Ārai Whakamōmori: An Exploration of Te Whakaruruhau's Suicide Prevention Strategy

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Abstract

Te Whakaruruhau, Waikato Women's Refuge, have been able to achieve a suicide free environment for their clients for over 31 years. This research sought to understand how Te Whakaruruhau have been successful in preventing suicide for women and their partners. Intimate partner violence is closely associated with suicide risk, depression, anxiety, post-traumatic stress disorder, and helplessness and hopelessness. Interviews were held with 11 staff using kaupapa Māori (principles/philosophies) methodologies of: *kānohi kitea* (greeting, meeting face to face), *ako Māori* (learning, teaching, reciprocity, cultural pedagogy) and *manaaki ki te tangata* (caring, hosting people). A thematic analysis provided four main themes: identifying safety and risk issues, prevention methods, following tīkanga, and training and supervision. Sub themes that supported and expanded on each main theme showed that staff interacted and cared for their clients using distinctly Māori worldviews and practices of tīkanga: manner of approach, mā te whakarongo and kōrero (listening and talking), awhi (support), redirecting the focus, and whakamana (to empower), to prevent suicide with their clients. As Te Whakaruruhau is founded on principles of kaupapa Māori, it was evident that staff responded to their clients using manaakitanga (to care for, show respect), aroha (show love, empathy and sympathy), awhi, both physical and emotional support, and whakawhanaungatanga (relationship). A concern for staff was the lack of resourcing to access appropriate training and supervision which they felt impacted on their ability to do their job well. The implications of this study are that more training, specifically around suicide awareness, and mentoring and guidance is needed for staff to continue to provide a suicide free space. Also, this research serves to guide the formation of an indigenous national suicide prevention strategy for clients who access refuges. Ultimately, the research is for families who experience disruptions to their lives through violence offering a pathway and place for them to recover and rebuild their lives.

Keywords: Te Whakaruruhau, suicide, suicide prevention, indigenous suicide prevention, women's refuge.

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Permission was received by Te Whakaruruhau CEO, Ruahine Albert, for this photo to be published in this thesis document.

Introduction

Women experiencing intimate partner violence seek help from a women's refuge shelters. Te Whakaruruhau, Waikato Women's Refuge, was the first indigenous refuge in New Zealand. Women's refuge advocates are employed to assist women with leaving the abusive relationship, gain access to services, help women to become independent, financial and otherwise, and to live healthy, and stable lives free of violence (Te Whakaruruhau Inc., 2011). An important part of their work is the ability to identify risks and prevent further harm, specifically in the form of suicide.

Suicide is one of the main types of preventative death across the world (World Health Organisation, 2014). Research has shown that there are certain factors that can either increase or decrease the likelihood of attempting suicide. Domestic violence, specifically intimate partner violence, has been identified as increasing risks of anxiety, post-traumatic stress disorder, depression and suicidal ideation.

In New Zealand reports of domestic violence, or intimate partner violence, are unfortunately high, from 2014-2016 there were 13,567 police recorded assaults towards a female from a current or ex-partner/boy/girlfriend. (New Zealand Family Violence Clearinghouse, NZFVC, 2017). From 2015-2016, the National Collective of Independent Women's Refuges received around 73,000 crises calls, assisted 2,446 women and children with safe housing services, and supported 11,062 women and children access advocacy services within the community. (NZFVC, 2017). Reports of self-harm or attempts of suicide by victims of intimate partner violence is unknown, however, research indicates that women that are exposed to IPV are at risk for multiple health problems, including depression, which can mediate suicidality (La Flair, Bradshaw, & Campbell, 2012).

There are differing arguments for how intimate partner violence impacts on the suicidality for victims, centring on the type of abuse suffered, physical vs psychological or emotional vs sexual or a combination of them all. Recently, one argument for suicidality within victims of intimate partner violence is the trauma that victims suffer as a result (Smith, Kuhlman, Wolford-Clevenger, Faulk, D'Amato, & Granato, 2016), and suicide is argued to be a means of escape from the pain it has caused. It is in this respect that suicidal risk in victims of intimate partner violence seeking shelter is important to be aware of.

Women seeking shelter for intimate partner violence are increasingly vulnerable, this vulnerability is caused by several debilitating effects of the trauma caused by intimate partner violence, anxiety, depression, post-traumatic stress, hopelessness and helplessness and many more psychological and behavioural health problems. (Santo-DiLorenzo & Sharps, 2007; Hedtke, Ruggerio, Fitzgerald, Saunders, Resnick, & La Greca, 2008; Seedat, Stein & Forde, 2005).

This study is an exploration of the strategies utilised by staff of Te Whakaruruhau, in minimising risk and prevention/intervention of suicide with their clients. This study used a Kaupapa Māori Methodology in the approach to conducting and analysing interviews. A thematic analysis was the analytical tool used for identifying similar codes or themes from the interview summaries.

This research opens a new field of exploration in the sphere of intimate partner violence. Te Whakaruruhau have been successful in preventing suicide with their clients, victims of intimate partner violence. Literature around suicide and intimate partner violence indicates that victims of intimate partner violence are vulnerable and at an increased risk of suicidality, and so the purpose of this research is to identify the specific strategies that staff at

Te Whakaruruhau use to answer the question, “What makes Te Whakaruruhau a suicide free safe space?”

Literature Overview

Women’s Refuge Shelters

The development for shelter or refuge for women began during the time of the feminists’ movement in the 1960s-70s throughout the U.K, Canada, and the U.S. With the rise of feminism came the realisation that abuse towards women in relationships was no longer acceptable and the development for shelters for women began. (Missions Services of Hamilton, 2017). Like in Canada, the need for safe housing and refuge shelters in the U.S. evolved and by the late 1970s there were close to 100 refuge shelters operating across the country (Clevenger & Roe-Sepowitz, 2009). Transitional housing and emergency shelters are most commonly known today, and emergency housing is believed to be the first step for women escaping abusive relationships.

Though refuge shelters started emerging from the mid-1960s, they were founded on the beliefs and values of the western world, with the initial purpose to assimilate aboriginal families into this westernised society. Shelters were perceived as lacking in indigenous values, and so, women’s shelters founded on the beliefs and values of the aboriginal people. (Janovicek, & Janoviécek, 2007).

The Beendigen shelter, in Canada, is a facility specifically for aboriginal women and children facing all sorts of crisis, most commonly leaving a violent relationship. Initially it was created to help aboriginal women integrate from reservation life to the city atmosphere. They did this by helping the women learn to cope with the racism that came with living off the reservation and running programmes that emphasized the importance of retaining culture.

This programme was viewed as a necessity because aboriginal children were uprooted if their family was enduring crisis. (Janovicek, & Janoviécek, 2007).

There is a similar pattern to the history of women's refuge here in New Zealand. Inspired by the progressions overseas, New Zealand advanced women's welfare with the opening of the first women's shelter in 1973 in Christchurch, the Christchurch Women's Refuge. (Aviva, 2017). Since its establishment, women's refuge has spread throughout the country. The first indigenous women's' refuge, Te Whakaruruhau was created in 1986.

Te Whakaruruhau

Te Whakaruruhau was first established in 1986 as a Māori women's refuge for women experiencing intimate partner violence within the Waikato area. Te Whakaruruhau was initially formed as a women's refuge affiliated yet separate and distinct from the standards and protocols typically found in a refuge organisation. The founding members of Te Whakaruruhau established the organisation on values of tīkanga, such as manaakitanga; values that were found to be lacking in the mainstream system of women's refuge. Initially they provided a 24/7 crisis support and safe housing for women who needed it, however over the years Te Whakaruruhau expanded its service and now works with all, not just Māori, victims of intimate partner violence, as well as family members, and men in rehabilitation. (Waikato Women's Refuge, 2016).

There are three teams providing support and advocacy within Te Whakaruruhau: Crisis, Residential, and Community. The crisis team is responsible for receiving and assessing clients, and instigating referrals to external agencies; the residential team is responsible for providing safe and supportive residential services, and the community team provides support and advocacy for whānau who remain in the community. The residential

team also advocates for the clients with external agencies, such as Work and Income. (Te Whakaruruhau Inc., 2011, p.5).

Te Whakaruruhau is based on the principles of kaupapa Māori (Smith, 1997) and whānau ora (family wellbeing); (Boulton & Gifford, 2014). Te Whakaruruhau relies on the Māori cultural values and practices of *manaakitanga*, (to show kindness, care, and respect); *whakawhanaungatanga*, (establishing relationships with others), either within, or outside of the whānau whakapapa (family genealogy); *wairuatanga*, spirituality; and *moemoea* (dreams or aspirations). By incorporating the principles of Māori tīkanga, the organisation is transferable for people of different cultures, and while the outlook is inherently Māori, the staff utilise reintegration into one's own cultural practice as part of recovery; for example, helping women to find their own identity.

The Whānau Ora Wellbeing Programme run by Te Whakaruruhau, which evolved from the Well-Being and Transition Programme, focusses on individual and whanau goals (of the victim and perpetrator) in the short, medium and long-term. (Te Whakaruruhau Inc., 2011, p. 11). Five key elements are necessary for this whānau centred approach that impacts on service delivery. 1) whānau action and engagement, 2) whānau -centred design and delivery of services, 3) Iwi leaderships, 4) Active and responsive government, and 5) Funding.

In taking this approach, Te Whakaruruhau has become a leading organisation in family safety, as they incorporate not only child safety and well-being, but also the rehabilitation of abusive partners, into the service that they provide. Te Whakaruruhau is distinctly focused on whānau rather than individuals, thereby promoting health for women and/or children, and providing healthy, stable and sustainable well-being for men. The focus

on men's health is relatively new for Te Whakaruruhau, which started in the mid to late 2000s.

Whānau ora.

By looking at health and well-being through the lens of whānau ora, Te Whakaruruhau has established a wider range of service provisions. Through relationships with the Department of Corrections, Te Whakaruruhau found a missing link in health and wellbeing for the whole family. Originally the partnership between Te Whakaruruhau and the prisoners in the community team from the Te Ao Marama unit, was one of physical labour and maintenance projects which involved men coming face to face with the impacts of domestic violence. By utilising the Te Ao Marama Unit of Waikeria Prison to conduct repairs and labour work around the residential unit, it was identified that working with the men and teaching them about the impacts of domestic violence enabled the building of healthy and functioning relationships. This approach allowed for the role and space of whānau to be acknowledged (Karapu, 2010).

Karapu, Simpson & Paipa (2009) noted that "this close working relationship has raised men's awareness around the impacts and work involved in rebuilding the lives of whānau who are affected by domestic violence" (p. 21).

The relationship with the Te Ao Marama Unit-Waikeria Prison became an essential part of the Whānau Ora Wellbeing Programme. The programme aimed to strengthen and achieve whānau ora through interventions which empower the whole whānau: "It is our belief that working with the 'whole whānau' and building capacity and capability is fundamental to achieving long term change and resilience against domestic violence" (Te Whakaruruhau Inc., 2011, p. 7). Due to funding issues, the partnership between Te Whakaruruhau and the Te Ao Marama Unit - Waikeria prison, is no longer operating; however, the on-going support

and rehabilitation, a key part of the work with the men, has continued. A male's advocate has since been employed by Te Whakaruruhau. Like advocates for women, the primary role is to advocate, support, and access services needed by clients that are necessary to break cycles of abuse; for example, anger management, and counselling.

The strategies and models created are constantly evolving, the latest model, Ka Awatea merges all previous programmes, frameworks and strategies. Ka Awatea has three focus points; whānau centred, whānau driven, and moemoea. Ka Awatea is driven by the needs and aspirations of the whānau and that clients participate in the decisions and plans for their life. This is achieved through the way that advocates engage with their clients. Ka Awatea outlines that engagement is achieved through the quality of the relationship between advocate and client. Key practices include listening to the client' narrative, identifying their needs, and ensuring that they feel supported in all areas, from accessing services such as Work and Income, Housing New Zealand, or Mental Health Services.

Throughout the evolving models and frameworks, whānau involvement and collaboration are integral to eliminating violence and improving the lives of women and children (Karapu, Simpson & Paipa, 2009). Collaboration comes in many forms for Te Whakaruruhau, most often it is seen in both the advocate and external agents working together for the betterment of the client situation in eliminating barriers that could hinder rehabilitation.

An important part of advocating for clients is gaining an understanding of the risks in the clients lives therefore a safety and risk assessment is conducted during the client process through crisis. The safety and risk assessment examines the abuser's history with gangs, drugs and alcohol, and the type and extent of abuse towards the client. Also examined is the client own personal history, looking at alcohol and/or substance abuse, psychiatric illness,

depression and suicidality. From the risk assessment, advocates can identify the types of services that may be needed for the client.

Psychological resilience, coping, and optimism.

Increasing psychological resilience and coping while enhancing ones' reason for living is believed to be linked with lower suicidal ideation, as they combat against feelings of depression and hopelessness. Studies that have focused on psychological and psychosocial resilience have found that while there is a definite relation to suicidal ideation, its significance has not been truly confirmed. Even so, resilience has remained as a determinant for hopelessness, as people who have reported feeling hopeless about the present and future have shown low resilience to change, and low coping ability when having gone through negative or stressful life events (Gooding, Sheehy, & Tarrier, 2013; Hirsch, Connor, & Duberstein, 2007).

Five reasons for living have been identified for mediating hopelessness and depression, and suicidal ideation; family relations; peer relations; survival and coping beliefs; future expectations; and self-evaluation. Of these, the most significant was survival and coping beliefs. Good survival and coping beliefs enhance resilience which aids in the reduction of suicidal ideation (Bagge, Lamis, Nardoff, and Osmin, 2014). Social support, or peer relations, is also a strong influencer of suicidal ideation. However, social support, and good survival and coping beliefs, are not enough. To influence social support, and build survival and coping beliefs, individuals also need to build the ability for positive self-appraisals, increased self-esteem and heightened sense of hope, and positive cognitive styles, all help to counter suicidal thoughts, plans, and attempts (Gooding, Sheehy, & Tarrier, 2013).

In a different view to psychological resilience Liu, Fairweather-Schmidt, Burns, Roberts, and Anstey (2016) found that resilience was not a predictive factor in determining

suicidal risk. That is not to say there was absolutely no relations between suicidality and resilience, merely that alone one could not determine the other. Liu et al (2016) found that suicidality was only predicted by low resilience if suicidal thoughts and behaviours were reported at both testing points. The results suggest that interventions should not focus solely on resilience, especially interventions targeting the community level, if suicidal thoughts and behaviours have not been reported.

