Mental Health
Foundation
Scotland

Support for those bereaved by suicide

A Qualitative Research Study

Contents

Acknowledgements

The Mental Health Foundation (MHF) benefited from a great deal of help and support setting up fieldwork and gaining access to organisations who deliver services to those bereaved by suicide and to individuals bereaved by suicide themselves. We would like to thank those organisations for the time and effort they put in including help with recruiting, setting up interviews and arranging interview rooms. Individual respondents are not named in this report to maintain MHF's promise of confidentiality and anonymity.

The researchers would also like to acknowledge the participation of the many individuals bereaved by suicide whose experiences and insights helped produce this report. The reflections in the report are those of the researchers and inevitably, a large volume of qualitative information has been condensed into this report. We hope we have done justice to the participants – any errors and omissions are, of course, the researchers.

We would especially like to thank all those bereaved by suicide who gave their time to be interviewed about their sensitive and upsetting experiences dealing with losing a loved one and the challenges on their journey.

If you wish to talk to someone about your own experiences of loss, from suicide or other means, the following organisations are available:

SOBS
If you have been bereaved or affected by suicide and you would like to talk with one of SOB's volunteers about your experience, you can get in touch in the following ways:

Email: **email.support@uksobs.org**

Helpline: **0300 111 5065
open 9am to 9pm, Monday to Friday**

Samaritans
Email: **Jo@samaritans.org**

Helpline: **116 123
open 24 hours a day**

Breathing space
Breathing Space is a free and confidential phone service for anyone in Scotland feeling low, depressed or anxious.

Phone: **0800 83 85 87
6pm to 2am weekdays and 24 hours at the weekend**

Researchers:

Julie Cameron, Head of Programmes – Mental Health Foundation
Susan Solomon, Research Manager – Mental Health Foundation

1. Executive Summary

Providing support for people bereaved by suicide is a key objective of the Scotland's Suicide Prevention Action Plan 'Every Life Matters' (2018)[1]. Action point 4 of the Strategy considers the 'postvention' needs of those people affected by suicide.

To assist in the development of robust, evidence-based support interventions for those people bereaved by suicide in Scotland, initial exploratory research was required to investigate existing models of intervention in this area. This enabled us to investigate best practice from any challenges experienced in set up and delivery and provide guidance to the National Suicide Prevention Action Group (NSPLG)[2] on developing the potential support services model further.

A literature review, mapping exercise and primary research was conducted. The research methodology chosen was qualitative in nature and comprised of both face-to-face and telephone in-depth interviews with both organisations that supported those bereaved by suicide (6 interviews), and those bereaved by suicide themselves (16 interviews).

Although it was envisaged that the depth interviews would be a standard one hour in length, many of the respondents needed time to talk through their journey and background reminisces about the deceased. Furthermore, in some cases, discussing a time in their lives which was incredibly traumatic sometimes caused further distress during the interview and consequently many of the interviews were over 2 hours long.

Experiences of initial support from services were limited and although many of those bereaved by suicide had contact with the police, funeral directors,, their G.P. and in some cases the church, no respondent received support from any specific bereaved by suicide services in the early days and weeks of their loss. Nor had the majority sought such support due to their overwhelming shock and sadness. At this time, close family and friends were the main source of both practical and emotional support.

A mapping exercise was conducted in May 2019. This was limited to an online search with supplementary telephone calls to uncover the types of support offered. This concluded that most bereavement support services in Scotland are designed to support wider bereavement. Support services are not equitable across Scotland and in particular there was little to no bereavement support services in the Highlands and Islands.

As part of the mapping, and subsequent interviews with service managers a range of models of support were identified with several defining features. The first feature related to whether the support provided was specific to bereavement from suicide or more general bereavement where people with different experiences of how

a person died come together. The second feature related to the type of support offered, being either group-based work or one-to-one. The third defining feature was the experience brought by support staff in terms of whether support was led by people with direct experience of bereavement from suicide or not. This was irrespective of whether the service was delivered by paid staff or volunteers.

Respondents mentioned several different reasons that led to the decision to investigate what support was available to help manage their grief. This included suicidal thoughts, drinking too much, a feeling that they were not getting better, difficulty functioning and performing daily tasks, and – for some – a perception that friends and family had grown tired of listening or felt that they had become a burden.

We also identified six main barriers to accessing support to help them with their grief: perceived stigma; geography and wider logistics; lack of acknowledgment that help was needed; feeling they had no right to grieve; and an inability to verbalise their feelings.

In addition, the research identified some facilitators that assisted some respondents in reaching out to professional support services. These included the level of awareness of support services that could be accessed and encouragement from others. We also found that a self-perception that the bereaved person was being a burden to others could act as a catalyst to seek help. Those organisations working with the bereaved also identified similar facilitators but added that clear referral pathways and having a strong profile

assisted this facilitation. Experiences of support amongst those bereaved by suicide covered a variety of support models. Many of the respondents had attended at least one support group and had a positive experience due to the non-judgemental membership; the supportive environment; the coping strategies they learned and – for some – the social aspects. For some however their experience of support groups for those bereaved by suicide was not as constructive and was felt to be negative due to dominant characters within the group, a feeling of persistent victimhood that pervaded the group, feeling like an outsider and fears around confidentiality.

Some of the respondents in the research had accessed one-to-one counselling to help them deal with their grief. For some respondents this was a positive experience with a variety of benefits including helping them move forward, processing guilt and anger and finding it easier to talk to a stranger. However, it was not without its challenges such as long waiting lists in some cases, a lack of specific suicide bereavement counsellors and – for some – a lack of connection with their counsellor. For a minority of the bereaved involved in the research they had found online support helpful such as specific Facebook groups and forums.

Respondents were asked what would have been their ideal support service to help them, considering their needs at that time. Their main thoughts were around early advice and assistance; a named contact; quick assessment of need; lived experience support; and – for some – flexible ongoing support available as required but often around anniversaries or other difficult times.

