wide range of therapies to service users. Participants indicated a desire for a wider range of treatment options outside of the medical model and this was supported by the positive effect many participants reported after using mindfulness and meditation practices.

Data presented within the broad theme of 'spirit' included participants' reflections on their religious and spiritual experiences as well as impacts on their sense of spirit. These reflections acknowledged health and wellbeing improvements as being more than physical adjustments or medical treatments.

For Ghost and Frances, community centres provided "a lifeline" to the outside world, helping them to feel connected to peers, educators and health practitioners so that they could learn household and employment skills whilst being active members of their community. And, as Amy's experience reminds us, places of worship, faith groups and the connections which these bring, can be powerful support systems for people during mental health distress and as sources of ongoing support.

According to Tiatia-Seath (2015), churches and other places of worship have a large part to play within the support of people's mental wellness and, more specifically, suicide prevention. Equally, community support and outreach initiatives, such as those provided by community centres, can provide non-medical approaches to improving emotional, behavioural and mental wellbeing.

Conclusion

The varied interventions, treatments and services that participants discussed are compatible with strengths-based and recovery focussed perceptions of mental health and connected social work practices. The resulting themes of this research demonstrate the importance of viewing health and wellbeing holistically. It is hoped that this article exhibits the benefits of incorporating a holistic model, such as Te Whare Tapa Whā into health policy. The model's durability, simplicity and its widespread application mean that it can be used by healthcare and support services to deliver culturally appropriate and more holistically effective care for Māori and non-Māori alike.

Participants discussed the need for respectful, person-centred support from practitioners who were aware of their situation and who also listened to their whānau / family members. A sense of belonging to local community was also key to recovery for some, as were some psychological therapies. Medication was discussed with varying levels of positivity; some participants accepted that it was important to keeping them feeling stable, whilst others were disappointed with the lack of attention practitioners gave towards the wider picture of their lives.

The non-medical interventions discussed throughout this article advocate for strengths-based and recovery approaches to be used within the dominant medical model. Subsequently, social workers in clinical or community settings have an important role

to play, currently, and in the future of suicide prevention and wider mental health service provision. The Ministry of Health (2020) supports a recovery approach to mental illness and therefore, recovery approaches which view health holistically and which are aligned with the social work values of empowerment, respect and protection of human rights. Social workers are well placed to find out what works in terms of recovery for individuals with lived experience of suicidal ideation and/or attempt.

There are several reasons why service users are not often consulted, and this may include the idea that they are too vulnerable and (an understandable) fear exists that talking to people with such experience may increase the risk of suicidal behaviours and feelings. It is hoped this research shows the benefits of including experts-by-experience in research which aims to inform policy; even when there are risk factors, consultation with service users is vital.