Resilience can also be built using optimism. Optimism is cognitive characteristic that is often defined as a general, positive mood or attitude about the future with a tendency to anticipate a favourable outcome (Hirsch, Conner & Duberstein, 2007). Because optimism is a separate cognitive characteristic to hopelessness, an individual can feel both characteristics at the same time (Hirsch & Connor, 2006). Due to the high association of depression and hopelessness in shelter settings (Ferrari, Agnes-Davies, Bailey, Howard, Howarth, Peters, Sardinha, & Feder, 2015), intervention methods that target depression or hopelessness to prevent suicidal ideation should consider enhancing optimism, because one of the attributes of depression is the tendency to view things from a negative cognisance (Hirsch, Connor, & Duberstein, 2007; Gooding, Sheehy, & Tarrier, 2013).

Intimate Partner Violence and Suicide

Domestic violence committed solely by one partner to the other, known as intimate partner violence, has been a social health problem for many decades. It occurs predominantly to females and typically by male abusers, and is one of the most common forms of violence against women (Hegarty & O'Doherty, 2011; World Health Organization, 2014). Intimate partner violence is more than physical abuse. The World Health Organization (WHO) defines Intimate Partner Violence as "any behaviour within an intimate relationship that causes physical, psychological or sexual harm to those in the relationship." (Hegarty & O'Doherty, 2011, p. 1).

The WHO multi-country study on women's health and domestic violence against women found that intimate partner violence is widespread across the globe, impacting women of all ages, ethnicities, and cultures (García-Moreno, Jansen, Ellsberg, Heise, & Watts, 2005). This study also discovered that within abusive relationships there is usually more than one type of abuse present within the relationship. For example, where sexual abuse was found in the relationship there was usually co-occurring physical or psychological abuse. (García Moreno, *et al*, 2005; Pico-Alfonso, Echeburua, & Martínez, 2008). Research into intimate partner violence have found that at least 1 in 3 women experience some form of physical, psychological or sexual abuse in their lifetime. (Devries, Mak, Bacchus, Child, Falder, Petzol, Astbury, & Watts, 2013; Leiner, Compton, Houry, & Kaslow, 2008).

Women who are exposed to intimate partner violence are at risk for multiple health problems, including depression and/or anxiety (Leiner, *et al*, 2008; Vaeth, Ramisetty-Mikkler, Caetano, 2010). Research suggests that children who have been exposed to intimate partner violence are more likely to develop emotional and behavioural problems, which can sustain into adulthood, and make them more susceptible to becoming either victims or perpetrators of domestic violence. (Afifi, Macmillan, Cox, Asmundson, Stein & Sareen, 2009; Feigold & Capaldi, 2014; Pico-Alfonso, Echeburua, & Martínez, 2008). The intergenerational effects of IVP are significant disrupting the social, economic and relational potential of individuals, families and collectives.

Poor psychological health in victims of intimate partner violence is believed to be a result of the abuse committed against them, and often it is the poor state of psychological health that increases the likelihood of suicidal ideation and behaviour (Leiner, *et al*, 2008). Depressive symptoms, and traumatic stress and experiences, have been identified as key factors for suicidal ideation within victims of intimate partner violence. (Devries, *et al*, 2013; Leiner, *et al*, 2008; Ferrari, *et al*, 2015).

Feeling of helplessness is argued to be of greater concern for victims of intimate partner violence, as feeling helpless can hinder their resolve to exit the situation and their feelings are internalised, with no means of expressing themselves (Filson, Ulloa, Runfola, & Hokoda 2010; Leiner, *et al*, 2008). However, the interaction between loss of power and feeling helpless, mediated by the controlling abuse of their partner, that continues depressive symptoms even after victims have left the abusive relationship. (Devries, *et al*, 2013).

Johnson, Zlotnick, and Perez (2008) disagree with both studies. They argue that battered women are most affected by Post-Traumatic Stress Disorder and all other types of psychological/psychiatric illness are a result of this post-traumatic stress disorder. Their argument stems from their research on post-traumatic stress disorder in battered women in shelters. One of their main findings argues that it was the severity of post-traumatic stress disorder rather than trauma severity that impacted on battered women's psychosocial functioning, and this impairment can lead women to be unable to utilise the resources available at women's shelters.

Not all research around intimate partner violence and suicide focus on the risk factors or factors that mediate and increase suicidality. Meadows, Kaslow, Thompson, and Jurkovic (2005) identified protective factors for victims of intimate partner violence. Hopefulness, spiritual well-being, self-efficacy; the perceived ability or skill level to produce certain behaviours, such as coping, or conflict resolution; how to manage and navigate through stressful problems based on emotional and cognitive responses to the stressful stimuli; social support by family and friends; and effectiveness of obtaining resources were identified as key factors for reducing suicidality within victims of intimate partner violence.

While mental health issues, such as a diagnosis, or alcohol and substance abuse are main focal points of attention when giving aid to victims of intimate partner violence,

depressive, anxiety, and post-traumatic stress disorder symptoms have a large impact on suicidal ideation and behaviour for victims of intimate partner violence (La Flair, Bradshaw, & Campbell, 2012; Seedat, Stein & Forde, 2005). Intimate partner violence can create environments that increase the likelihood of developing some form of mental illness which, can influence suicidal ideation and behaviour (Meadows, *et al*, 2005; Devries, *et al*, 2013). Given the increased risk of suicide for victims of intimate partner violence, prevention and support is vital, particularly when the victim leaves the family home and enters the refuge shelter.

Suicide Risk in Women's Shelters

For over three decades, women's refuge has assisted women to leave abusive relationships and set them up with the tools necessary to live a healthy lifestyle. There are many different components to the work provided by women's refuge, one of these components is suicide prevention. Suicide risk is a feature that has been long since established that intimate partner violence has a wide range of due to the impact on the physical and psychological health of the victims, this poor state of health unfortunately puts these victims at an acute risk of suicide (Pico-Alfonso, Echeburua, & Martínez, 2008; Devries, *et al*, 2013; Campbell, 2002).

Suicide risk assessment at the intake stage is important due to the multiple effects of intimate partner violence (Wolford-Clevenger & Smith, 2015) highlights the importance of suicide risk assessment at intake of refuge shelters. They argue that the events that precede and are associated with seeking shelter; such as, abuse from relationship, specifically psychological abuse, and feelings of hopelessness and helplessness, are triggers for the processing of suicidal ideation. Furthermore, they theorised that because intimate partner violence can have such a debilitating effect on the victims' psychopathology, that the breakdown of the relationship, and complete environmental change that occurs with entering

a shelter, highly impacts the woman's suicidality, increasing ideation, behaviour, and planning (p. 172).

Suicide risk assessments, and preventative measures for women in shelters address the difficulties associated with entering a shelter. Intrapersonal trauma, feelings of thwarted belonging, being perceived as a burden, short-term stays and the lack of time available to attend to mental health issues are common effects of shelter stays (Smith, et al, 2016; Wolford-Clevenger & Smith, 2015).

This study highlights numbness as a coping mechanism developed by the trauma of abuse suffered by the women, and impacts on their relations with not only staff of the shelters but also other residents, making assistance and utilization of shelter services problematic. They also suggest that trauma exposure impacts on the vulnerability to suicide by influencing women's Acquired Capability for Suicide (ACS), however, this alone could not account for suicidal ideation within ITS, whereas post-traumatic stress disorder symptoms were discovered to impact chances of suicide risk, because symptoms of post-traumatic stress disorder increased the desire for suicide.

As with Wolford-Clevenger and Smith (2015), this study identified shelter activities that increased feelings of self-worth, developed healthy coping techniques, and increased their sense of belonging, as tools for prevention strategies for women identified as at risk for suicide within a women's refuge shelter. Literature surrounding suicide prevention with women seeking refuge shelters is relatively new, with current studies founded on a theoretical basis that proposition the causal relationships of specific factors within help seeking victims of intimate partner violence. (Wolford-Clevenger & Smith, 2015; Smith, *et al*, 2016).

Suicide Theories

Historically suicide was not considered to be an issue of mental health for Māori, but instead was a result of some type of loss or grief (Emery, Cookson-Cox, & Raerino, 2015). The very first understanding of suicide in Māori history was in the story of Hine-titama, the dawn girl. When Hine-titama discovered that her husband, Tane, was really her father, she retreated from the world of humanity, in a sense, killing herself. Hine-titama fled to the underworld taking the name Hine-nui-o-te-po, the goddess of death (Mikaere, 2002). Taking ones, life is a feature of the oral history of te ao Māori, the Māori worldview. Before the coming of missionaries, rather than viewing suicide as being a shameful act, it was considered a sad loss over the future potential of that person, and their life, and did not ruin the mana of the person, whānau, or hapu/iwi, as it is viewed today (Emery, Cookson-Cox, & Raerino, 2015).

Modern views of Māori suicide differ to the historical views of suicide. Today, suicide and Māori, are often discussed as a consequence of historical trauma caused by colonization (Lawson-Te Aho, 2016). Trauma such as the disadvantages brought by loss of land, culture, and identity, racism, financial and educational disparities, and barriers to opportunities provide context for suicidality for Māori. (Collings & Hirini, 2005; Pihama, Reynolds, Smith, Reid, Smith, & Nana, 2014). While there is a rise in the reclamation of lost land, culture, and social status Māori still have high rates of health problems compared to non-Māori, particularly within mental health (Baxter, Kokaua, Wells, McGee, & Oakley Brown, 2006; Baxter, Kingi, Tapsell, Durie, & McGee. 2006; Liu, Lawson-Te Aho, & Rata, 2014).

To better understand mental health from a Māori indigenous perspective, Mason Durie developed the Te Whare Tapa Wha model for health in 1982. Te Whare Tapa Wha is a holistic model of health which looks at aspects that make Māori whole. It represents the four

posts that keep the wharenui standing, and each post is a representation of Māori well-being. The physical, *taha tinana*, good physical health; mental or psychological, *taha hinengaro*, expression of thoughts and feelings; the family, *taha whānau*, belonging, sharing and caring; and the spiritual, *taha wairua*, faith and spiritual awareness. To understand Māori health and well-being, there must be an inclusion of the whānau and the wairua, because these are elements which impact on Māori health and well-being (Rochford, 2004).

Suicide is one of the top three leading causes of death for both male and females aged 15-44 years of age across the world (Pompili, 2012). Approximately 800,000 people die from suicide per year, with attempts estimated to be at least double. (World Health Organization, 2014). Suicide is a continually growing social health problem because of the many different reasons that attempts and completions occur. Suicide and suicide attempts, have significant impacts on the social and psychological well-being of families and communities, as well as the financial cost for developing and implementing suicide prevention strategies at a community and national level (Ministry of Health, 2017).

Theories of suicide are focused around the notion that there is some form of intensive pain that the person can no longer bear. The pain can be either psychological, emotional, interpersonal or a mixture of these. In Western academic research, suicide has been viewed as a disruption and fragmentation of a person's social and intrapersonal connections; a means of escape from psychological pain, or a psychache, which is preceded by a breakdown of cognitive processes and the dissolution of self. (Durkheim, 1897; Menninger, 1938; Shneidman, 1996).

Hopelessness and emotional dysregulation are prevalent features of psychological pain and suicidality, and it is this dysregulation, paired with negative experiences, that predisposes a person to suicidal ideation and behaviour (Beck, Brown, Berchick & Stewart,

1990; Linehan, 1993). Joiner's (2005) interpersonal theory of suicide proposes that to commit suicide there must be a desire and a will to commit the act. Joiner (2005) argues that the interaction between perceived burdensomeness, the amount of burden that we believe we are to others, hopelessness, and thwarted belongingness facilitates the desire to commit suicide

Despite differing opinions or theories proposing intent for suicide, chances of suicide are either increased or decreased depending on individual circumstances. Risk factors for suicide include, but are not limited to: mental illness, particularly depression, anxiety, and bipolar disorder; history of attempts, age, gender, and ethnicity (e.g., for Māori and Pacific Peoples) (Ministry of Health, 2016). Sociological and environmental stressors including, poor socioeconomic status; relationship break-up, the death of a close family member or friend, especially if the death was a result of suicide; and access to means, such as firearms or medication; individual stressors include loneliness, perceived helplessness; impulsiveness, and high emotional reactivity. (Ministry of Health, 2016; Nock, Kessler, & Watson, 2006; Nock, Borges, Bromet, Cha, Kessler, & Lee, 2008).

Factors that protect against suicide, also known as resilience factors, include strong familial connections and family support, positive relations and social support; good coping abilities; good problem solving and conflict resolution skills; religious belief and practice, spirituality; and cultural beliefs, behaviours, and identify (Kleimen & Liu, 2013, Nock, *et al*, 2008; Waiti, 2016). Past research has focused primarily on the identification of risk factors to combat suicide at an individual and community level, rather than working with and increasing protective factors (Borges, Walters, & Kessler, 2000; Yen, Shea, Pagano, & Sanislow, 2003).

Suicide Risk Assessment

Prevention of suicide includes the ability to assess a person's level of risk for suicide. Suicide risk assessments are conducted by many different agencies, hospitals, mental health services, schools and other health and wellbeing organisations. Suicide risk assessments consider the risk and protective factors present in a person's life. Risk factors can include depression, anxiety, history of suicidal ideation and behaviour. Protective factors identify factors such as problem-solving capabilities, strong relationships, and reasons for living. (Beck & Steer, 1987; Beck & Steer, 1990).

Suicidal risk assessment has three or four main areas that gets assessed depending on the assessment tool; individual or personal history and psychosocial or demographic information, these categories are sometimes combined; personal characteristics, and psychiatric history. The *individual or personal history*; this assess the history of attempts or self-harm, death of a loved one by suicide, and desire or will to attempt of an individual. *Psychosocial or demographic information*; this assess age, gender, ethnicity, employment, level of education, involvement in a relationship (good or bad), and self-destructive behaviours of an individual. *Personal characteristics*; this assesses an individual's coping and conflict resolution skills, cognitive style, and hopelessness or helplessness. *Psychiatric history*; this assesses the mental health history of the individual, as well as substance or alcohol abuse (Sanchez & Kenkel, 2001; Nock, et al, 2008; Wingate, Joiner, Walker, Rudd, & Jobes, 2004; Bagge, Lamis, Nardoff & Osmin, 2014).