2. Introduction

In 2017, there were 680 probable deaths by suicide in Scotland[3]. The Scottish Government believes that no death by suicide should be regarded as either acceptable or inevitable.

When compared with people bereaved through other causes, those bereaved by suicide are at an increased risk of suicide, psychiatric admission and depression[4]. A primary concern is the increased risk for the bereaved to attempt suicide as a result of having a connection with someone who has died by suicide[5].

It has also been suggested that the cost of each suicide is around £1.67m, with 70% of that figure representing the emotional impact on relatives[6].

Whilst the cost of suicide is high, there is also evidence to show that postvention support has a beneficial effect on people bereaved by suicide with people who were contacted and received support less likely to be at high risk for suicidality[7] in addition to having lower depression scores and anxiety[8].

Postvention in this context is defined as interventions to address the care of bereaved survivors, caregivers, and health care providers; to destigmatise the tragedy of suicide and to assist with the recovering process; and to serve as a secondary prevention effort to minimise the risk of subsequent suicides due to complicated grief, contagion, or unresolved trauma[9].

Despite this evidence, survey data suggests that two thirds of people in the UK who are bereaved by suicide receive no formal support from health or mental health services, the voluntary sector, employers or education providers. Substantial stigma remains and is a barrier to the bereaved seeking help, along with barriers to offering support[10]. Nationally and internationally, postvention support has traditionally been underrepresented within suicide prevention strategies worldwide, despite its importance in society.[11]

Providing support for people bereaved by suicide is a key objective of Scotland's Suicide Prevention Action Plan 'Every Life Matters' (2018)[12]. Action point 4 of the Strategy considers the 'postvention' needs of those people affected by suicide.

To assist in the development of robust, evidence-based support interventions for those people bereaved by suicide in Scotland, initial exploratory research was required to investigate existing models of intervention in this area. This enabled us to investigate best practice from any challenges experienced in set up and delivery and provide guidance to the National Suicide Prevention Action Group (NSPLG)[13] on developing the potential support services model further.

Thus, between July and October 2019, the Foundation undertook an exploratory research study interviewing both organisations that supported those bereaved by suicide, and those bereaved by suicide themselves.

The project was funded by the Mental Health Foundation using donations from a family bereaved by suicide, with additional funding from the Scottish Government on recommendation from the NSPLG. The remainder of this report details our findings.

3. Background from the Literature

3.1 Introduction

Estimates of how many people are impacted by a suicide range from a traditionally cited 6 survivors (Shneidman, 1972)[14] to as many as 135 individuals (Cerel et al., 2018)[15]. Berman (2011)[16] noted that estimates vary depending on the age of the deceased, the type of relationship, and the frequency of contact prior to the death, and determined that between 45 and 80 individuals are thought to be deeply and intimately affected by a suicide death. A meta-analysis from 2017 suggested that 22% of people have been exposed to suicide during their lifetime, with 4% exposed in the past year (Andriessen, Rahman, et al., 2017)[17]. Based on the latest national statistics, up to 91,800 individuals were exposed to suicide in Scotland in 2017.

Being bereaved by suicide is associated with a range of adverse consequences. Over and above the impact of experiencing any loss, suicide survivors may experience specific components of grief, such as feelings of rejection, shame, stigma, guilt, and the need to conceal the cause of death (Sveen & Walby, 2008)[18]. Suicide bereavement has been linked with a range of mental and physical health problems, and increased risk of self-harm and suicide. Pitman and colleagues (2014; Erlangsen & Pitman, 2017)[19] reviewed published work comparing suicide bereavement to other modes of death. Suicide survivors were found to have an increased risk of depression, anxiety, post-traumatic stress disorder, personality disorders, alcohol and drug use, and admission to psychiatric care. In addition, physical health disorders and poorer social and occupational functioning were more common among those suicide bereaved. Risk of self-harm was greater, particularly among children and young people, and risk of suicide was higher in partners, parents, siblings, and other family members (Erlangsen & Pitman, 2017; Pitman et al., 2014)[20]. Indeed, exposure to suicide has been acknowledged as a relevant factor preceding suicidal behaviour in several prominent theoretical models of suicide (Joiner, 2005; Klonsky & May 2015; O'Connor, 2011; O'Connor & Kirtley, 2018).[21,22,23,24]

A concern arising from deaths of an unexpected or violent nature is the risk of complicated, or prolonged grief. This is experienced as long-lasting acute grief that causes distress and impairs functioning. Individuals may face intense feelings of distress, shock, numbness, denial, and longing for the deceased which last over a prolonged time and are associated with adverse psychosocial and physical health outcomes as well as suicidal ideation and behaviours (Young et al., 2012)[25]. Complicated grief may develop following any bereavement, but particularly a suicide death. Given the potentially devastating outcomes, interventions for suicide survivors should address aspects of complicated grief (Mitchell et al., 2004)[26].

3.2 Postvention Needs of Suicide Survivors

While most of those bereaved by suicide perceive a need for support following a suicide, many do not receive it, or are left unsatisfied with the support (Wilson & Marshall, 2010)[27]. Postvention refers to "those activities developed by, with, or for suicide survivors, in order to facilitate recovery after suicide, and to prevent adverse outcomes including suicidal behaviour" (Andriessen, 2009)[28].

Such activities span a range of support and services for those bereaved by suicide. These can include informal sources of help such as friends and family, as well as professional support from general practitioners and specialised grief counsellors, support groups, and self-help information accessible online or in print (McDaid et al., 2008)[29].

Postvention activities are offered to individuals or groups, and can be based in schools, family-focussed, or in community settings.

3.3 Research on The Effectiveness of Postvention Activities

Despite the growing interest in the experiences and needs of suicide survivors and the postvention efforts to address these needs, very limited empirical work has been done in this area. The available research is mainly from the USA, Europe and Australia, with a notable lack coming from the United Kingdom.