Accepted 23 May 2021

Published 1 September 2021

ORCID: <https://orcid.org/0000-0002-8991-9616>

References

- Allen, R. (2014). *The role of the social worker in adult mental health services*. The College of Social Work. https://www.basw.co.uk/system/files/resources/basw_112306-10_0.pdf
- Ali, B. (2019). *What works? Individuals' experiences and knowledge of suicide prevention interventions in Aotearoa/Aotearoa/New Zealand* [Unpublished doctoral dissertation]. University of Auckland. <https://researchspace.auckland.ac.nz/handle/2292/46315?show=full>
- Aotearoa New Zealand Association of Social Workers. (2019). *Code of ethics*. <https://anzasw.nz/wp-content/uploads/Code-of-Ethics-Adopted-30-Aug-2019.pdf>
- Appleby, J., Staniforth, B., Flanagan, C., & Millar, C. (2020). Clinical social work in Aotearoa New Zealand: Origins, practice, and future implications. *Aotearoa New Zealand Social Work*, 32(4), 103–115. <https://doi.org/10.11157/anzswj-vol32iss4id798>
- Bennett, S., Flett, R., & Babbage, D. (2014). Culturally adapted cognitive behaviour therapy for Māori with major depression. *The Cognitive Behaviour Therapist*, 7, E20. doi:10.1017/S1754470X14000233
- Benros, M. E., Waltoft, B. L., & Nordentoft, M. (2013). *Autoimmune diseases and severe infections as risk factors for mood disorders: A nationwide study*. <https://jamanetwork.com/journals/jamapsychiatry/fullarticle/1696348>
- Booyesen, P. (2017). *Aotearoa New Zealand strengths based counselling practice framework for social work* [Unpublished doctoral dissertation]. University of Auckland.
- Bradshaw, C., Atkinson, S., & Doody, O. (2017). Employing a qualitative description approach in health care research. *Global Qualitative Nursing Research*, 4(1), 108–113.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77–101.
- Cherrington, L. (2009). *The process of reconciliation: Towards a Māori view*. <https://www.msd.govt.nz/about-msd-and-our-work/publications-resources/research/conduct-problems-best-practice/te-hohounga-mai-i-te-tirohanga-maori.html>
- Clark, T. C., Robinson, E., Crengle, S., Fleming, T., Ameratunga, S., Denny, S. J., Bearinger, L.H., Sieving, R. E., & Saewyc, E. (2011). Risk and protective factors for suicide attempt among indigenous Māori youth in New Zealand: The role of family connection. *Journal of Aboriginal Health*, 7, 16–31.
- Cooper, B., & Parsons, J. (2010). Dialectical behaviour therapy: A social work intervention? *Aotearoa New Zealand Social Work*, 21(4), 83–93.
- Coronial Services of New Zealand. (2019). *Annual suicide statistics since 2011*. <https://coronialservices.justice.govt.nz/suicide/annual-suicide-statistics-since-2011/>
- Cramer, R. J., & Kapusta, N. D. (2017). A social-ecological framework of theory, assessment, and prevention of suicide. *Frontiers in Psychology*, 8(1756), 1664–1078. <https://doi.org/10.3389/fpsyg.2017.01756>
- Creswell, J. (2009). *Research design. Qualitative, quantitative and mixed methods approaches* (3rd ed.). Sage.
- Dobl, S., Beddoe, L., & Huggard, P. (2017). Primary health care social work in Aotearoa New Zealand: An exploratory investigation. *Aotearoa New Zealand Social Work*, 29(2), 119–130. <https://doi.org/10.11157/anzswj-vol29iss2id285>
- Doughty, C., & Tse, S. (2005). *The effectiveness of service-user-run of service-user-led mental health services for people with mental illness: A systematic literature review*. Mental Health Commission.
- Drisko, J. (2017). Active collaboration with clients: An underemphasized but vital part of evidence-based practice. *Social Work*, 62(2), 114–121. <https://doi-org.ezproxy.auckland.ac.nz/10.1093/sw/swx003>
- Durie, M. (1994). *Whaiora: Māori health development*. Oxford University Press.
- Fawcett, J., & Busch, K. (2014). The pharmacologic treatment of suicidal patients. In M. Nock (Ed.), *The Oxford handbook of suicide and self injury* (pp. 385–396). Oxford University Press.
- Flaxman, P. E., Blackledge, J. T., & Bond, F. W. (2010). *Acceptance and commitment therapy*. Routledge.