Suicide Prevention

As noted earlier, suicide risk is under-researched in women's shelters. It also follows that suicide assessment and prevention may not receive the same clinical attention and expertise training that is found in psychiatric services. While suicide assessment and

prevention training is an absolute necessity, funding issues, training costs and the high volume of acute cases may limit the capability of staff to attend regular development opportunities. When abused women enter a refuge setting, risk of suicidal ideation and behaviour is increased due to mental health issues, such as depression or anxiety, becoming heightened by entering into new environment and the triggers that come with it (Wolford-Clevenger & Smith, 2015).

Suicide prevention largely relies on the assessment of suicidal risk. Without risk assessment, a strategic plan for care cannot be identified. Refuge staff therefore need reliable guidelines from which to assess risk for their clients. Clinical assessment tools, discussions with clients and family are some of the ways that risk of suicide can be assessed.

Gatekeeper training has been identified as an effective method of identifying people at risk of suicidality. Gatekeeper training is tailored and developed depending on the level of expertise and can be utilised by anyone who is willing to take on that role in their community (Cross, Matthieu, Cerel, & Knox, 2007; Cross, Matthieu, Lezine, & Knox, 2010). The purpose of gatekeepers is the underlying notion that at-risk individuals are not always willing to visit their GP for help, but may communicate their distress to others who may have appropriate training who then respond appropriately (Cross, *et al*, 2007).

Gatekeeper training is triage method that assesses risk, empowers clients and their families, encourages discussion of suicidal thoughts, and encourages help-seeking behaviour (Teo, *et al*, 2016; Cross, *et al*, 2010). The values of self-determination, whanau involvement, and empowering clients is consistent with the foundational principles of Te Whakaruruhau. Whether these principles are seen in their suicide management protocols will be uncovered in the findings chapter.

Suicide prevention in New Zealand

Most countries across the world have some form of a nationwide suicide prevention plan, New Zealand developed theirs in the early-mid 2000s (Ministry of Health, 2013). In 2005 the total number of deaths by suicide was 511 and in 2006 the total number of deaths by suicide rose to 526. (Ministry of Health, 2016). Within the nationwide suicide prevention plan involves decreasing the availability to methods of committing suicide within the public, such as putting wall barriers on bridges to decrease jumping, or more restrictions on accessibility to firearms.

Apart from better collaboration between healthcare and social services, and families, a key area outlined in the NZSPAP was to "build the capacity of Māori whānau, hapū, iwi, Pasifika families and communities to prevent suicide" (p. 3). Ensuring that Māori and Pasifika families and communities can develop resolutions that are culturally appropriate to their communities, and ensuring they are given the tools necessary to aid in their prevention. The call for attention to Māori and Pasifika families and communities is a result of the overwhelming rates of Māori and Pasifika suicides across the country (Coronial Service New Zealand, 2015). Those most affected by suicide in New Zealand are males' teenagers aged 15-24, with Māori and Pasifika ethnicities having the highest rates of suicide across all age groups and both genders (Coronial Service New Zealand, 2015; Ministry of Health, 2016).

Research conducted on the community health of indigenous populations that live within a predominantly westernised society, show that many indigenous people come from low to middle class families, deprived neighbourhoods or communities, have low income; are less likely to finish a high school level of education, and are more likely to have some types of substance abuse (Gracey & King, 2009; King, Smith & Gracey, 2009: Katz, Elias, O'Neil, Enns & Cox, 2006; Elliott-Farrelly, 2004). These social factors combined with mental health diagnosis increases the chances of suicidal ideation, attempt and eventual suicide.

Suicide has different meanings and concepts to Māori, Pasifika and European. By applying an indigenised perspective to health and well-being in New Zealand, the Ministry of Health (MoH) are allowing a space for culturally appropriate prevention of suicide that may not have been developed had this capacity not been opened. This is an important aspect for suicide prevention within New Zealand, because research shows that taking a culturally appropriate route when dealing with people of different ethnicities enables them to feel safer and more comfortable (Tiatia-Seath, 2013).

Suicide preventions that target indigenous communities are designed specifically to suit the needs of those communities. Apart from accessibility to information and proper dissemination of information for indigenous communities, core components in any intervention program that targets an indigenous community are cultural sensitivity and training; strength-based programs that enhance and build factors that protect against suicide; and ensuring community connectedness. (Sahota & Kastelic, 2014; Ridani, Shand, Christensen, McKay, Tighe, Burns, & Hunter, 2015; Clifford, Doran, & Tsey, 2013)

Due to the lack of research available around Māori suicide prevention interventions, and suicide risk in shelters, this study will examine research from overseas, due to similarly high rates of suicide in other indigenous cultures, and the general suicide assessment and prevention literature. Collaboration between agencies improves cohesion between agencies, and access and dissemination of suicide information (Sahota & Kastelik, 2014; Ridani *et al*, 2015). Indigenous communities/groups have also been identified as more creative and effective for the development and implementation of a suicide prevention intervention for an indigenous population (Ridani, *et al*, 2015). Identifying that for suicide prevention that targets indigenous populations, implementation of the intervention would be more effective if it was conducted by indigenous people.

Empowerment

The empowerment approach is the collaboration of resources, knowledge and most importantly education of risk factors, warning signs, and treatment plans specifically when that treatment is for suicide, and preventing future suicide (Tighe & McKay, 2015).

A key aspect of collaboration is the learning and disseminating of information. Education on risk factors, awareness of signs to identify, are an important part of collaboration. Education and collaboration were the main factors identified in empowerment in suicide prevention (Tsey, Wilson, Answell-Elkins, Whiteside, McCalman, Cadet-James, and Wenitong, 2007). The development and implementation of prevention programs by the cultural communities that they are targeting, aid in the empowerment of indigenous peoples, because indigenous individuals are involved in identifying the information for the program, and can identify sensitive and culturally appropriate information (Tsey, *et al*, 2007; Ridani, *et al*, 2015; Grant, Ballard, & Olsen-Madden, 2015).

Chapter Summary

Victims of intimate partner violence are at an increased risk of suicidal ideation and behaviour, due to the development of mental health issues, such as depression, anxiety, feelings of hopelessness and helplessness (Ferrari, *et al*, 2015; Leiner, *et al*, 2008). Entering a women's refuge shelter exacerbates the individual's mental health problems resulting in a heightened risk for suicidal ideation (Wolford-Clevenger & Smith, 2015). Suicide prevention in victims of intimate partner violence who are entering a women's refuge shelter involves strengthening psychological resilience, through enhancing survival and coping skills and optimism, and empowering the victims, so that they may become independent (Gooding, Sheehy, & Tarrier, 2013; Hirsch, Connor, & Duberstein, 2007; Bagge, *et al*, 2016). The

ability to prevent suicide within a refuge shelter is impacted by the refuge staff's ability to identify and assess suicidality in the women.

Te Whakaruruhau, Waikato Women's Refuge, was the first indigenous refuge developed in New Zealand in 1986. Te Whakaruruhau is based on the principles of kaupapa Māori (Smith, 1997) and whānau ora (family wellbeing) (Boulton & Gifford, 2014). Te Whakaruruhau relies on the Māori cultural values and practices of *manaakitanga*, *whakawhanaungatanga*; *wairuatanga*; and *moemoea.* Te Whakaruruhau assess health and well-being from a holistic perspective, which includes their spiritual health, which is not included in many mainstream models of health (Te Whakaruruhau Inc, 2011). Te Whakaruruhau have successfully achieved a suicide free environment in their 31-year history.

This study looks to identify the specific techniques Te Whakaruruhau staff use to prevent suicide with their clients', and provide evidence to the literature around suicide prevention with women accessing women's refuge services. This study also hopes to identify how a foundation in kaupapa Māori is used by staff, and what impact that has on victims of intimate partner violence in New Zealand.

Methods

Kaupapa Māori Methodology

Kaupapa Māori methodology was used throughout this research because Te Whakaruruhau is a Māori organisation, with majority of staff being of Māori descent and because Te Whakaruruhau utilizes Māori tīkanga in their service delivery. Encompassing this research in a perspective that does not trample on the mana of the organisation was also important to me as a Māori researcher.

Kaupapa Māori is shaped by the knowledge and experience of Māori (Pihama, 2015), it provides a cultural template to conducting research either as a Māori researcher, or with Māori communities being researched, this template is guided by Māori philosophies and tīkanga and the values and customs of Māori.

Smith (1997) developed Kaupapa Māori Theory for Māori education to improve the outcomes for Māori. Six main principles have been used to guide research for Māori : *tīno rangatiratanga* (self- determination): to have meaningful control over one's own life and cultural well-being; *taonga tuku iho* (cultural aspirations): acknowledging the strong emotional and spiritual factor within kaupapa Māori; *ako Māori* (learning, teaching): promotes the teachings and learning practices unique to tīkanga Māori (customs) and acknowledging that Māori are able to choose their own pedagogies; *kia piki ake ngā raruraru o te kāinga* (socioeconomic principle): the Māori socio-economic disadvantages and negative pressures this bears on the whānau and their children; *whānau* (the extended family structure): the importance of whānau, that cultural values, customs and practices are taught through and by whānau and how the practice of whanaungatanga is integral to Māori identity and culture, and lastly; *kaupapa* (collective philosophy, principle): notions of foundation, philosophies, plan and strategies and the sharing of important information.

Kaupapa Māori methodology in research involves the application of values and principles from Kaupapa Māori theory into the conduct and analysis of research with Māori. Kaupapa Māori methodology is described as the "tailoring of research practices to the needs and aspirations of the participants, and through genuine engagement with the community as a partnership for research i.e. 'by, with, and for' Māori" (Jones, Ingham, Davies & Cram 2010, p.2).

Kaupapa Māori research methodology identifies seven values and principles for working with Māori and our communities. Each value and/or principle is linked to those identified previously in the kaupapa Māori theory. *Aroha ki te tangata* (a respect for people); *kanohi kitea* (the seen face, present yourself face-to- face); *titiro, whakarongo ...kōrero* (look, listen … speak); *manaaki ki te tangata* (share and host people, be generous), *kia tūpato* (be cautious), *kaua e takahia te mana o te tangata* (do not trample over the mana of the people), *kaua e mahaki* (do not flaunt your knowledge).

The principle of *kanohi kitea* (the seen face): was used in the presentation of the research purpose to team managers. Meeting with the team managers allowed for a rapport to be built between me and the team managers, and enabled them to trust (whakapono) that I would treat staff with respect during interviews and throughout the research process. It was made explicitly clear that any information shared during interviews would not get back to a whanau member of mine who works at Te Whakaruruhau. This alleviated any fears or concerns staff members had, and allowed them to speak openly and honestly during the interviews.

Titiro, Whakarongo…. kōrero (to look, listen, and speak): I used this principle throughout the engagement process, and at every contact point with participants. Due to the intensely personal, and risk-filled nature of Te Whakaruruhau services, it was vital to have a reflective discussion with participants. It was important that I listened carefully to what they

were saying, and that I allowed them the space to talk freely without interruption, and once they were finished talking, to validate their experience by offering support and empathy.

Kia tūpato (taking care): for this kaupapa it was important for me to be cautious of the vulnerabilities that could come from the kōrero. It was essential that the anonymity of participants was upheld, especially when discussing personal stories, and experiences.

Aroha ki te tangata (a respect for people): treating participants with respect. Aroha ki te tangata, like kanohi kitea, is about building and maintaining relationships, through showing aroha, manaakitanga, whakapono.

Kaua e takahia te mana o te tangata (do not trample over the mana of the people) and *kaua e mahaki* (do not flaunt your knowledge) were used simultaneously. To not trample on the mana of the participants, the organisation, and the client, I could not flaunt the knowledge that i had. That would have been considered rude and disrespectful to the participants.

Participants

Participants were both male and female, however, participants were predominantly female with only 1 male participant. Participants were predominantly of Māori ethnicity, with 3 participants being of Pākeha descent. Participants involved in this research were the staff of Te Whakaruruhau, Waikato Women's Refuge Residential, Community and Crisis Teams. Participants had a range of experience working at Te Whakaruruhau, ranging from 10 months to 31 years, and had experience working medium-high risk cases. The purpose of interviewing staff from different perspectives was to gain a better understanding of the strategies and principles staff used to prevent of suicide for their clients. For this study, it was important to identify the different types of services provided by the teams.

The Crisis team are usually the first point of contact for women coming into Te Whakaruruhau. Crisis team typically handle the safety and risk assessments that enable the

community and residential teams to understand the behavioural and psychological point that the clients are at, as well as any specific needs the client and their family may have.

Residential team are involved with the day to day running of the residential safe house, and the care of all the women and children currently in the safe house. The Community team advocates for women who are dealing with the many stressors of leaving a violent relationship but who can stay in their own, or whānau homes, if they, and their children are safe. Community team members take women to important appointments, such as Work and Income or doctor's appointments.

The team help clients to utilise and access services that may not have been available to them previously due to the nature of their relationship. In the Community team, there is 1 male advocate who works with the male partners who are receiving help through Te Whakaruruhau. The male advocate was interviewed to gage the suicidality of males who no longer want to commit acts of intimate partner violence, and to discover if there were differences between male and female client issues.

Data Collection

Reflective discussions were used in this study. Like qualitative semi-structured interviews, reflective discussions involve informal techniques, where participants reflected upon the work that they do every day. Unlike semi-structured interviews, there were no set question list involved during these discussions. This technique was determined the best way to gather thoughts and opinions of participants because it allowed them to divulge information and enhance answers that may not be investigated with a set questions list.

Participants were given an information sheet (appendix a, p. 76) which outlined the areas that would be investigated, before the interview process so that they could think about these areas while working, and could then reflect upon them during the interview discussions.

From the question guide, participants could reflect on their work, and questions were developed throughout the interviewing process. All interviews were recorded using an MP3 recording device with additional note taking. It was important throughout this process to keep the informed consent of participants, not only for participation but also the recording of discussions. Consent was gathered before interview proceedings.

Research Procedure

A presentation of my research purpose was conducted with the team managers, this allowed them to ask questions regarding the research and to gain a deeper understanding. This meeting was the actuation of kanohi kitea within the research, specifically in the building of trust and rapport with participants. After the meeting with the team managers, my contact information was then dispensed to the staff at Te Whakaruruhau, and I was contacted to conduct interview with staff who were willing to participate.