Several systematic reviews have been conducted looking at the effectiveness of interventions for suicide survivors. The most recent publication by Andriessen et al. (2019)[30] focused on peer reviewed studies of the effectiveness of interventions. A total of 12 articles were identified (consisting of 11 studies) spanning from 1984 to 2018, which compared interventions for suicide survivors with a control group (either no intervention, an active control group, or treatment as usual).

Support was provided in a group/school setting, family, or individual basis, and incorporated supportive, therapeutic, and educational aspects. Overall, the methodological quality of the studies was deemed weak however, and provided inconclusive findings on the effectiveness of the interventions. Outcomes measured across studies included grief, mental health, and suicidality.

With regards to grief symptoms, Andriessen et al (2019) found one study of an 8-week support group (Survivors After Suicide) led by a mental health professional and trained survivor volunteer, which showed a decrease in negative emotions following the support (Farberow, 1992)[31]. However, there was mixed evidence from a 4-session family based cognitive behaviour grief counselling (GC) programme (de Groot et al., 2007; de Groot et al., 2010)[32,33] a cognitive behavioural therapy (CBT) and psycho-education based intervention for CG, a professional-led CG therapy in conjunction with antidepressants (Zisook et al., 2018)[34], group psychotherapy (Constantino & Bricker, 1996)[35], a group intervention programme (Constantino

et al., 2001)[36], and a 2-week suicide-related writing task (Kovak & Range, 2000)[37]. In some cases, reductions in grief or complicated grief were apparent, however these did not persist over time, were not statistically significant, or could not be replicated in subsequent analyses.

Some evidence of effectiveness for psychosocial outcomes came from a CBT and psycho-education based intervention for adults; a 10-week bereavement group intervention for children (Pfeffer et al., 2002)[38], a community church-based intervention for adolescents (Sandor et al., 1994)[39]; and weekly group support for adults (Battle, 1984[40]; Constantino & Bricker, 1996;[41] Constantino et al., 2001[42]). However, findings were mixed, with some outcomes not significantly different between intervention and control groups, effects failing to last in the long term, or difficulties with replicating findings with larger samples. Furthermore, Hazell and Lewin (1993)[43] found no evidence of benefit to mental health and behavioural outcomes following a schools-based group counselling session following a pupil's suicide.

Finally, two of three studies reviewed by Andriessen and colleagues measuring suicidality found no differences in suicide ideation following a CBT-based psychotherapy compared to control groups (De Groot et al[44]., 2010; Wittouck et al., 2014[45]). Zisook and others (2018)[46] showed a decrease in suicide ideation following therapy for complicated grief compared to medication.

Overall, this review suggests that while the body of evidence on the effectiveness of interventions is sparse and generally low in quality, particularly for interventions aimed at reducing complicated grief, some important considerations are recommended: ensuring a sufficient number and length of sessions is offered, using trained facilitators, and ideally having an accompanying manual to aid in the delivery of support. Interventions which incorporate the wider social context of survivors and use supportive, therapeutic, and/or educational approaches may be particularly effective (Andriessen et al., 2019)[47].

Other systematic reviews in this area overlap with the findings from Andriessen and colleagues. Linde et al. (2017)[48] assessed seven studies that looked at interventions to reduce grief. Several showed effectiveness in at least one outcome measure. However, the authors cautioned about the low methodological quality of studies, outcome measures which could be considered inadequate, and interventions that were short and mostly group-based and lacking follow-up assessments. Furthermore, the largely homogeneous study populations (mostly white, female, middle-aged, with close

relationships to the deceased) limit the generalisability of the findings. Linde et al. also noted that some interventions may only be effective for a subgroup of bereaved individuals, such as those with high levels of suicide ideation. In research by de Groot et al (2010)[49], experiences of suicide ideation at baseline predicted the effectiveness of CBT-based grief therapy in preventing negative outcomes (including suicidality) 10 months later. Those in the suicide ideation group also reported higher levels of pre-loss mental disorders, neuroticism, lower self-esteem and a lower sense of control.

While further research is needed in this regard, Linde et al. considered the potential benefits of screening individuals to identify those at high risk for complicated grief and ensuring that targeted postvention is offered. Such screening could be based on the intensity of grief reactions and the presence of established vulnerability factors (such as insecure attachments, underlying mental health diagnoses, relationship with the deceased, and resources and supports available to the individual).

Szumilas and Kutcher (2011)[50] reviewed 16 studies of postvention programmes (including uncontrolled studies) and found no evidence of effective postvention to reduce suicide or suicide attempts, and/or suicide contagion. Suicide contagion is the exposure to suicide or suicidal behaviours within one's family, one's peer group, or through media reports of suicide and can result in an increase in suicide and suicidal behaviours. In fact, one case study showed an increase in hospitalisations and suicide attempts following a schools-based programme, suggesting

the programme may have romanticised and glorified the suicides unintentionally (Callahan, 1996)[51]. However, gatekeeper training for school staff was found to be effective in increasing knowledge and skills for crisis response (Grossman et al., 1995)[52], and outreach at the scene of suicide was associated with survivors presenting sooner for support, compared to a passive model of postvention (Cerel & Campbell, 2008)[53].

McDaid and colleagues (2008)[54] identified 8 randomised controlled trials or studies using a control/comparison group. They concluded that while most research (6 of 8 studies) showed a benefit on at least one outcome measure, it is difficult to attribute effects to the intervention itself. Further research with larger samples and more controlled variables is necessary. Evidence for the improvement of complicated grief is also not conclusive.