- Gibson, S., Benson, O., & Brand, S. L. (2012). Talking about suicide, confidentiality and anonymity in qualitative research. *Nursing Ethics*, *20*(1), 1–12. <https://doi.org/10.1177/0969733012452684>
- Government Inquiry into Mental Health and Addiction. (2018). *He Ara Oranga (Pathways to Wellness)*. <https://mentalhealth.inquiry.govt.nz/inquiry-report/he-ara-oranga/recommendations/>
- Halvorsrud, K., Kucharska, J., Adlington, K., Rüdell, K., Brown Hajdukova, E., Nazroo, J., Haarmans, M., Rhodes, J., & Bhui, K. (2019). Identifying evidence of effectiveness in the co-creation of research: a systematic review and meta-analysis of the international healthcare literature. *Journal of Public Health*, 1–12, fdz126. <https://doi.org/10.1093/pubmed/fdz126>
- Hammad, T. A., Laughren, T., & Racoosin, J. (2006). Suicidality in paediatric patients treated with antidepressant drugs. *Archives of General Psychiatry*, *63*(1), 332–339. <https://doi.org/10.1001/archpsyc.63.3.332>
- Lawson-Te Aho, K., & McClintock, K. (2020). *Māori suicide prevention research, policy & practice*. University of Otago & Te Rau Ora.
- Le Va. (2020). *Our work*. <https://www.leva.co.nz/our-work/>
- Linehan, M. M., Korslund, K. E., Harned, M. S., Gallop, R. J., Lungu, A., Neacsiu, A. D., & Murray-Gregory, A. M. (2015). Dialectical behavior therapy for high suicide risk in individuals with borderline personality disorder: A randomized clinical trial and component analysis. *JAMA Psychiatry*, *72*(5), 475–482. <http://doi:10.1001/jamapsychiatry.2014.3039>
- Loughran, H. (2018). *Counselling skills for social workers* (1st ed.). Routledge. <https://doi-org.ezproxy.auckland.ac.nz/10.4324/9781315145853>
- Matlin, S. L., Molock, S. D., & Tebes, J. K. (2011). Suicidality and depression among African American adolescents: The role of family and peer support and community connectedness. *American Journal of Orthopsychiatry*, *81*(1), 108–117. <https://doi.org/10.1111/j.1939-0025.2010.01078.x>
- McMain, S. F., Links, P. S., Gnam, W. H., Guimond, T., Cardish, R. J., Korman, L., & Streiner, D. L. (2009). A randomized trial of dialectical behavior therapy versus general psychiatric management for borderline personality disorder. *American Journal of Psychiatry*, *166*(10), 1365–1374. <https://doi.org/10.1176/appi.ajp.2009.09010039>
- Mead, S., Hilton, D., & Curtis, L. (2001). Peer support: A theoretical perspective. *Psychiatric Rehabilitation Journal*, *25*(2), 2–29.
- Mental Health Foundation. (2018). *Physical activity for mental wellbeing*. <https://www.mentalhealth.org.nz/assets/.../FS-11-Getting-active.pdf>
- Ministry of Health. (1998). *In our hands. Youth Suicide Prevention Strategy*. [https://www.moh.govt.nz/notebook/nbbooks.nsf/0/A95F484F5F299C7C4C25665D006F43D4/\\$file/nzyouthsuicidepreventionstrategy-inourhands.pdf](https://www.moh.govt.nz/notebook/nbbooks.nsf/0/A95F484F5F299C7C4C25665D006F43D4/$file/nzyouthsuicidepreventionstrategy-inourhands.pdf)
- Ministry of Health. (2015). *Kia Piki te Ora Suicide Prevention Programme evaluation final report*. Ministry of Health. <https://www.health.govt.nz/publication/kia-piki-te-ora-suicide-prevention-programme-evaluation-final-report>
- Ministry of Health. (2019). *Every life matters – He Tapu te Oranga o ia Tangata: Suicide Prevention Strategy 2019–2029*. <https://www.health.govt.nz/publication/every-life-matters-he-tapu-te-oranga-o-ia-tangata-suicide-prevention-strategy-2019-2029-and-suicide>
- Ministry of Health. (2020). *Mental health and addiction workforce development*. <https://www.health.govt.nz/our-work/mental-health-and-addiction/mental-health-and-addiction-workforce-development>
- OECD. (2019). *Health status – Suicide rates – OECD Data*. <https://data.oecd.org/healthstat/suicide-rates.htm>
- Pattoni, L. (2012). *Strengths-based approaches for working with individuals*. <https://www.iriss.org.uk/resources/insights/strengths-based-approaches-working-individuals>
- Royal New Zealand College of General Practitioners. (2018). *You and your GP*. https://www.rnzcgp.org.nz/RNZCGP/l_m_a_Patient/you_and_your_GP/RNZCGP/lm_a_patient/You_and_your_GP.aspx?hkey=dc057656-a40f-4d58-b9ee-3897e2942b60
- Ruiz, F. J. (2010). A review of acceptance and commitment therapy (ACT) empirical evidence: Correlational, experimental psychopathology, component and outcome studies. *International Journal of Psychology and Psychological Therapy*, *10*(1), 125–162.
- Silver, H. (2010). Understanding social inclusion and its meaning for Australia. *Australian Journal of Social Issues*, *45*(2), 183–211. <https://doi.org/10.1002/j.1839-4655.2010.tb00174>
- Tarrier, N., Taylor, K., & Gooding, P. (2008). Cognitive-behavioral interventions to reduce suicide behavior: A systematic review and meta-analysis. *Behaviour Modification*, *32*(1), 77–108. [doi:10.1177/0145445507304728](https://doi.org/10.1177/0145445507304728)
- Tiatia-Seath, J. (2014). Pacific peoples, mental health service engagement and suicide prevention in Aotearoa New Zealand. *Ethnicity and Inequalities in Health and Social Care*, *7*(3), 111–121. [doi:10.1108/EIHC-10-2013-0023](https://doi.org/10.1108/EIHC-10-2013-0023)
- Tiatia-Seath, J. (2015). *Suicide prevention for Tongan youth in New Zealand*. Report to the Health Research Council of New Zealand and Ministry of Health for the Pacific Partnership Programme.
- Ward-Ciesielski, E. F., & Linehan, M. M. (2014). Psychological treatment of suicidal behaviours. In M. Nock (Ed.), *The Oxford handbook of suicide and self injury* (pp. 367–384). Routledge.
- Washburn, A., & Grossman, M. (2017). Being with a person in our care: Person-centered social work practice that is authentically person-centered. *Journal of Gerontological Social Work*, *60*(5), 408–423. [doi:10.1080/01634372.2017.1348419](https://doi.org/10.1080/01634372.2017.1348419)
- World Health Organisation. (2019). *Suicide: Key facts*. <https://www.who.int/news-room/fact-sheets/detail/suicide>