Interviews with participants from the residential staff were conducted first, followed by interviews with participants with staff from the community and crisis teams. Participants were presented with a consent form before interviews began and any questions they had were also answered. Because of time constraints relevant to the work that staff do, some interviews were conducted in groups of 2 or more participants. Interview times varied based on the amount of information shared, how long participants had worked at Te Whakaruruhau, what the participant had experienced while working at Te Whakaruruhau, and the number of participants present for the interviews, therefore interviews ranged from 15 minutes to 1 hour.

Participants were all asked the research question, “what do you think makes Te Whakaruruhau a suicide free safe space”. From here questions varied based on the answer given to that first question. Questions for participants usually centred around strategies they employed with clients to minimise risk of suicidality; how they incorporate tīkanga Māori

principles through their service with clients, identification of signs or indicators of risk for suicide, training in suicide awareness, and the changes or improvements they believe Te Whakaruruhau should make.

After interviews were completed, participants were reminded of their rights, especially those surrounding confidentiality and anonymity. At a later stage, this research will be presented to Te Whakaruruhau as whole, and a copy of the research findings as well as a copy of the completed thesis will also be given to the organisation. The findings of this research will be used to inform a framework for a suicide prevention strategy for Te Whakaruruhau.

Comparative Analysis

A comparative analysis was conducted on the risk assessment forms that are used with clients at entry into Te Whakaruruhau. A comparative analysis is an analysis of similarities and/or differences between two or more cases, where causality can be identified (Pickvance, 2001). For this study, variables examined in suicide risk assessments were analysed and compared against the variables examined in Te Whakaruruhau risk assessment forms for similarities to determine if the risk assessment forms are best practice for identifying suicide risk in clients when they enter Te Whakaruruhau.

The Assessment forms used by Te Whakaruruhau form the basis for client aid. They are inherently important in understanding the level of risk posed to the client, and their family, as well as aid in enabling the staff to be able to identify the needs of the client.

Forms 1 and 2 of the Safety and Risk Assessment outline the history of abuse and the ways in which abuse was committed against the client. They enable to staff to get a better understanding of the relationship between the client and the perpetrator. Form 1 discusses the extensiveness of control partners used to manipulate the client. Form 1 also considers the

child and pregnancy history of client and any concerns they may have about child safety.

Form 2 is like Form 1, in that it also asks about the history of the perpetrator, however, it is more detailed and extensive. Where form 1 discusses the history of domestic violence, form 2 extends to other areas of health and concern for the perpetrator. Topics range from overall health, mental and physical, to gang affiliations, gambling, or alcohol and drug use. This form also focuses on the lethality of tactics used as well as co-occurring risk factors, such as use of weapons. The main point of this form is to gather enough information about perpetrator and abuse history to enable Te Whakaruruhau in implementing a safety and immediate needs plan.

Form 3 is called the Additional Health and Drug Assessment form. This form focuses solely on the client. Much as the title suggests this form is used to assess the client own history, physically and psychologically. Separated into 2 sections, the 1st section discusses addictions, health problems, and drug and alcohol use, ascertaining whether detox may be necessary. The 2nd section explores areas of physical and psychological health. It is important for staff to know if there are any conditions that can affect participation in programmes or that may require follow-ups during the period of assistance. A major part of this section explores any health risk behaviours that the client may be using. Health risk behaviours were identified as suicide attempts, self-inflicted violence, seizures, and hospitalization for psychiatric illness.

The safety and risk assessment forms utilise 3 out of the 4 components of suicide risk assessment previously discussed. Psychiatric illness is discussed on form 3, when clients are asked about their history of mental illness, substance abuse and so on. Personal history of suicide is also discussed on form 3, this is where staff can gain an understanding of past or present suicidal ideation, behaviour, or planning. Most discussed throughout the risk and safety assessment forms is the client psychosocial environment. This component is followed

throughout most of the assessment. Staff are then able to gain insight into the client demographic information, socioeconomic status, level of education, and a thorough investigation of the client intimate relationship, which has broken down due to abuse.

From the analysis of the Safety and Risk Assessment forms that Te Whakaruruhau staff use when initiating services with clients, it was identified that based on suicide risk assessment literature, these forms are considered best practice for suicide risk assessment at entry to the organisation (Beck & Steer, 1990; Bagge, Lamis, Nardoff & Osmin, 2014; Nock, et al, 2008). When utilized by staff these forms become necessary tools for assessing the history of abuse of the client, any health concerns for the client and their children, concerns about the abuser and any risk potential. These forms acknowledge the factors that impact on suicidality, such as: abuse, health, physical and psychological, history of mental illness, including suicidal ideation or attempt, any support structures in place, and relationships with whānau and friends.

Ethical Considerations

This research was approved by the Human Research Ethical Committee at the University of Waikato. This research was particularly focused on maintaining the anonymity and confidentiality of the participants because participants were staff of the Te Whakaruruhau organisation. Fears of being recognised by management and others were alleviated by applying false names to participants, removing identifiable information in the interview summaries, and maintaining generalisability when summarising examples of behaviour or actions. Participants were also able to comment on interview summaries before they were added to the final data information set for analysis.

Findings

Thematic Analysis

A thematic analysis was conducted on the interview summaries. Thematic analysis is the identification of codes generated by raw data that have been developed into specific themes. (Boyatzis, 1998; Braun & Clarke, 2006). Boyatzis (1998) positions thematic analysis as a tool which can be used, "a) as a way of seeing, b) a way of making sense out of seemingly unrelated material, c) a way of analysing qualitative information, d) a way of systematically observing a person, interaction, group, situation, organisation, or cultures, and e) a way of converting qualitative information into quantitative data" (p. xi).

Boyatzis (1998) outlines three steps for conducting a thematic analysis, step 1, deciding on sampling and designing themes, step 2, developing themes and establishing codes, and lastly step 3, applying a code to each theme. Within step 2, three different stages for developing a thematic code emerged; 1. *Theory driven*, 2. *Past research and past data driven*, and 3. *Inductive or raw data driven* (p. 29). For this research, the inductive method was the most appropriate method to develop codes and themes because there was no previous research, data, or theory applied to the analysis process.

The inductive method for developing themes and codes is conducted through five smaller steps (p.44-50). Step 1. *Reduce the raw information*, Boyatzis (1998), explains that the researcher can collect the raw data and process the information to draw conclusions (p. 45). Step 2. Is the *development of themes* from a *subsample of the information.* This is necessary for large sets of data to make analysis easier (p. 45-46). Step 3, is the *comparing of themes from the separate subsamples*. Step 4. *Creating a code*, and step 5. *Determining the reliability of the code*.

Within the analysis stage of this research all five steps from the inductive method for developed thematic codes. The data was summarised from the raw audio recordings and as follows, step 1. All interview summaries were grouped into pairs and the raw data was coded. This process identified similarities, differences, and patterns across the data, step 2. Similarities, differences and patterns were then compared across all interview summaries and a list of preliminary themes was developed, step 3. From the preliminary themes, codes were developed and the themes were revised, step 4. Once the codes were developed, a sample of interview summaries were picked at random to apply the codes to, an external source was also used to validate the reliability of the codes developed, step 5.

Themes

There were four themes identified throughout the data. Each theme has a set of sub-themes that relate to the research question, "What makes Te Whakaruruhau a suicide free safe space?"

1. Identifying safety and risk issues
    - Experiential learning/personal experience
    - Awareness of risk potential
    - Āhua/Client presentation
2. Prevention Methods
    - Manner of Approach
    - Mā te Whakarongo & Kōrero
    - Awhi
    - Redirect Focus
    - Whakamana
3. Following Tīkanga

- Manaakitanga
- Aroha
- Awhi
- Whakawhanaungatanga

4. Training and Supervision

- Experiential learning
- Mentoring

Identifying Safety and Risk Issues

Participants said that it is important to identify safety and risk issues for creating and maintaining a suicide free space. To do that participants described the processes they used to assess any risks that might impact on their client well-being. Within this theme, three sub-themes emerged: experiential learning, awareness of risk potential, and āhua/presentation. Each sub-theme highlighted the responsive nature of working within a complex and risk filled environment.

Experiential learning

This theme relates to the lack of training participants felt they had (this will be further discussed in theme 4) in relation to identifying suicidal risks, and signs/symptoms of risk-related issues (depression, anxiety, safety). Despite this finding, the participants discussed how their own experiences, personally and professionally, had given them some knowledge of identifying risk and safety issues presenting from their clients. In this respect, experiential learning relates to learning on the job, and using pre-existing knowledge and skills.

Awareness of risk potential

Each participant commented that they were aware that there was always a possibility for suicidality due to the high-to extreme risks associated with client needing to access the refuge service. The awareness demonstrated by the participants showed that they had experiences with women and their families that enabled them to identify signs of risk, and safety issues. For example, the way women and their children presented, while idiosyncratic, signals to the staff that there may be risk issues.

> *Being aware of any changes in the women's behaviours or attitudes towards the kaimahi and other residents (Mere).*

Mere commented about the importance of being able to recognise changes in behaviour and attitude from clients towards others in the residential house. In their view, such changes included negative responses to kaimahi (workers) and other residents indicating that something else is going on with the client. Staff picked up on these silent cues and understood that there were possible risks present.

> *Usually we already know of their history, if they suffer from depression or other mental illness, so that is in the back of our minds (Harry).*

Harry's response referred to the safety and risk assessment (appendix d, p. 80) that all clients go through when entering Te Whakaruruhau. The assessment allows staff to gain an insight into the client health risks, including mental health. Harry's response shows that when the mental health history of the client is known, staff are mindful of potential concerns when engaging with the client and variations in behaviour of the client are understood. Because of this staff are then able to respond appropriately and/or adequately when clients are presenting with problems, for example, by creating or revising the client safety plan.

Āhua/Client presentation

A person's āhua are the things that make up that person. Their characteristics, personal attributes, form and how they present themselves. The participants identified that the client āhua or presentation was a big indicator of their client well-being. How they interact, their responsiveness to engagement, and appearance on a consistent level are all indicators of the client āhua.

> *Through how she presents, unkempt or appears to be down or in low moods (Sally).*

Sally's response described how the presentation of the client was important, because the client might usually be generally well kept and tidy, however, the participant noticed that during the last couple of visits the client had appeared unkempt or not caring of how she looked. Sally discussed how the client appearance was associated with their emotional state.

> *Their conversations are guarded and don't allow you to get to the heart of them…The demeanour is like they are absent while they are present (Manawa).*

Here Manawa discussed how the language and the way the clients speaks can be indicative of an internal struggle. Guarded conversations and absent demeanour can be a sign of many things in this line of work. Being able to identify possible risks through language, speech, and presentness in conversations, staff can then try different ways to engage with the client, and delve further into the problems.

> *She might isolate herself, or sleep a lot, or her and her babies are just staying in the room (Aroha).*

In this instance Aroha talked about when the client is in the residential house. At the residential house, there is always a staff member, or kaimahi, on site. Aroha described how in that environment where there is always somebody around, a client may isolate themselves, which is an indicator of a client āhua, and how there may be underlying issues present.

Some participants also described how the use of their own āhua was part of identifying unwellness within the client. An underlying notion of āhua is a person's intimacy and acknowledgement of their own wairua. The wairua of the staff would let them know if something was off with their client āhua.

> *I use my instincts (Anna).*
>
> *I go off instinct, which comes from my wairua (Rangi).*
>
> *We can feel it in our wairua, we rely a lot on our instinct and wairua that we get into that gate before anything happens (Mere).*

Anna, Mere and Rangi all described using their instincts when working with clients. This instinct came from their wairua which helped them identify whether their client was emotionally or psychologically unwell. Rangi and Anna's responses came as a direct answer to identify distress, anxiety or depression in their clients. Mere's response was more around keeping the client safe, and preventing further possible harm.

Identifying risk and safety issues were discussed in a variety of ways. While they are not the only ways to identify risk and safety issues, these sub themes were the most common methods used by all the participants, thus being recognised as valuable methods.

Prevention Methods

Identifying the prevention methods used by Te Whakaruruhau staff was important in gaining a better understanding of how Te Whakaruruhau have created a suicide free space. From the interviews participants identified the methods that were used on a frequent or constant basis when clients appeared in distress, and to explain how overall Te Whakaruruhau have been able to successfully create a suicide free environment for their client.

Referrals are a standard of practice conducted when specialised services have been identified as needed. For instance, if a client is presented with substance abuse, alcohol abuse,

or has a history of mental illness but is not prescribed medication. Then the client is put through a referral and follow up process. The following sub-themes are prevention methods that staff at Te Whakaruruhau use both separately and alongside assisting clients with referrals and follow-up appointments.

Manner of approach

The manner of approach was the way that participants addressed any issues identified with the client. The way that clients were welcomed, and how the participants conducted themselves and the techniques that they used with their clients were identified as important to creating a suicide free space. Two styles for the manner of approach were identified by the participants which was a strengths based approach or a whanau based approach.

Strengths-based approached: The strengths-based approach involved identifying client strengths, likes, and capabilities, and building upon them.

> *When doing the mahi with the women it's about identifying those strengths, and instead taking a strength-based approach... So, for us if we have whanau like that, what do we do as 'kaimahi' or staff is to be able to mahi with her (Aroha).*
>
> *Identifying the things that they enjoy, that they are good at and giving them access to those things that can help with their own healing (Mere).*

Aroha and Mere described what a strengths-based approach might look like and how the clients are not left to do it by themselves, but rather with the aid of the staff member or other kaimahi. Mere talked about how allowing the client to build on their abilities can be a form of healing; indicating a strengths-based approach would also aid in the strengthening of the client own abilities, and could also help with her recovery.

Whanau-based approach. This involves the client determining what they want for the future for them and their whanau. The staffs' roles are to assist in navigating other agencies and achieving the needs, dreams, goals, and aspirations of the whole whanau.

> *Whanau driven, whanau centred; our expertise will help to unpack it (the problem) and help the whanau to make sense of the situation, and our planning will give them a sense of control of what's happening, and we take it one step at a time to not overwhelm them (Marama).*

In this quote Marama discussed how taking a whanau based approach helped clients to gain control of their situation, while utilising the staff skill set to alleviate some of the stressors that can have a debilitating effect on the client. Te Whakaruruhau is a whanau first organisation, this approach was developed by the organisation to include the whanau perspective and to aid in the whanau recovery of domestic violence. By taking this approach, the client and the whanau are then responsible for maintaining their commitments, as they are the commitments that they chose, for example, taking parenting classes to get the removed children back into the mother's custody.