Overall, the lack of empirical data limits conclusions about the effectiveness of interventions for suicide survivors, and implications for practice. Further research is needed to address the gaps in our knowledge and investigate whether subgroups of survivors may benefit from specific approaches. The extent to which postvention efforts are impacted by factors such as cultural or social backgrounds, kinship relationship with the deceased, circumstances surrounding the death, age, gender, sexuality, occupation, and other factors, are not well understood. Furthermore, the effectiveness of postvention efforts for each group on the continuum model of survivorship – that is – the different levels of impact on those left behind by

suicide, ranging on a continuum from those exposed to suicide through those who are affected by it and finally to those who are bereaved by suicide in the short- or long-term, as a function of their loss of a close emotional attachment through this tragic form of loss. (Cerel et al., 2014)[55] has yet to be fully explored.

3.4 Postvention Literature in the UK: Uncontrolled Studies and Grey Literature

Currently in Scotland and the wider UK, a range of support services cater for people who are bereaved by suicide but these are not equitable across the country. A search of uncontrolled studies and grey literature was conducted to identify research looking specifically at UK-based postvention activities. Searches were conducted on several databases and platform using keywords related to bereavement, suicide, and postvention[56] (e.g. Medline, PsycInfo, Embase, Scopus, Web of Science, OpenGrey, F1000Research). In addition, websites of national and international bereavement or suicide organisations, libraries and health/research institutes, and governmental reports were searched, as well as keyword searches on Google.

Overall, limited additional evidence was found, and was generally not of high quality, suggesting that UK-based postvention activities are under-evaluated (particularly in work using comparison groups). The limited evidence and sources of information are summarised below, with an indication of their effectiveness provided where it was available.

Support for Professionals

Saini et al. (2016)[57] investigated the support for GPs affected by a patient suicide. Twenty-seven percent of GPs reported having access to some form of support, while 37% had no access, and 35% were not aware of support services for GPs. The types of support recognised as being helpful by GPs included informal help from peers, colleagues, family and friends, as well as secondary care, the BMA, and opportunities to debrief. The data from this study suggests that most GPs are affected by a patient suicide to varying degrees, and some benefit to an extent from these formal and informal systems in place.

Internet Support

Chapple and Ziebland (2011)[58] looked at the influence of the internet on the experience of bereavement, through a series of interviews with suicide survivors. Participants reflected that email and social networking can play a positive role in helping inform others about the death, lessening the burden and emotional toll of this daunting task. They also offer the chance to gain support from and connect with an online community of survivors and provide opportunities for memorialisation and making sense of the death. In contrast, concerns were raised about the nature of online communities and support, including the potential risk of encouraging suicide, the lack of a personal face-to-face connection, coming across upsetting material, and the abundance of time needed to find information. Nonetheless, many individuals felt that the internet could be a useful channel for accessing support after a suicide loss.

3.5 Conclusions

Individuals bereaved by suicide may face significant challenges when dealing with the death of a loved one. It is recognised that timely support can be crucial for survivors, yet the exact nature of how this should be offered is unclear. The evidence of the effectiveness of postvention approaches is not robust and is often based on low quality studies. Consequently, recommendations for best practice can unfortunately not be made here. Crucially, further evaluative work which assesses the effectiveness of interventions in different groups and settings and which incorporates the views of people with lived experience is urgently needed.

4. Research Approach

4.1 Research Aim and Objectives

The main aim of the research was to investigate experiences of existing models of intervention for supporting those bereaved by suicide and provide guidance and recommendations to the NSPLG on developing a support service model. Specific research objectives were to:

- Undertake a review of evidence-based literature to investigate best practice in terms of support for those bereaved by suicide

- Investigate level of effectiveness of current models of intervention across groups affected

- Examine the level and type of support required by those bereaved by suicide

- Gather perceptions of the benefits and weaknesses of the various potential models of intervention amongst those bereaved by suicide

- Inform decisions around pilot activity / tests of change.

4.2 Research Methodology

The research methodology chosen was qualitative in nature and comprised face-to-face and telephone in-depth interviews with organisations that supported those bereaved by suicide, and those bereaved by suicide themselves. Qualitative tools are commonly used in the exploratory phase of a project to provide insight – and as a secondary objective – provide better guidance for any subsequent stage.

In-depth one-to-one interviews were also chosen here as they enabled respondents to share their sensitive and personal story without interruption from others (and in this case to be able to tell their own very specific 'story'). Furthermore, the variety of backgrounds and varying demographics of potential respondents could make rapport and group discussion disjointed. Conversely, with in-depth interviews the interviewer can acquire more qualitative data and explore more specific answers with the respondent. The interviewer can probe and more candid confidential information can be obtained in a private setting.

Most interviews were conducted face-to-face in the respondents' home although some were conducted by telephone where distance was a barrier, or because a telephone interview was preferred by the respondent. For support services, one-to-one depth interviews were a convenient method of participation. In many cases due to time-schedules and /or distance many of the in-depth interviews with organisations were conducted by telephone.

Details of the recruitment approach for each of these groups is outlined below.

Research Group	Recruitment Methodology	Number
Support Services for those Bereaved by Suicide	• Emails and telephone calls to services identified during mapping exercise • Mental Health Foundation contacts approached. • In most cases one representative from each organisation was interviewed although in one interview there was both a support worker and a manager present	6
Individuals Bereaved by Suicide	• Requested permission from support services interviewed to forward email to their service users who fulfilled our criteria. • All who wished to participate were sent an information sheet and consent form and followed up by Mental Health Foundation staff to arrange time and date for interview. • Individuals were interviewed on their own	16

After discussion with the Scottish Government, and guidance from the Ethics Board, it was agreed that we should interview those who had been bereaved between 1 – 5 years ago.

Over one year due to the rawness of their grief in the first year, and holding it at 5 years due to recall challenges and ensuring relevance to present day support services available. In addition, there was agreement that the research would focus on the experience of family and friends bereaved by suicide rather than wider groups affected or exposed to suicide.

Taking this into account the final sample profile was as follows:

• 9 Interviews with Parents

• 2 Interviews with Partners

• 2 interviews with Siblings

• 2 Interview with Friends

• 1 Interview with an Aunt

In total 16 interviews were conducted. The ages of the deceased ranged from 19 years to over 40 years old and we included respondents from the central belt, the Highlands and Orkney in the research.

Although it was envisaged that the depth interviews would be a standard 1 hour in length, many of the respondents needed time to talk through their journey and background reminisces about the deceased. Furthermore, in some cases, discussing a time in their life which was incredibly traumatic caused further distress during the interview and consequently many of the interviews were nearer 2 hours long.

It was also agreed with the Scottish Government that six depth interviews with support services would be included in the research. In approaching organisations, we were looking to ensure a broad spectrum of local and national services, organisations that offered group support and / or one-to-one, and – if possible – had specific bereaved by suicide support services.

Of course, we could only interview those organisations that wished to participate.

Organisations that participated included those with national and local focus and that provided different types of support including counselling and/or group support. Four of the organisations operate in Scotland and two in England. The latter were included due to a specific gap identified in Scotland.

4.3 Discussion Guides

A broad discussion guide for each research group was discussed and developed. The topic guide was structured to elicit open and honest responses, to understand the issues, and enable respondents to speak openly.

4.4 Qualitative Analysis

All interviews were audio-recorded with respondent permission, a signed consent form and a transcript written up by either the researchers or a professional transcription service. Thematic analysis was conducted and compared across all interviews in order to identify recurrent themes.

4.5 Ethics Approval

This research was granted ethical approval by the University of Strathclyde Ethics Committee and the University of Strathclyde is the sponsor of this research. An information sheet and consent form was sent to all respondents prior to the interview and signposting information was highlighted at the end of each interview as a safeguarding measure if the discussion had triggered any need for additional support.

4.6 Limitations of the Research

As with all qualitative work the emphasis of this study was to gain an in-depth understanding of support available and experiences of accessing that support from a small number of people bereaved by suicide. Although attempts have been made to engage a breadth of experience including those living in rural and urban areas of Scotland and different types of relationship with the person who completed suicide inevitably not all experiences will be captured in this report.

4.7 Note on Findings

This report is based on qualitative research. The nature of qualitative research means there can often be a wide range of differing views. Where a consensus was reached across many depth interviews this has been made clear – along with any caveats that should be considered. Similarly, it has been indicated where any other findings should be interpreted with contextual caveats in mind.

The remainder of this report looks at experiences of respondents after the death of a loved one to suicide; the barriers and facilitators to seeking support; an evaluation of the models used by some of the support services; and what the 'ideal' support would look like to those bereaved by suicide.

Key findings

5. Experiences of Initial Support

This section examines the nature of the support available to those bereaved by suicide in the first few days / weeks following their loss.

5.1 The Police

Following their bereavement, for all our respondents, their first contact was the police. Although most mentioned their kindness and empathy, it was felt that the police are limited in the support they can provide in such circumstances. For the majority the extent of their contact was that initial disclosure about the death of their loved one and then telephone conversations that focus on the process including autopsy, any formal investigation, and when to collect the deceased's clothes (usually at a much later date).

A minority of respondents were given some information, with one respondent passed a 'Help is at Hand' leaflet explaining how to arrange a funeral. In another case a family liaison officer was assigned but never contacted the family:

"...the wee police lady was quite sympathetic but that was about it. Then they left and took the body with them... and I was just left there thinking what I do now...?"
Female, Bereaved by Suicide (Partner)

"They gave me a liaison officer and his number and told me if I needed anything to phone him. But I never ever phoned him. I mean... what was I supposed to say..."
Female, Bereaved by Suicide (Son)

"...there was no real contact with the police [which] really upset me. There was somebody at the police that my friend phoned, and they gave him information... but there was no offer of, would you like someone to come out?"
Female, Bereaved by Suicide (Son)

"...you go to the police station... report at the desk and then you have to publicly say why you are there... then somebody comes in with his clothes... in a police evidence bag... harsh..."
Male, Bereaved by Suicide (Brother)

5.2 Funeral Directors

In a minority of cases the Funeral Directors were an initial contact that offered support. This tended to take the form of explaining several practicalities related to the death of the loved one by suicide – all of which were extremely useful at the time. In addition, one respondent was handed a leaflet for a local bereavement group (not a specific bereaved by suicide group).

As the Funeral Directors were one of the few organisations that the bereaved have contact with, many respondents considered them a natural source of practical information.

5.3 The Church

Where the respondent regularly attended church, their Minister and other church attendees became a source of both practical and emotional support in the early days of the death of their loved one.

Respondents felt they gained a great deal from their church's support and – in one case – believed that their faith was the only support they have needed since their loss. This however was only the case with two respondents:

"I've got strong Christian faith and the minister was very good at helping us...I'm actually happy with the fact that my faith has really taken me through this... I didn't need any other support..."
Male, Bereaved by Suicide (Son)

5.4 The General Practitioner

For most respondents in the research, one of the first people outside close family and friends who provided support in the immediate aftermath of a suicide was their General Practitioner (G.P.).

In most cases this support was limited however. For example to prescribing sleeping tablets or anti-depressants, with little or no follow-up care discussed or arranged, but in other cases – where the bereaved had more of a historic relationship with a specific G.P. in the practice – this support was on-going and included regular appointments / telephone check-ups, signposting to other services and arranging fast-tracked pathways to counselling:

"My G.P. was great. He came around with some leaflets around death and people I could call. He called me just before the funeral and asked if there was anything he could do and then got his receptionist to call and make an appointment with me about a month later just to check how I was doing"
Male, Bereaved by Suicide (Son)

"My mum knows her doctor really well and was able to have that conversation. She was provided with medication as well as another support touchpoint. Whereas for me... it was kind of like... where do you go?"
Male, Bereaved by Suicide (Brother)

5.5 Support Services for the Bereaved

No respondent in the research received any help from support services in the early days and weeks after their loss. Nor had the majority considered looking for such services in the immediate aftermath. Two respondents however did contact bereavement services within the first week to ten days of being bereaved due to their poor mental health.