Mā te whakarongo and kōrero

All the participants identified that knowing how to listen, without interrupting the client was a key part of what they do. To be able to be still and present. Then followed by kōrero, or commenting, about what they have just talked about, can help to clear their minds creating more stability for the client.

> *The main thing is to listen, because if you interrupt, it leads them away from what they were going to say. And when they finish talking, to reiterate what they have said, it helps to make things clearer for them, and helps them to know that you were listening to them (Hine).*

Hine's response shows that not only is listening important, but how interrupting a client can turn them away from opening, and when talking with the client, the kōrero should be about what the client have said rather than staff putting their own interpretations on the topic. Marama talked about how listening to the client helped the staff to identify the client needs and this enabled staff to respond to client needs and help eliminate some of the barriers that the clients could have not faced. Listening and responding to client needs enabled staff to provide greater support to their clients.

> *Our approach is to listen to their kōrero, what is their narrative? What is their experience? That they have with each other, in regard to the Family Violence, and with the systems? From those kōrero we can pick out the issues they are facing… so when we are listening to their stories we can identify where the needs might be and can identify our networks that we can contact (Marama).*

Harry tells us that keeping the client talking is important *"...the important part is keeping them there talking to us"*, in this context Harry was responding directly to preventing suicide specifically when a client was presented with signs of distress, depression, or anxiety. Similarly, Mona also identified that listening and talking things through with the client makes them more open and honest when discussing their problems

> *Listen to them, talk things through… Makes them feel as if they have been heard, because no one else has, and if you allow them to talk, usually they become more open and honest and give you more detail than you expected (Mona).*

As advocates for their clients' participants identified that listening was not only important as a preventative method for suicide when their client is presented with risks, but by giving clients the opportunity to talk about their problems allowed for more responsive, open and honest conversation between staff and their client. Which allows the staff to be able to talk through some of those things with the client. Listening and being able to identify the client needs was also found to be helpful in alleviating stress, which enabled the client to think clearer.

Awhi

To awhi is to give support, and to help in some way. Participants identified that this often involves showing client their options, and building good relationships with them. Part of their awhi was also to give assurance and reassurance to the client when changes had been made or when they were contemplating some of their choices. For example, alleviating some of their stressors, helping them to de-stress and stabilise, and negotiate public systems for the client.

Trust is an important part of the advocacy role because gaining client trust has been described as sometimes difficult, and as Aroha and Mere described it, the clients have learnt not to trust but through working with the clients it can be rebuilt.

> *All round, they have come from somewhere where they can't put their trust in anybody, and then when they come here they learn to trust in people (Mere).*
>
> *Trust is important, they have had trust squeezed out so we help to put it back bit by bit (Aroha).*

Awhi can be shown in a variety of ways, from assisting with practical things such as kai, food parcels, "doing things for them such as offering transportation if she has transport issue or offering kai, helping them to get more kai" (Marama), and taking the clients through a healing process. Manawa talked about how taking women through a Whakawatea, to purge or get rid of, allowed for her clients to remove their baggage and move forward with their own recovery.

> *Take them through a cleansing process, much like on the marae. No matter what that process might look like, it's about acknowledging the hurt and finding ways to process the hurt. We can't stop the hurt for them, or make it disappear, but we can support them through that process (Manawa).*

Marama explained that advocacy and support were the biggest part of the work participants do. Dealing with crisis response, safety and risk, identifying needs, and navigating systems were all parts of supporting and advocating on behalf of the client. She acknowledges that Te Whakaruruhau is not equipped to formally support client that need specialist services, such as drug and alcohol counselling, but that they can make contact to those services for the client.

> *Our biggest mahi is support and advocacy, awhi and manaaki, and crisis response. Support and advocacy is navigating whanau through those systems, and crisis response is dealing with the safety and the risk because that's where whanau are killed and seriously hurt. We are not specialist services, but we know the people who are so we navigate those services for our clients, make those referrals (Marama).*

By giving awhi, or support, staff are showing clients that they have someone to turn to, someone that they can count on and trust. In doing so the staff have allowed client a space and person to go to when things are troubling them or they simply need help.

Redirect the focus

Finding something for clients to focus on was identified by most of the participants as a method to prevent suicide, because it allowed the client to shift their focus on something positive rather than negative. For instance, shifting the focus on the goals clients identified, both short and long term, creating plans, and using positive redirection, dreams and aspirations.

Huia and Anna talked about using external focal points as ways of shifting or redirecting the clients' focus, to not be so transfixed on themselves and their problems.

> *Find something positive to focus on, for example how much they enjoy their HAIP group, something outside of themselves and how they are feeling (Anna).*

> *Helping them to look outside of themselves and their experiences, such as focusing on the children, and helping them to see focus on their kids need for them to be around (Huia).*

Anna focused on group support or things that the client might be involved in, and Huia focused on children and their need for their parent. Both women pointed out that positive goals refocus their clients towards a positive path and this was also commented by Sally. Shifting and redirecting the focus changed the client perspective to something else. Sally also noted that the clients focus needs to be something that will motivate the client. For example, Sally mentions this by,

> *Identifying a motivating factor, something to keep them moving keep them going forward. This is very important (Sally).*

Rangi talked about reminding the client of their goals to motivate them and push them past their problem.

> *...Finding things for them to focus on… Helping them to put things into perspective, with goals and focus/motivation, especially when they are experiencing bad days (Rangi).*

Aroha and Mere talked about focus in a different way, she suggested that focusing on suicide risks, or specific factors that affect the overall well-being of the client as opposed to looking at the client person, can do more harm than good.

> *Focusing on their suicide or aspects of suicide, doesn't help them (Aroha).*
>
> *We are aware of the possible suicidality of women, but not putting emphasis on that, and not making it a thing (Mere).*

While redirecting the client focus, Anna stressed the importance of not minimising the client feelings.

> *Redirecting focus, not minimising their feelings, but not making it a staple to focus on, shifting focus from the problems (Anna).*

Shifting or redirecting the focus of the client to look at something external, outside of themselves, and positive, allowed for clients to stay out of distress, depression or anxiety, because they were not focusing on the problem at that time, this allowed for clients to gain another perspective to their problem that they may not have considered previously.

Whakamana

To whakamana is to empower. Empowering the client was identified as a fundamental part of the work they do with their clients. It involves identifying client skills and strengths and building on them, helping them find their hope and resilience, and allowing them the space to rebuild their pride and integrity. By helping them find independency, give up drugs or alcohol, or become healthier and stable parents, staff are helping their clients to find themselves.

Aroha describes empowering as an everyday thing, and that for different people the approach will look and be delivered differently.

> *When I think about empowering our women, they come in all different shapes and forms and it's not just one person's particular job, as a team every single kaimahi or staff has that ability to be able to empower and everyone does it differently, there is not just one approach for what empowerment looks like for our women… Empowering our wahine is an everyday ongoing thing, sometimes it's not just about sitting there and helping to build them up, sometimes it's just about being quiet and still, doing things together such as folding the washing or making riwai together (Aroha)*

Mere describes whakamana as a process of client finding out who they are, and helping them to find their sense of belonging by connecting back with their roots.

> *I suppose it's about 'Ko wai au' - Who am i? That's an important part, and from that we may start to whakapapa… and so we start connecting for them, teaching them the stories that are passed down. It gives them their mana, they start picking it up and in the end, that becomes a priority to learn that rather than focusing on those dark thoughts or that unwellness (Mere).*

Marama identified empowerment as one of the main goals of the work that staff do.

> *Ultimately, the goal is to empower and strengthen the family, to be able to navigate and negotiate themselves when they can. When whanau are going through crisis, a lot of they are quite paralyzed and you can't expect a lot from them, so the work can be quite extensive at the beginning (Marama).*

Empowering the client builds confidence to stand and do things independently, through identifying self, the goals of the client and their whanau, the potential barriers to those goals and finding ways to overcome those barriers. When the staff are successful in empowering the client, the client is then able to have and sustain a healthy lifestyle, as opposed to the toxic environment they had previously been dwelling in.

Following Tīkanga

Using tīkanga Māori is a core component of Te Whakaruruhau. It is embedded in the staffs' behaviour, their language, and the way they address and work with their clients. Tīkanga Māori is essentially the Māori way of doing things, the practices and behaviours that are inherently Māori.

By doing this Te Whakaruruhau have taken a different approach to the standard practice of women's refuge shelters. Rather than having a rigid structure to operate within,

the principles and behaviours of tīkanga Māori allow for a more relaxed, open, and welcoming approach used by staff. This created a somewhat familiar environment for the clients as majority of people that use Te Whakaruruhau's services are Māori.

> *Our organisation is tīkanga based, which puts us on a limb, because all that we do is based off the principles and foundation of tīkanga. For example, the residential house is set up like a marae, which allows for women to be able to identify themselves, and the tīkanga of the house is the same as on the marae, and this can open a space for women to be comfortable because it is a familiar environment (Mere).*

Using tīkanga strongly when working with clients that are not used to the cultural practices was noted to possibly make clients uncomfortable, regardless of this, there are practices and behaviours of tīkanga are always used, but tailored for specific clients.

> *When I meet whanau that use tīkanga, then I will use it, but sometimes it's not appropriate, such as with people from other cultures, it can make them uncomfortable, but I use principles of tīkanga such as respect. We learn how to deliver to the different audiences (Rangi).*

Awhi

As mentioned in the previous theme, awhi is to give support, however and wherever it is needed, emotionally or practically, and it is embedded so deeply into the work participants do with clients. Within tīkanga Māori, to awhi means to embrace, for the staff, embracing their clients and surrounding them with the support systems and tools they need to recover from their abuse is vital for the success of the well-being of the client.

> *Be there for them, talking or offering support (Sally).*
>
> *Bit by bit, every time they come in and ask for help, they are receiving something, they learn something every time they come in… with continued support and never closing off that help for them they learn that they can actually do it and that there will be things or people in place to help them when they finally make that decision to change (by getting help) or to leave (Rangi)*

Rangi and Sally talked about how offering that support and being there for the client will be worthwhile in the long run, because continued support and awhi can lead to changes.

Manaakitanga

Participants identified manaakitanga as the practice of tīkanga, apart from awhi, that is used most with the clients. It is the process of showing respect, generosity, and to care for others. It is essential that participants show clients that they care, otherwise clients are hesitant to engage. To be kind, welcoming, and hospitable is part of the Māori culture, for participants, kindness, respect and generosity, were the main forms of manaakitanga practiced with their clients.

Mere described her work at the residential house as a normal part of manaakitanga, from the sharing the everyday workload of house duties, to the hospitality and acceptance of different cultures.

> *Even other cultures that come in, they have a little bit of difference and we are willing to learn, for example when we have had Muslim whanau come in giving them the use of the separate freezer for their halal meat and cooking for them and them also for us, that sharing of experiences… (Mere)*

Manawa talked about how staff are more likely to be hired if they can display manaakitanga, she talked of how this work is reliant on the staff knowing who they are, and the ability to utilise compassion and understanding.

> *What is important is what is in their heart, and staff are more likely to be hired based on experience with working with compassion (Manawa)*

Using manaakitanga with clients is an informal part of the advocacy, awhi, and support the staff provide.

Aroha

Aroha is to feel compassion, and use empathy. Participants used this when listening to the client story or narrative, and showing them understanding and care. Aroha is often intertwined with manaakitanga because you cannot show manaakitanga without showing or giving aroha.

Children of clients were identified as unable to express or communicate their hurts and it was through demonstrating aroha to them that they can learn those skills.

> *It is very apparent within the children, what has led to their family coming into the service, the way they interact, behave or language used. Their dynamic is usually angry or withdrawn, and it indicates to where their hurt is. Sometimes all they want or need is love, aroha, but they don't know how to communicate that and can be unsure of trusting at first (Manawa).*

Whakawhanaungatanga

Whakawhanaungatanga is the process of establishing relationships. Participants described building relationships with their clients as essential for establishing positive engagement with their clients.

Sally spoke of how building a relationship with the client as a core component of the job, and that clients should not be treated as simply another case file.

> *It is a core component of the job, and it is the most important aspect, they are not just another case (Sally)*

Mona discussed the treatment of clients, as if they were her own family and with respect and incorporated whakawhanaungatanga in her practice. She believed that follow through by staff was important in not only building, but also sustaining, that relationship with the client, being transparent and open was how a rapport and eventually a positive relationship is formed.

> *Follow through is very important, and immediate follow through, because if you don't she will see you as someone who doesn't do what they say they will. It's about being transparent and honest with them, and communicating, so if something changes then tell them why, so that they understand, the reasoning (Mona)*

The atmosphere that staff work out of create a whanau environment, with each other and their clients. Anna described the way that staff of Te Whakaruruhau work with the clients and their whanau as something ingrained in indigenous cultures, as opposed to Western or Pākeha culture, where the focus is often on self.

> *It's a collectivist culture rather than an individualistic (Anna)*

Following tīkanga practices is used in a variety of ways, most participants identified more than one type of tīkanga that they followed with their clients. *"I use manaakitanga, aroha, whakawhanaungatanga, awhi" (Anna).* Utilising these practices and behaviours is a key part of how Te Whakaruruhau has been able to create a safe environment for clients that they have and this has reduced the risk with of suicide. The women's refuge shelter in New Zealand incorporates tīkanga into their practice which is why it has been very successful.

Training and Supervision

When staff are adequately trained and supervised, it is easier to identify the risk and safety issues presented with clients and to prevent them from developing into larger problems. It was found that participants had little to no training, minimal professional development and little mentoring while working at Te Whakaruruhau. Despite this, Te Whakaruruhau staff have been very successful in achieving a suicide free space for their clients. Participants discussed the importance of being provided support for training, professional development and mentoring to improve themselves to provide a better quality of service for their clients.