One respondent felt – at this point in time – that she had no one to listen to her, felt suicidal and found the number of an organisation that provided bereavement support online:

"I phoned them up because I thought I was really losing it... it was horrible. But they said: "we can't talk to you until you're 6 months after the death" I was screaming down the phone... I need someone now!"
Female, Bereaved by Suicide (Partner)

After discovering there was no support services that could help her in the local area – she found a Facebook page for those bereaved by suicide she felt was useful and supportive in the first few months due to the lack of support elsewhere:

"I typed in... 'I'm scared... I've just done this with a knife, and I think I'm losing my mind. They came back with... because everybody was in the same position... with no... it's normal to feel like this..."
Female, Bereaved by Suicide (Partner)

5.6 Close Family and Friends

For all respondents in the research close family and friends tended to be the main support in those early days of bereavement. They were more likely to assist in managing several practicalities necessary after a death by suicide – even though in many cases they had no idea what to do either in the case of a suicide.

Most respondents felt that they 'muddled through' those early days and so in many cases they had no idea about several practical issues that had been dealt with by other members of the family at the time:

"To be honest those first few weeks are a total blank still... I don't know how I got through them... my sister dealt with so much of the stuff... calling people... sorting out the bank stuff... the funeral... I just couldn't make a decision... I was just so lost..."
Female, Bereaved by Suicide (Son)

6. Current Support Services in Scotland

A mapping exercise was conducted in May 2019 and was limited to an online search with supplementary telephone calls to uncover the types of support offered. The mapping therefore offers a snapshot of bereavement support services available in Scotland and insight into the different models of support that exist. This includes good practice models from within the UK where gaps were identified in Scotland. Based on the results obtained during the mapping exercise, the following conclusions can be drawn:

- Most bereavement support services in Scotland are designed to support wider bereavement. Whilst these services do support those who have been bereaved by suicide, the vast majority are not able to provide a support group or counselling service that it is specific to those who have lost someone to suicide.

- Some organisations adhere to a strict timeline for offering counselling support for those bereaved. This tended to be 6 months after the loss of a loved one.

- Of the services that have been put in place to specifically support those who have been bereaved by suicide:

  - All are third sector organisations/ services and in many cases local. The support provided across these organisations includes confidential helplines and email support (serving the whole of Scotland or the UK), with some local services offering weekly or monthly peer group support sessions.

- We found one organisation that offered individual counselling, psychotherapy sessions and holistic treatments specifically to those bereaved by suicide.

- There was a gap in provision around rapid early support in Scotland; this type of support was identified in England with an emphasis on practical support, advocacy and navigation of services in the early days following a bereavement by suicide.

- The majority offer support to adults over the age of 18 years old. Where help is available to children and young people, this tends to come in the form of national helplines and email support although we did uncover a local support service for children that included grief counselling.

- Where adult support services are concerned, limited peer support groups are available. However, these tend to be localised and do not offer coverage across Scotland.

- All services stated that duration of support was extremely variable across the individuals that they were supporting, with some seeking support as a one off and others engaging with support for several years.

- We found little local bereavement support services in rural areas – in particular the Highlands & Islands.

7. Models of Support

This section is largely based on the mapping and subsequent interviews with service managers and outlines key features of different models of support that have been identified. An overview of the different models of support identified is provided in the Appendix.

7.1 Summary of Defining Features

As part of the mapping and subsequent interviews with service managers a range of models of support were identified with several defining features. The first feature related to whether the support provided was **specific to bereavement from suicide or more general bereavement** where people with different experiences in terms of how a person has died come together. The second feature of support related to the type of support offered being either **group-based work or one-to-one work**.

Within one-to-one work this included counselling and rapid early support (not available in Scotland). The third defining feature of **support was the experience brought by support staff in terms of whether support was led by people with direct experience of bereavement from suicide or not**. This was irrespective of whether the service was delivered by paid staff or volunteers.

7.2 Suicide Specific or General Bereavement

The general bereavement services offered group-based work and one-to-one counselling with suicide specific bereavement support offering group based or rapid early support. Overall, the organisations we spoke to indicated that people need choice around whether they want to receive support from a suicide specific service or general bereavement service with ultimately the organisation supporting the model of delivery that their service offered.

Within general bereavement services the view was that although bereavement from suicide can raise specific issues it also has many commonalities with others forms of grief. However, those that worked in suicide specific services felt the grief experienced from a suicide was unique and required specific support. This aligned into views about stigma perhaps preventing people accessing group drop-in support if it was not suicide specific, and the needs of people in the immediate aftermath of a suicide requiring practical support and information to help them navigate processes such as inquiries, autopsy, among other things.

The increased risk of people bereaved by suicide going on to complete suicide was also raised as an important factor to why suicide specific bereavement support is required.

"Survivors of suicide, of any bereavement, have to deal with it themselves. There ain't any quick fix and there ain't any medication and there ain't any magic wand but if they can be given the reassurance that their response to this loss is normal – how do they know that unless they sit down with somebody or with a group of people who can give them the reassurance that that's the case. They need the normalising of their response including all the guilt and all the unfinished business and all the could I have done, should I have said, did I miss something and so on..."
Service Manager, Service A

"I've tried to talk to a number of people who've been bereaved by suicide to try and get an understanding of what it feels like in that first week, two weeks, month and the feedback I receive is it's kind of bewilderment"
Service Manager, Service C

7.3 Group Based and One-to-One Support

The group-based support services generally ran on a monthly drop-in basis and were available long term. A key feature of this was sharing experiences, developing coping mechanisms and building peer support between those attending. Less frequently, group-based work was provided over a time limited period, on a weekly basis with a focus on education, sharing experiences and building skills and coping mechanisms. All examples of group-based work had open access with no time restriction on when people could access it following their bereavement. In many instances organisations that primarily offered group-based support also offered informal individual support. This generally included meeting with people prior to attending a group or offering support over the phone or following meetings.

The one-to-one support models identified were bereavement counselling or rapid early support. All bereavement counselling support had open access in that people could self-refer either to a large national provider free of charge or to a wide range of private counsellors who charged (or people accessed via workplace insurance/employee assistance schemes). Access to counselling had more restrictions on when people could attend with the largest Scottish national provider seeing people a minimum of six months after the bereavement with no upper time limit. People requesting support prior to this were offered listening support or were referred into group-based support.

The number of counselling sessions provided were also capped at a maximum of fourteen (initially six, additional six as required, final two as required). Some respondents also discussed referring people into trauma counselling or general counselling due to emerging mental health problems. The needs of people accessing their own trauma counselling was felt to be very different from those who access bereavement counselling and support.

"The reason that it is only used for 6 months and over is because obviously counselling itself is only deemed to be helpful for bereavement counselling at that six months and over stage" Service Manager, Service F

Some organisations we spoke to felt strongly that counselling is rarely appropriate for bereavement of any type, and especially following a suicide:

"Mental health problems should be treated the same [as physical health], and counselling should be seen as the surgery option. You should try all of these other things before because recovering from counselling can be harder than the situation you were living in" Service Manager, Service E

There were no examples of rapid early support in Scotland with the two service managers interviewed operating in England. Both services had developed referral pathways from either the police or coroner's office. This involved an 'opt in' approach where families were asked if they would like their details passed over when there was a suspected suicide.

The services then make contact and offer practical support and advocacy to families and individuals bereaved by suicide. Although this was the main referral route into support, both services operated an open access policy in that people could self-refer. This meant that they also supported historic cases.

Within one service interviewed the focus was on providing support in the early days of grief generally up to the point of inquest (in England). However, there

was recognition that some flexibility was required due to the individual response to grief. Respondents within both services indicated that they also provided some form of longer-term support. The form of this support varied but included the provision of memorial services and in one service people being able to access group work and different forms of counselling.

When discussing some of the pros and cons of different forms of support peer support emerged as a key benefit from group-based work – whether suicide specific or within general bereavement support:

"The people who come along vary in age, the youngest we've had is 18, the oldest we've had is 85. They both happened to be in the same programme as it turned out. ... You would think that they wouldn't have anything in common but actually they got on like that, it was lovely, beautiful..." Service Manager, Service A

A specific concern raised – most often in the context of group-based support – was the danger of people becoming dependant on support or 'stuck' in their grief. It was felt that this doesn't always reflect length of time in engaging with support. For example, someone may have engaged with a monthly drop-in for many years but have 'moved on' significantly within that time.

On the other hand, people may have attended for months but appear stuck. In this context 'moving on' was perceived as emotional development rather than related to time:

"I don't decide when they're finished or when they're not. I've got ones that have been with me 6 or 7 years that are on the committee now, but I remember how far they've come. I find my AGM very, very, emotional. I look out and I see these folk laughing and carrying on and I saw them at their worst... but... I need to know that somebody's moving on; if they're not moving on then there's a problem. Now that problem might be me, so I need to look at that..."
Service Manager, Service B

Across all respondents from support service organisations they stressed the importance of their service being flexible. There was recognition that grief is very individual and due to this the support provided to each person needs to be individualised.

In practice this meant that people were able to access all forms of identified support services more than once. This included one-to-one counselling, within the rapid early support services, and group work. This was felt to be important because of the many triggers of grief including anniversaries and future bereavements.

7.4 Lived Experience of Bereavement from Suicide

Across the different models of support one important feature was whether the staff or volunteers came from the perspective of having their own experience of bereavement from suicide. Within organisations where all support staff brought this perspective this was

viewed as a central principle of their approach. They discussed the many benefits they felt this brought including shared understanding, increased empathy with those being supporting and a demonstration to others that they would get through the pain of their loss and the agony of often never finding answers.

There was also a recognition of the personal development and growth it brings to the person now providing support. Many of the respondents from support services had their own experience of bereavement from suicide with the lack of support available following their own loss being a key motivator for establishing their organisation. The main drawback of a peer support approach identified within organisations that utilise it was that it can restrict the number of volunteers or staff they hire:

"We have put into the constitution that everybody that works here, whether they be a volunteer or whether they be a member of staff they have to be touched by suicide; you can get penalised for it because you've got folk that would love to volunteer but they can't; It's because there's a big trust thing so you've got to build that trust and for me, if I'm sitting there and somebody's sitting and going, oh, so what do you think? and they don't give me anything back I would shut down to that. For me it's the positive that's come out of the negative. Even on my worst day I'll think, well, do you know, look what you've done."
Service Manager, Service B

"The lived experience is important for us. We've found it works... There's nothing normal about this grief, but to be able to have an understanding that you're not alone in those feelings."
Service Manager, Service D

Among the respondents where this was not a feature of their support, the hesitation of using peer support as a model often related to their views on the emotional burden of this work and the need for highly skilled staff or volunteers.

One interviewee felt strongly that a peer led approach was not helpful within the area of suicide bereavement because of this:

"One of my biggest concerns is that well-intended people will try and run these groups, or worse, my pet hate, experts by experience"
Service Manager, Service E

7.5 Skills of Staff and Volunteers

All organisations interviewed felt it requires a special person with specific skills to work with people bereaved by suicide. This was irrespective of whether support was provided via paid staff or volunteers or whether people brought lived experience to their role. Due to the emotional toll that supporting people can have, all services placed significant emphasis on the training available to staff or volunteers and had strong supervision systems in place. Often this consisted of monthly clinical and management supervision.