Experiential learning

Experiential Learning is the knowledge that was gained prior to, and on the job, working at Te Whakaruruhau. It is knowledge gained from experience in both a personal and professional capacity. Staff rely heavily on their experience to identify risk and safety issues and applied methods of prevention. Training for participants consisted of learning on the job, with little oversight. On the job training was commented by Rangi,

> *There is no practical training, you learn on the job, or through doing the job (Rangi).*

Rangi discusses how no practical training was provided for her when she worked and she had to learn on the job. Anna also talked about how learning to engage with clients from

the very beginning takes time to build because staff receive fundamental training, and are then relying on previous knowledge and instinct,

> *Most of the training is on the job training. It takes a while to really learn the job because, depending on the area you work in, because you are going through situations that you never went through before. You learn the basic fundamentals of the job within a few months, but knowing that when you talk to someone you get the first impression, you're listening to your instincts, and then listening to the story you are able to pick up things that they might not be telling you, this can take quite some time to build (Anna)*

Anna discusses about the importance for providing safety training when working with clients. This was important because it allowed staff to identify how to keep themselves safe when working with clients in different situations. However, a comment from another participant spoke of a different approach to training,

> *For staff, learning how to be safe, especially for new or inexperienced staff, how to be aware of surroundings (Rangi).*

Rangi disagrees with training surrounding suicidal awareness, she believes that staff, especially new staff, should be trained around safety not just of their clients, but themselves, more specifically about what to do in certain situations

Other areas for professional development included leadership, team building, and practical skills (engagement).

Mona described the consequences of a negative first engagement due to inexperience.

> *Learning how to engage with clients, and how to engage properly, because those first moments are crucial. And if it's not done properly, it can lead to a negative relationship, or a relationship where the client does not trust or open up to their advocate (Mona)*

Across all the participants there was mix response towards the need for training and suicidal awareness as they had different views.

Rangi also spoke about another aspect of training and how training staff to identify signs, symptoms and risk factors for suicide could be dangerous,

> *There is a risk... they may see one small sign, and make it into something that it's not (Rangi)*

Aroha and Mere believed that the skills necessary for doing this work and working with this specific clientele could not be taught, rather than learnt through building relationships with the client.

> *Our biggest training is through building relationships with the women, and being able to identify variations in behaviour depending on her circumstances (Aroha)*

Suicidal awareness training was discussed with the participants and though not all participants agreed that it would be beneficial due to different reasons, most believed that some training would benefit their service.

> *You don't know the signs unless you have been taught them in some way or another (Sally).*

Mentoring

Mentoring is ensuring that staff are capable to do their job and are providing a good quality of service. A mentor is someone higher up that staff can turn to if they need help or if they are unsure about a plan they have developed, and provides adequate supervision. While staff are experienced and capable of doing their job, most participants discussed that more mentoring was needed.

Rangi outlined specifically where mentoring or supervision needed to be improved, and what that could look like.

> *Better or more supervision, so that new or less experienced staff are working with someone who is more experienced, and learn how to engage not only with the clients, but also the client partner, if they are still involved, so learning what to say to not escalate the situation for the client if partner is unaware of client seeking help from Te Whakaruruhau, also learning how to engage with client family, and how to advocate for the client with other service providers (Rangi).*

Similarly, Huia also described the need for mentoring as some staff are inexperienced and need guidance.

> *We have inexperienced people working with this group of people and they don't really know what they are doing (Huia).*

Sally discussed the importance of providing more mentoring for staff health, and commented on how an overload of client cases could risk burnout for staff members.

> *More emphasis on staff wellbeing, safety, and training. A stronger foundation of knowledge and experience, through appropriate training, supervision, and better knowledge of the supports (for the staff) around them… Making sure that everyone took care of themselves, enhance the quality of service, focus on the quality of service given rather than the quantity of cases being closed (Sally)*

Mentoring was an area that participants described as an area that they needed more of but it was not offered to them. Despite the barriers found from little mentoring the staff have shown their skill in being able to provide their clients with access into the services they needed, and were able to create an environment that is suicide free for their clients despite the lack of mentoring.

Peripheral Themes

From analysing the interview data other themes were identified which were relevant to the research question but not necessarily key findings.

When coding *Identifying safety and risk issues*, children was emphasised in one interview. Their behaviour and interactions were indicative of protectors, especially in older children, when mothers were experiencing bad days.

> *When talking about the unwellness of the wahine, it is also the wellness of the children and you must help the children to be children rather than the responsible adult that they have been put into (Mere)*

Children specifically older children, are often left the responsibility of caring for other siblings when parents are unwell, Mere emphasised that part of the work is to remove them from that position, and allow them to be the child.

Within *Prevention Methods*, resourcing was identified as a method for prevention that is a part of the awhi and support that staff give their clients. Resourcing involved identifying what resources are needed for the client and accessing them. This was discussed as a means

of relieving client stressors, and helping them to remove some of the barriers that may have been presented to them. It also involved performing actions to aid the client, actions such as helping with Work and Income NZ, Housing NZ, finding employment, finding day care for children, *etc.* The staffs' role was to aid in access, and to act as an advocate when necessary. Resourcing, comes under both awhi and manner of approach, and while important as a part of their work, was not necessarily a key finding on its own.

> *Making sure that she is safe, and has access to resources, such as kindergarten and financial aid (Huia).*

When discussing changes or improvements to better their service the topic of funding was discussed. For many participants, funding was identified as an issue to staff, because less funding means that less staff can be hired. Low number of staff can lead to case overload, and staff burnout which was discussed as a strong possibility due to the high-extreme nature of the cases that Te Whakaruruhau staff work with. As described by Rangi and Anna,

> *There is a definite need for more staff, caseloads are huge… there is a definite understaffing issue (Rangi).*
>
> *Currently the staff are overloaded with cases. When we work intensively with clients we do a really good job, but being short of staff sort of hampers that because you want to get through as many files as you can (Anna).*

Similarly, Aroha explained some funding issues are due to evidentiary issues, and documenting the successful outcomes of the client and whanau,

> *More funding would be good but it is hard to evidence the outcomes in order to receive the funding. In terms of outcomes and successes, it's what we hear and see, for example the gradual change in behaviour in children with opening or when the women leave with housing, work, and budgeting plans in place. These sorts of outcomes we see over and over but cannot always be evidenced (Aroha)*

Anna identified other areas that could be improved within Te Whakaruruhau if the funding could be applied,

> *Resources made available for in-house practices. This would minimise referrals out of house, and see follow-ups happen quicker than referrals out of*

> *house. Things like counselling, women's groups, and financial planning. Also, that way we have control of the approach and quality of service, we don't know if we are sending them to a councillor who is actually good or not (Anna)*

Anna commented on providing more services to clients within the Te Whakaruruhau organisation, instead of referring them to an external service. As this would regulate the quality of the service and more support can be provided to clients.

Chapter Summary

From the thematic analysis conducted four themes were identified. Identifying safety and risk issues, prevention methods, and following tīkanga were identified as themes that explain how Te Whakaruruhau has avoided a suicide in their 31-year history. Training and supervision was the theme developed based on improvements to service that participants identified.

These findings show that to prevent suicide within a refuge shelter, staff use experiential learning, awareness of risk potential, and āhua/presentation to identify safety and risk issues, they use manner of approach, mā te whakarongo and kōrero, awhi, redirecting the focus, and whakamana to prevent suicide with clients, while using tīkanga practices of manaakitanga, aroha, awhi, and whakawhanaungatanga in the way they address clients.

The findings also show that while staff can identify some risks and signs of possible suicidal ideation or behaviour, they are not confident in their abilities and more training would be welcomed. Also identified was a lack in mentoring for staff, the need to have someone to be able to take concerns to or to get feedback on how staff are doing with their cases, gain support, and maintain staff health and well-being was minimal.

Discussion

The purpose of this research was to explore how Te Whakaruruhau have avoided having a completed suicide in their 31-year history, especially when victims of intimate partner violence are at a heightened risk for suicide (Campbell, 2002; Devries, *et al*, 2013). The research question for this study was "What makes Te Whakaruruhau a suicide free safe space?" The four main themes that were explored in the findings were: Identification of risk and safety issues, prevention methods, following tīkanga, and training and supervision. This chapter will discuss how the themes relate to the literature as identified in chapter 2, and will also discuss the practical implications this research presents.

Identifying Safety and Risk Issues

Within Te Whakaruruhau, the ability to identify the client risk and safety issues is a key aspect to preventing suicide and ensuring the wellbeing of whānau and future generations. Within Te Whakaruruhau, staff identify risk and safety issues by using suicide assessment forms, and experience developed prior to, and on the job. Staff identified the importance of recognising signs and symptoms of suicide; that victims of intimate partner violence have a heightened potential to develop suicidal ideation and behaviour, and an ability to notice changes or deviations in the behaviour or presentation of the client.

Staff at Te Whakaruruhau use Safety and Risk Assessment forms when initiating services with clients as it was identified that based on suicide risk assessment literature, these forms are considered best practice for suicide risk assessment at intake (Beck & Steer, 1990; Bagge, Lamis, Nardoff & Osmin, 2014; Nock, et al, 2008). When used, these forms become necessary tools for assessing the history of abuse of the client, any health concerns for the client and their children, concerns about the abuser and any risk potential. The forms acknowledge the factors that impact on suicidality, such as: abuse, health, physical and

psychological, history of mental illness, including suicidal ideation or attempt, any support structures in place, and relationships with whānau and friends. Staff therefore used a combination of best practice evidence, and on-the-job experience.

While no formal training on addressing signs or symptoms of suicide had occurred with the staff, they already had some knowledge because suicide is such a large social issue; particularly, depression or anxiety, loss and grief, risk (Depression, 2017). On the job training occurred where staff learned that risk factors and symptoms are most influenced by intimate partner violence.

The theme *awareness of risk potential* aligns with literature highlighting the importance of knowing the psychiatric history of the person or client to better understand changes in the client demeanour or mental status (Bagge, *et al*, 2014; Nock, *et al*, 2008). Knowing client mental health history allowed staff to discover different ways to engage with clients, and to understand factors that make clients vulnerable; such as history of self-harm/parasuicide or mental illness. Staff also gained an understanding of their client strengths or personal characteristics, such as their coping behaviours or cognitive style. All of which have been established as important in identifying suicidality.

An unexpected finding of *āhua* was the use of wairua and instinct, to identify risk and safety of the client. Staff discussed the use of listening to their 'gut', or instincts, which in Te Ao Māori (Māori worldview), means staff are using their wairua to feel things that are unseen in the physical realm (Valentine, 2016). Māori view health from a holistic perspective, meaning that spirituality is understood as part of a person's overall health and well-being and in a refuge setting, knowledge of disruptions to wairua is important. The *Te Whare Tapa Wha* model of health, identifies te taha wairua, spirituality as an important aspect of health (reference Durie). The inclusion of wairua in staff understanding of health and perceptions of

health demonstrate a distinctly holistic approach to health and well-being that has yet to be addressed in previous women's refuge shelters (Rochford, 2004).

Prevention Methods

Identifying suicide prevention methods that staff of Te Whakaruruhau use with their clients was the purpose of this study. When potential for suicide, or suicidal ideation or behaviour has been identified staff make referrals to the appropriate experts. Alongside these referrals is the work that staff put in with their clients.

This theme is the development of the specific informal techniques that staff use in their everyday practice. Staff identified five sub-themes within prevention methods: manner of approach; mā te whakarongo and kōrero (through listening and talking); āwhi (support); redirection of focus; and whakamana (to empower). Staff identified that the most common method used was mā te whakarongo and kōrero. Listening and allowing the client to divulge their burdens, and then sympathise and talk through specific issues with them was found to be most helpful in alleviating stress.

Having someone to talk to has been used in suicide prevention for many decades. In most cases the use of a hotline, or crisis support service, has been shown to be effective for preventing suicidal attempts, although no study has been able to identify the effect that using a crisis hotline service has on ideation (Arias, *et al*, 2015; Gould, et al, 2007). Talking is argued to reduce suicide as it allows for people to explain how they are feeling without fear of judgment, and often when the thoughts have been externalized the person is able to think clearer, or at least past their current emotional state. Staff identified that by letting the client relieve their burdens, they could gain some stability and control.

Supporting clients who present with distress, or signs of suicidal ideation or behaviour, reduces their desire to act (Goody, Sheehy & Tarrier, 2013), while receiving awhi,

emotional and physical support, enables psychological resilience to be built. While Liu, *et al* (2016) argues that resilience does not impact on suicidal risk, this study identified that through the awhi that staff gave to their clients, and through maintaining engagement, psychological resilience was developed. Suicidal risk was decreased as self-esteem, hope, and self-determination, tīno rangatiratanga, was increased.

Previous research has identified that reasons for living acts as a mediator between feelings of hopelessness and suicidal ideation (Bagge, *et al*, 2014). Staff identified that changing clients focus to something positive, or directing them to things in their life worth fighting for, helped clients to look beyond their current situations. Hopelessness can leave a person feeling lost with no way out. By countering these feeling through redirection of focus, staff aided their clients to see beyond themselves, as well as rebuilding hope (Bagge, *et al*, 2014; Gooding, Sheehy, & Tarrier, 2013). Children were identified by staff as the biggest reason for clients to persevere, as they helped to renew their sense of worth, by focusing on meeting their needs. Reasons for living also increases optimism, which impacts the cognitive perspective a person may take.

Empowerment or the ability to whakamana for staff includes being able to access the right information that clients need, provide education, and the capability to provide clients with the appropriate service (Grant, Ballard, & Olsen-Madden, 2015; Tsey, *et al*, 2007). Staff identified that collaborating with external agencies is often a difficult, but, necessary part of their work. Collaboration between service providers has been identified as a necessity for working with indigenous communities or people, because it offers a better cohesion for clients (Tsey, *et al*, 2007). Empowerment in Te Whakaruruhau is mainly for recreating mana wahine, the strong, unique, independent women, who go through are transformed through the different stages of life (Simmonds, Longhurst, Johnston, & Yates-Smith, 2014).

The suicide prevention methods identified are those that are most successful within Te Whakaruruhau. Staff identified that these techniques are used when clients appear in distress, anxious, or frequently low or in a negative emotional state. The findings also show the use of uniquely indigenous methods as a framework for suicide prevention and strengthening families.

Following Tīkanga

Te Whakaruruhau means to shelter, protect, guard, mentor, shield, and keep safe. Staff of Te Whakaruruhau adhere to this definition by the work they do with their clients. Advocacy is more than finding the right services for the client or helping them to access and navigate new pathways. Advocacy also includes building relationships and trust with a client; acting as an emotional soundboard and many more things; however, to accomplish this, Te Whakaruruhau utilises the indigenous practice of tīkanga Māori. The use of an indigenous framework or practice is not a new concept (Clifford, Doran, & Tsey, 2013).

In Australia, Canada, and U.S.A, indigenous practices have been implemented in suicide prevention for a long time. (Ridani, *et al*, 2015; Clifford, Doran & Tsey, 2013) enabling. Inclusion of indigenous practices allows staff to connect with their clients on a deeper level. Because Te Whakaruruhau was created as a response to the high rates of Māori women and children suffering from domestic violence. The organisations framework is inherently Māori, where and the practices and models of health are those best utilised for Māori clients. Familiarity with Māori customs enables staff to influence the social contexts in a client life (Wexler & Gone, 2012).

This study found that staff at Te Whakaruruhau utilise a range of techniques and methods to prevent suicide with clients that present with associated risks, all while using practices of Māori tīkanga that guide their actions and behaviours in certain situations. In

every aspect of their roles as advocates, staff used tīkanga practices of *manaakitanga,* to care and show respect, generosity, and hospitality; *aroha,* show love and kindness, empathy and sympathy, and understanding; *awhi,* support both physically and emotionally; and *whakawhanaungatanga,* the building and maintaining of relationship.

When the stressors of everyday life and responsibilities became overwhelming for clients, the ability to maintain relationships, identify supports, and seek help becomes problematic. Fortunately, the practice of whakawhanaungatanga between staff and clients, and the immersion of a whānau ora approach within Te Whakaruruhau, mobilises staff to be able to break through the overwhelming stress to alleviate some of the burdens clients experience (Robertson, *et al,* 2013). Some staff discussed the importance of whakawhanaungatanga in their work, maintaining that the building of the relationship with clients was based on trust, and that it was through trust that clients could divulge information and speak honestly.

As Te Whakaruruhau is the first indigenous women's refuge shelter in New Zealand, their approach to working with victims and perpetrators of intimate partner violence has been ground-breaking in informing Crown services of possible areas to consider (Robertson, *et al,* 2013). The whānau ora approach designed by Te Whakaruruhau is a framework that is derived from tīkanga. Through the whānau ora approach perpetrator rehabilitation and advocacy was established, enabling Te Whakaruruhau to influence the behaviours of perpetrators and reduce the recidivism of men restarting or forming new abusive relationships. Their work with the rehabilitation of perpetrators allows for Te Whakaruruhau to achieve whānau needs, and try to work with the whole whānau, meaning partners and fathers do not get cut out of the whānau and are actively involved. The inclusion of whānau and whānau needs, tīno rangatiratanga, aroha, manaakitanga, and whakawhanaungatanga, are all practices that staff use to help in their work, not only in suicide prevention, but as

advocates in helping women and men to develop new violent free behaviours (Te Whakaruruhau Inc., 2011).

Training and Supervision

Training and supervision is important for staff to be able to adequately perform in their work as well as provide suicide prevention with their clients. As with training, staff identified a lack in mentoring from upper level staff. This finding was unexpected as staff had previously identified the organisation as being like a whānau where they discussed issues to identify possible pathways for their clients. This finding suggests that with more supervision and mentoring, staff would feel more supported, and feel more inclined to discuss any issues that may arise with management.

More training was identified as needed for the continuance of suicide prevention. While staff identified that they get general training relevant to the organisation and the work they do with clients, specified training in other areas that impact on the client health because of the abuse is needed, for example, suicidal awareness training. A key issue for staff, was that having no formal training, meant that staff were reliant on their own knowledge, experience from on-the-job learning, and instinct. The ability to understand the risk factors and the warning signs is necessary; however, it is also important to know what to look for, as well as having the confidence to talk to people who may be at risk.

Gatekeeper training is something that is often discussed in suicide prevention. It is the notion that people in the community can be trained to identify specific behaviours when others are presenting in distress (Cross, *et al*, 2010; Cross, *et al,* 2007). Most of the staff believed that it would be worthwhile or that it was necessary to learn more about suicidal awareness, risk, and behaviours. They believed that having some knowledge about it was better than none. Most of the staff identified that they had received no formal or personal

development since having been employed by Te Whakaruruhau, indicating that some form of gatekeeper training is a necessity for the continuation of a suicide free environment. Simple and brief gatekeeper training has been found to be significant in improving higher confidence in helping someone with mental health concerns, the ability to persuade someone to seek help, ability to effectively tell when someone is at risk, and self-efficacy (Teo, *et al*, 2016).

Funding was identified by most staff as one the main reasons that little training and supervision, has occurred. Staff believed that if more funding was awarded to Te Whakaruruhau, more staff could be employed, and the organisation would also be able to produce their own services outside of advocacy, such as men's or women's support groups or financial and budgeting assistance. The ability to conduct some services themselves would mean that clients would not be subject to long-wait periods, which has been identified as a factor that impacts on engagement with refuge services (Wolford-Clevenger and Smith, 2015).

Limitations of the Present Study

One of the methodological limitations of the present study was not having the ability to observe staff working with their clients. Observing the staff as they engaged with their clients would offer the opportunity to see their identified methods in practice, and allow for an evaluation of the techniques. This would also enhance any findings and provide evidence for the use of such methods. Due to ethical issues this would have presented, interviews about staff practice was more appropriate. However, this is something that future researchers may be interested to study.

Another limitation to this study was the inability to gather more information about other refuge shelters. It would have been a good opportunity to look at the frameworks used by the National Collective of Independent Women's Refuge and Te Whakaruruhau, to

analyse the similarities and differences between the two organisations. This would have made a comparison of methods or techniques possible; however, due to the time restraints of this study, it was not a possibility.

The lack of national and international indigenous frameworks for suicide prevention in refuges was a limitation for this study. A few suicide prevention strategies use an indigenous framework are from Alaskan Indians and Native Indians (AI/NI) of America and Canada, and the Aboriginal in Australia (Clifford, Doran, & Tsey, 2013), so it is not known whether those models could be used in New Zealand. Similarly, suicide resources for Te Whakaruruhau and the National Collective of Independent Women's Refuge, and suicide, do not exist. The findings gathered in this research came solely from the interviews, which, while very valuable, is a concern, given the real risk of suicide in intimate partner violence and its effects. Future research could include wider conversations with women's refuges around the country to develop a suicide prevention plan, based on tīkanga Māori.

Practical Implications of the Present Study

This study highlights the methods and techniques that Te Whakaruruhau advocates utilise to prevent suicide with their clients. This study will be used for the development of an official suicide prevention strategy for Te Whakaruruhau. As such, it is essential that advocates can adequately identify risk and safety issues, as such appropriate training and supervision is important.

Due to the low funding that Te Whakaruruhau receives, staff in every area of the organization are often working with heavy caseloads, and are overworked. As a result, training and supervision, has been scarce. More funding towards Te Whakaruruhau is something that should be seriously considered, specifically to be able to hire more staff, as heavy caseloads and being overworked can lead to staff burnout (De beer, Pienaar, &

Rothmann, 2015). Funding could also be used to provide more in-house services. This would enable staff to put into practice the skills and knowledge they have learnt while working with their clients, as well as shortening wait periods, as services can be provided within the organisation rather than by external agencies, thereby reducing further risks and encouraging meaningful engagement (Brown & Green, 2014).

This research identified that the incorporation of an indigenous framework or practice is beneficial as it enables a foundation for better rapport, connection, and relationship, between advocates and clients. This can be applied in practice in many ways. In Te Whakaruruhau the use of a whānau ora approach facilitates working with perpetrators of intimate partner violence. This is something that has not been practiced previously in women's refuge shelters, and is something to be considered for non-indigenous shelters, as well as other Crown services that work with intimate partner violence. Applying a tīkanga framework is about the way we treat our clients; ensuring they are cared for, treated with respect, sympathy and empathy, are building healthy and meaningful relationships and enable the building of their self-determination, and independency. These values and practices are consistent with kaupapa Māori principles noted in the introduction section.

Conclusion

This research explored the different techniques that staff at Te Whakaruruhau, Waikato Women's Refuge, use to prevent suicide to create a suicide free, safe space for their clients. Using a Kaupapa Māori approach to interviewing staff enabled a richer and deeper discussion of the techniques utilised by staff to prevent suicide, and helped to identify the use of tīkanga Māori within the organisation. Previous literature on suicide risk and prevention within refuge shelters has predominantly focused on reasons for suicidality in shelter settings, and theories as to why suicide occurs. This research build evidence to suicide risk and prevention in shelter settings.

Despite staff receiving minimal supervision and training in suicide awareness risk and signs, they were highly responsive, using their experiential learning, knowledge (past, present, and personal), and safety and risk assessment forms to identify and prevent suicide risk. This study found that key to creating a suicide free safe space within a refuge shelters, and building healthy families, was the ability to identify risk and safety issues, and the use of indigenous practices, particularly, tīkanga, manaakitanga, aroha, awhi and whakawhanaungatanga. While these values and practices are used in refuges around the country, and the world, an indigenous world-view based on Māori knowledge and values is a key factor of Te Whakaruruhau's success.

A further point is that Te Whakaruruhau also work with male victims of violence, and they offer programmes for perpetrators with the view to keeping families together. While this may not be ideal in every situation, the value of whakapapa, relationships and future potential for families is considered where appropriate. Finally, Te Whakaruruhau have provided a service for women and their families for over 31 years, they are a much-needed resource in our community, and their contribution to society is immense. With the change in Government in 2017, it is hoped that further funding will be provided to help them continue with their work.

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Appendices

Appendix A: Participant Information Sheet

Suicide prevention in a Women's Refuge

Information Sheet

Who am I and what is my research about?

Kia Ora, my name is Waikorihiata Jones; I am a student at The University of Waikato currently undertaking my Master's Thesis. I am conducting research into suicide prevention and working with Te Whakaruruhau to provide research evidence to support the organisations service delivery.

International research indicates that battered women seeking shelter or refuge are at a higher risk for suicide attempts. (Wolford-Clevenger & Smith 2015; Wolford-Clevenger, Smith, Kuhlman, & D'Amato, 2016). Surprising, Te Whakaruruhau has reported zero suicides amongst women utilizing their residential/safe housing in their 30+ year history. This is a remarkable achievement and worth investigating so that I can develop some guidelines and protocols for Te Whakaruruhau, so that they can develop a suicide prevention policy. This is the goal of my research.

My approach to this study is to invite staff to share their experiences and knowledge about the responsiveness of the Te Whakaruruhau service, and explanations that staff may have about what makes the refuge service a suicide free space. I will be onsite at Te Whakaruruhau during lunch and tea break times, on certain days over the period of May, June, & July 2017, to have conversations with staff either individually or as a group, the research discussion should take no longer an hour. While the guiding question for the discussions will be: **"What makes the refuge service a suicide free / safe space and what improvements, if any, should Te Whakaruruhau make?"** I would also like to discuss with staff their thoughts about:

1. the circumstances under which clients come into the service,
2. the approaches that staff use with clients,
3. specific strategies that staff employ when women appear to be in distress, anxious or depressed, and,
4. staff perceptions of other 'critical stress' points in the lives of clients during their stay with Te Whakaruruhau for which support is provided.

If you wish to have a confidential conversation with me, or you wish to have the research discussion away from the Te Whakaruruhau office, please contact me to make arrangements.

How can you tell me that you want to participate?

This research is completely voluntary. If you would like to participate you can contact me by

a) sending me an email wgma1@students.waikato.ac.nz,
b) call or txt me on 0221853188
c) you can approach me while I'm at Te Whakaruruhau on the advertised days
d) or you can get a group together and let me know a convenient time to meet

What will happen with your information after the research conversation?

After our research conversations, I will spend time writing summaries of the themes and topics developed in the discussions, which I will return for further discussion, comments and approval. After that, I will complete a final summary of findings report for Te Whakaruruhau.

If participants should wish to withdraw their participation in this study, they are to advise me of this by the 30th of August 2017, so that I can withdraw their information from the information set. Please be aware that it may not be possible to withdraw information given in group discussions, as it may not be possible to determine individual contributions.

A presentation of the Summary of Research Findings will be offered to Te Whakaruruhau once the results have been finalised. As I am also completing this study as part of my post-graduate degree, I will also produce a hard copy of the final thesis document for Te Whakaruruhau, which will be available towards the end of this year 2017. Lastly, I will be making public presentations of this study at conferences, in community and university fora.

Will others know who you are?

Your colleagues at Te Whakaruruhau may know that you have participated, especially if you take part in a group discussion. However, I will not tell others who have participated in this study. In any reports, presentations, and the final thesis publication all attempts will be made to keep participants' anonymity.

Any identifying information that you provide will be kept securely on my password protected audio device and computer. Any written material that has identifying information will be scanned and stored electronically. Only myself and my supervisors, Professor Linda Waimarie Nikora, and Dr. Waikaremoana Waitoki, will be privy to this information.

What rights do you have as a research participant?

You have a right to:

a) receive an information sheet and consent form about this project and be given sufficient time to consider whether to participate in this study;
b) ask questions about the study and have them answered to your satisfaction;
c) refuse to make comments or answer any questions;
d) decline to participate in any part of the research activity;
e) complain about any aspect of the study including the researcher;
f) anonymity in any report or presentation made by the research;
g) make comment or corrections on a draft report of the study.

Who else is involves in this project?

I have two supervisors who will guide me through the research process, Professor Linda Waimarie Nikora and Dr Waikaremoana Waitoki. They are both based in the Māori & Psychology Research Unit in the School of Psychology at the University of Waikato and welcome the opportunity to work with Te Whakaruruhau in this way. Rolinda Karapu of Te Whakaruruhau is the organisational contact for the project.

Contact information

Waikorihiata Jones - Email: wgma1@students.waikato.ac.nz, Ph: 022 1853188
Professor Linda Waimarie Nikora - Email: psyc2046@waikato.ac.nz, Ph: 07 838 4080
Dr Waikaremoana Waitoki - Email: moana@waikato.ac.nz, Ph: 07 838 4080
Rolinda Karapu – Email: rolinda.karapu@waikatowomensrefuge.co.nz

This project has been reviewed and approved by the University of Waikato Psychology Research and Ethics Committee. If you have any concerns about the conduct of this research, please contact the convenor of the Ethics committee, Dr Rebecca Sargisson, phone 07 5578673, email: rebecca.sargisson@waikato.ac.nz

Appendix B: Participant Consent Form

CONSENT FORM

A completed copy of this form should be retained by both the researcher and the participant.

Research Project: Ārai Whakamōmori: An exploration of Te Whakaruruhau's Suicide Prevention Strategy

Please complete the following checklist. Tick (✓) the appropriate box for each point.	**YES**	**NO**
1. I have read the Participant Information Sheet and I understand it.		
2. I have been given sufficient time to consider whether to participate in this study.		
3. I am satisfied with the answers I have been given regarding the study and I have a copy of this consent form and information sheet.		
4. I understand that taking part in this study is voluntary (my choice) and that I may withdraw from the discussion at any time without penalty.		
5. I have the right to decline to answer a question during the discussion.		
6. I give permission for this interview to be recorded.		
7. I know who to contact if I have any questions about the study in general.		
8. I understand that if I choose, my participation in this study is confidential and that no material, which could identify me personally, will be used in any reports on this study.		
9. I understand that I have until the three weeks after the interview to withdraw my participation from the study.		
10. I understand that my contribution may be unable to be withdrawn because my individual contribution was unidentifiable, if this occurs, I give consent for my contribution to remain in within the data set.		

Declaration by participant:

I agree to participate in this research project and I understand that I may withdraw at any time. If I have any concerns about this project, I may contact the convenor of the Psychology Research and Ethics Committee (Dr Rebecca Sargisson, phone 07 557 8673, email: rebeccas@waikato.ac.nz)

Participant's name (Please print):

Signature: Date:

Declaration by member of research team:

I have given a verbal explanation of the research project to the participant, and have answered the participant's questions about it. I believe that the participant understands the study and has given informed consent to participate.

Researcher's name (Please print):

Signature: Date:

Appendix C: Interview Schedule Guide

Semi - structured Reflective Interview - Guiding Questions

1. What makes the refuge service a suicide free / safe space?
2. What are the specific strategies that you use when women appear to be in distress, anxious or depressed?
3. How do you know if someone is possibly having suicidal ideation?
4. How do you use tīkanga in your service to clients'?
5. What improvements or changes, if any, do you think Te Whakaruruhau should make that would help your service?

Appendix D: Te Whakaruruhau Safety and Risk Assessment Forms

Form 1: Risk Assessment 1

REFFERAL FROM: CYF ☐ POL PH ☐ POL CBR ☐ POL EMAIL ☐ SELF ☐ HOSPITAL ☐ OTHER ☐ _____

CLIENT PERSONAL DETAILS

Client ID (Database Number): _____ Date of Birth: _____

Surname _____ First Name: _____

Ethnicity _____ Hapuu_____

Iwi_____

Address 1: _____

_____

City: _____ Post/C: _____

Phone Hm.: _____ C/Ph.: _____

Emergency Contact Person & Address: _____

Phone Hm.: _____ C/Ph.: _____

How Many Children: _____: Please Complete Page 2:

ABUSER DETAILS

Surname: _____ _____ First Name _____

Date of Birth _____ Relationship to Client: _____

Ethnicity _____ Hapuu_____

Iwi_____

Address 1: _____

_____

Abuser Arrested Y / N Police Action: PSO/Trespass/Removed to: _____

REFERRAL REASON/BRIEF (What happened in the most recent incident)

SURNAME/FIRST NAME	Ethnicity	DOB	Gender	With Mother	CYFS Involved
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N
			F / M	Y / N	Y / N

Is he the biological father to the children? Yes No
How long have you been in this relationship? Year's _____ Months _____
Do you have concerns for your children? Yes No
If yes please describe: (If yes – refer to child advocate for full assessment)
_____
_____
_____
_____
_____
_____
_____
_____
Are Child Youth and Family involved? Yes No. If yes are there orders in place i.e. (Section 78, Section 101 etc.): _____

Police attend? Yes No

Is there a protection order in place? Yes No

ASSESSMENT OF DANGER/RISK (Lead Advocate to discuss Power & Control Wheel and provide some examples of how he uses these tactics against her. (use the template to capture her experiences)

Power and Control Wheel Template – Tactics the offender has used against the victim/s, write down the most serious examples in her words

Coercion & Threats	
Uses Intimidation	
Using Emotional Abuse	
Uses Isolation	
Minimising Denying and Blaming	
Using the Children	
Using Male Privilege	
Uses Economic Abuse	
Uses Sexual Harassment	

Determine and discuss risk level based on the severity and frequency of tactics he has used on her and/or the children through their relationship.

Low ☐ (P3) Medium ☐ (P2) High ☐ (P1)

Is there a protection order in place? Yes No
Did anyone need medical attention? Yes No

(If yes state what for)

_____
_____
_____
_____
_____

IMMEDIATE SAFETY NEEDS

PANIC ALARM Yes No Date Installed: _____ No. _____

WELLBEING CHECKS Yes No Arrange with client and POLICE

POLICE ALERT ON HOUSE Yes No Arrange with POLICE

TRANSFER TO SAFE HOUSING OR OTHER Yes No Please state other: _____

BAIL CONCERNS

SAFETY STRATEGIES

LEGAL:

_____

FINANCIAL:

_____

DV COUNSELLING:

_____

DO YOU HAVE FRIEND & WHĀNAU SUPPORT: (what can they provide): (eg. Safe Housing , Safety, Support, Transport, Food, Finance, Clothing Anything Else **Please Circle**.

_____

ARE YOU ENGAGED WITH OTHER AGENCIES? **Please State** _____

_____

DOES NOT WANT REFUGE SUPPORT ☐ TANSFER TO RESDIENTIAL ☐ TRANSFER TO COMMUNITY ☐ REFER BACK TO SAMS ☐ (If no engagement or no support needed)

Client Name: _____ Signature: _____

Staff Name: _____ Signature: _____

Additional Information/Notes:

Form 2: Risk Assessment 2

WAIKATO WOMEN'S REFUGE

FULL CRISIS RISK ASSESSMENT

Name of Client: _____

Address: _____

Client Signature: _____

Kaimahi: _____

Time Started: _____Time Completed: _____ Date:_____

ALERTS

CHILDREN

Is he the biological father to the children? Yes No

How long have you been in this relationship? Year's _____ Months _____

Do you have concerns for your children? Yes No

If yes please describe: (If yes – refer to child advocate for full assessment)

_____

_____

_____

Are Child Youth and Family involved? Yes No. If yes are there orders in place i.e. (Section 78, Section 101 etc.): _____

EXTERNAL/WHĀNAU SUPPORT

Do you have Whānau or Friends who can support you at this time? Yes No

_____

_____

_____

If yes what supports can they provide?

Safe housing	☐	☐
Safety	☐	☐
Support and advocacy/transport/food/clothing	☐	☐
Other (describe below)	☐	☐

_____

_____

Iwi: _____ Hapuu:_____ Don't Know ☐

ABUSER HISTORY

Gender: Male/Female Ethnicity: _____ Iwi: _____

Employment Status: Fulltime Part-time Student Benefit: _____

Does he have a history of Violent Offending? (describe) Yes No

_____

_____

_____

_____

CIRCLE THOSE RISK FACTORS THAT ARE PRESENT IN HIS LIFE (and describe)

Gang Affiliations/Connections	Alcohol/ Drugs	Gambling
Mental Health	Has Weapons	Has been violent in previous relationship

Unemployment	Pornography	Financial/Economic

Has he ever used weapons on anyone else? Yes No

_____

_____

Does he have any martial arts/boxing/military training? Yes No

_____

_____

Have you ever needed medical attention as a result of injuries by him? Yes No
(Describe the worst injury that you've experienced from him)

_____

_____

_____

Has he ever assaulted you while pregnant? Yes No
(If yes describe most serious assault)_____

_____

_____

_____

_____

Are you pregnant? Yes No

Has he ever threatened to:

Smash things up, destroy your property? Yes No
Harm or kill family members? Yes No
Harm or kill pets? Yes No
Harm or kill himself? Yes No
Take the children from your care? Yes No
Tell the authorities on you? Yes No
Comments:_____

_____

_____

<u>CO-OCCURING RISK FACTORS</u>

Are you Separated/Separating? Yes No How long have you been separated? _____
Does he accept the separation? Yes No
(If no please describe)_____

_____

_____

Are there Custody or Access issues? Yes No
(if yes describe what these are) _____

_____

_____

SEXUAL ASSAULT

Were you ever forced to do things sexually that you didn't want to do?	Yes	No
• rape		
• forcing sex		
• using sex as a bargaining tool so they won't physically abuse		
• sexual harassment		
• unwanted sexual touching		
• forcing you/children to watch pornography		
• infidelity against your will		
• not using contraception when asked to		

Comments:

_____
_____
_____
_____

FREQUENCY AND SEVERITY OF VIOLENCE IN CURRENT RELATIONSHIP

Does he do any of the following to you?

Behaviour	No	First Time	Sometimes	Often	Always
EXCESSIVE JEALOUSY	1	2	3	4	5
EXTREMELY OBSESSIVE	1	2	3	4	5
SLAPPING	1	2	3	4	5
PUNCHING	1	2	3	4	5
CHOKING/STRANGULATION	1	2	3	4	5
PULLING HAIR	1	2	3	4	5
PUSHING	1	2	3	4	5
HOLDING DOWN	1	2	3	4	5
KICKING	1	2	3	4	5
BURNING	1	2	3	4	5
THROWING THINGS	1	2	3	4	5
USED WEAPONS	1	2	3	4	5
KIDNAPPING	1	2	3	4	5
STALKING/SOCIAL NETWORK	1	2	3	4	5
TOTAL					

TOTAL RISK SCORE _____

Low Risk - (Scores of 15 to 28) **Medium** Risk - (Scores of 29 to 42) **High** Risk - (Scores of 43 to 70)

Is his violence getting worse? Yes No

_____
_____
_____

Do you believe that he will kill or seriously harm you or your children? Yes No

RISK PROFILE - SUMMARY

Power & Control Wheel Risk Factors and Level of Risk

Uses some of the tactics – more at the lower end of the abuse scale	LOW
Uses at least half of the tactics – abuse may start to escalate	MED
Uses most of the tactics – at the higher end of the abuse scale	HIGH

Lethality Indicators			
He does not accept the separation		no	yes
Custody issues		no	yes
Alcohol/Drugs/Mental Health psychosis		no	yes
Suicide/Homicide Threats	no	sometimes	always
Victim is isolated	no	sometimes	always
Stalking/Harassment	no	sometimes	always
Extremely Obsessive	no	sometimes	always
Excessive Jealousy	no	sometimes	always
Escalating Risk Factors			
Is pregnant or has young baby		no	yes
New relationship		no	yes
Abuses the children	no	sometimes	always
Abuses Animals/Pets	no	sometimes	always
Strangulation/Choking	no	sometimes	always
Uses Weapons	no	sometimes	always
Uses sexual violence	no	sometimes	always
Victims perception of risk	low	med	high

Lethality Indicators show those victim/s are at risk of being killed by the perpetrator. Discuss the seriousness of these indicators and put appropriate safety plans in place such as a whānau safety plan and a multi-agency safety plan.

Escalating Risk Factors show that the violence is escalating and that her and her children are at risk of future violence occurring. The severity of the violence depends on the whether his violence is at the low or high end of the scale. Discuss the seriousness of these factors and what safety plans can be put in place.

Victim's perception of risk of harm: victims of domestic abuse often tend to underestimate their risk of harm from perpetrators of domestic violence. However, If they say they fear further harm to themselves, their child(ren) or someone else this should be taken seriously when assessing future risk of harm.

SAFETY PLANS

Discuss Safety Plan Strategies with Client/s and complete Safety and Multi- Agency Plans Template. If the client feels that she is in immediate danger, get her out of that situation immediately. If the client states that he will continue his violence and she fears for her and her children's safety, a multi-agency safety plan is best. With the clients' permission, make a referral to the SAMs team showing the high risk factors from the assessment and ensure this client gets the multi-agency support that her and her children need to keep them safe.

CONSENT

The information you have provided in this assessment will be kept strictly confidential, in a database that will only be used by Te Whakaruruhau. However, this information maybe shared with funding agencies from time to time for auditing purposes. The general information you provide (but not your

name, address or personal details) will be collated by our Office to help us build a clear picture of family violence in New Zealand, and to provide more effective services for women and children.

CONFIDENTIALITY:

- I will be consulted before any specific information within this file is released.
- I understand the importance of the confidentiality of the refuge and the safety of refuge residents and advocates.
- I understand there are times where for my safety or the safety of my children information may be shared with other agencies and or the Police.

Signed: _____ Date: _____

Risk Assess Completed Yes No	Case Plan Prepared Yes No
Safety Plan Done Yes No	Contract Completion Date: _____

REFERRED TO: **Residential Team** ☐ **Community Team** ☐

SAMS ☐ **External Agency** ☐

External Referral (name of agency) _____

IMMEDIATE SAFETY PLAN

SAFETY STRATEGIES		ACTION/REFERRAL	Who Person Responsible	When Date Task completed
Safe Housing **including, Whānau, Friends, Transfer out to other Refuge**				
Panic/Silent Alarm **(FST or Refuge)**				
Protection Orders/Parenting Orders/Legal Support-Advice				
Abuse Prevention Pack **given and explained**				
Wellbeing Checks **includes Crisis Drive-By**				
Whānau Support				
External Agency Support				
Other				

REVIEW

PLANS	REVIEW DATE	COMMENTS
Safety Plan		
Immediate Needs Plan		

Form 3: Additional Health and Drug Assessment

ALCHOHOL AND DRUG USE SUMMARY

Refuge to complete with Client

Please note if client is currently or has used any of the following in the last three months.

Substance	**Amount**	**Frequency**	**Date of Last Use**
Alcohol			
Barbiturates			
Cannabis			
Cocaine			
Crack Cocaine			
Meth Amphetamine			
Amphetamines			
Other			

(Please give a brief summary of history of alcohol and drug use/abuse)

_____

_____

_____

_____

_____

Is Detox required? Yes ☐ No ☐

Are there any special needs (i.e. literacy, disability, religious)? Yes ☐ No ☐

Please describe: _____

_____

Are there other addictions of concern (e.g. gambling, sex, shopping etc...)?

_____

_____

_____

HEALTH ASSESSMENT

Refuge to complete with Client

Please list physical or psychological conditions (e.g. migraines, dental, chronic acute conditions etc.) that may:

Impact your participation and retention in programme

_____

_____

_____

_____

Require medical follow up during programme

_____

_____

_____

_____

Are any of the following **health risks behaviours** currently present? (Within the last 6 months)

Suicide attempts	Yes ☐	No ☐
Seizures	Yes ☐	No ☐
Self-inflicted violence	Yes ☐	No ☐
Hospitalisation for Psychiatric Illness	Yes ☐	No ☐

Please Comment:

_____

_____

_____

Please indicate any allergies that you may have:

_____

_____