Some organisations also provided their staff or volunteers with additional self-care activities such as aromatherapy. In many of the services interviewed staff and/or volunteers brought with them a counselling background even if they were not in a counselling role. The skills developed for counselling were perceived as critical to this work, particularly listening, empathy and building trust.

"All our suicide liaison workers are ex-counsellors or counsellors predominately from bereavement counselling. So they'll have the empathy, understanding and skills to talk through with an individual who's going through bereavement. But it's not a counselling service. We have to be really clear, that's not what it is..."
Service Manager, Service C

Although support for staff or volunteers was widely recognised among respondents among those who brought lived experience of suicide to a service it was clearly evident that at times they went above and beyond what might be expected of any staff member. This was often due to them being well known locally as a source of support and lack of wider supports in local areas. In practice it meant them responding to people bereaved by suicide outside of usual working hours.

All respondents felt that the skills required to do work with people bereaved by suicide were enhanced through them being part of the third sector rather than statutory sector. This was because some of the people they work with have a deep mistrust of

statutory service, particularly where their loved one had completed suicide whilst in the care of mental health services or, in their view, had died as a result of not being able to access mental health support. This issue was also raised when discussing barriers to access.

Where staff or volunteers were delivering counselling, clear minimal standards were required as good practice and to ensure that, as organisations, they adhered to counselling codes of practice and ethics often as part of organisational membership.

"All the people who deliver the service are all volunteers. However, they're trained to quite a high standard. The baseline, if you like, would be that they have the COSCA four module in counselling and we top that up with a bereavement and loss module in-house"
Service Manager, Service F

Organisations interviewed had differing opinions around the merits of using volunteers or whether this work should be delivered through paid staff. Among those that felt the latter this tended to stem from the view that supporting people bereaved by suicide was too much to expect from volunteers.

This was raised in relation to group work where it was felt that the facilitators of groups required significant skills and experience to manage what could be difficult dynamics.

"You need to have the skills and the training and the experience to manage that. So you've got two people who are almost competing for pain level and competing for empathy within a group..."
Service Manager, Service E

This often related to respondents' views on whether a person leading a group or offering support should have lived experience of bereavement. Those that used a peer led model seemed more comfortable with support being volunteer led. However, volunteer led approaches were also used in practice within one-to-one counselling where lived experience was not a pre-requisite for support staff.

7.6 Network of Support

Organisations within the research stressed the importance of networking and building their own awareness of local supports so that they could inform and refer people onto different types of support available locally. There was general agreement that one service could not meet the needs of all people bereaved by suicide and should not necessarily try to be all things to all people.

Organisations within the research indicated that their model of support was only as good as the wider supports available locally. Some respondents provided insight into how they manage to keep their knowledge updated with two examples of local networks for bereavement services and one service feeling that this was helped by being a national provider with good public recognition and awareness among practitioners.

8. Accessing Support for their Grief

In this section we look at the respondent's experiences of seeking the types of support services discussed above to help them deal with their bereavement. What we found, was that in some cases a trigger could lead to a pro-active search for help but in others there was a more passive acknowledgement of help being necessary that led them to support services.

8.1 Proactive Search for Support

There were several reasons that respondents proactively made the decision to investigate what support was available to help them manage their grief:

- Suicidal thoughts

- Drinking too much

- A feeling that they were "*not getting better*"

- Difficulty functioning and performing daily tasks

- Perception that friends and family had grown tired of listening to them or they felt that they had "burdened" them long enough.

"...the one thing about a death by suicide is that your friends don't know how to deal with you...they don't want you to feel that they are being nosey or don't want to upset you..."
Female, Bereaved by Suicide (Son)

In most cases this was within the first six months of their loss and in all cases, respondents had initially turned to either their G.P. and / or the internet and this had led them to group support services or one-to-one counselling:

"The doctor fast-tracked me for counselling as I was suicidal. And it was the counsellor that said after a few weeks that I needed more counselling and I should speak to someone that deals with suicide bereavement"
Female, Bereaved by Suicide (Nephew)

"You're just aware that no one is asking how you are anymore... everyone goes back to normal... but you're not. I think they just got sick of listening to me... that's when I knew I needed more help..."
Female, Bereaved by Suicide (Partner)

8.2 Passive Acknowledgement of Support Necessary

For others however their journey to support services was a more passive move forward. Some saw an advert for a local bereavement group in their G.P. surgery or supermarket and thought it may help. In other cases, friends or family – already noticing their struggle – had found support for them.

"I was sitting in the surgery and I saw this advertisement for the bereaved by suicide group. I took down the number and tried to get myself round to phoning. It just kind of hit me and I said… 'I need to do something…'"
Female, Bereaved by Suicide (Son)

"It was my wife and daughter that found out about the group… they made me come… I didn't want to but I'm glad I did…"
Male, Bereaved by Suicide (Son)

8.3 Barriers to Seeking Support

During our discussions we identified amongst respondents several barriers to accessing support to help them with their grief:

Perceived Stigma
The perceived stigma that some associated with the death of a loved one by suicide resulted in a fear of opening up to support services. Although, in most cases this was a perception rather than reality, these feelings came from

the experiences of people avoiding them in the street, or when friends were unwilling to discuss the suicide with them anymore. These feelings of guilt and responsibility were especially true for those who were considering accessing a support group where they may have to speak about their grief in front of strangers:

"You're very conscious that you become the person walking down the street... there's the person who lost their son to suicide..."
Female, Bereaved by Suicide, (Son)

"...I felt that they'd automatically judge me and think there was something going wrong with the family... judge me as a mother... like there must be something I'm doing wrong..."
Female, Bereaved by Suicide (Daughter)

Geography / Logistics

For some respondents their physical location became a huge barrier to accessing bereavement support services. The lack of any local support in such instances resulted not only in physical isolation but also added to the emotional isolation many of those bereaved by suicide already felt:

"I had the support of my husband to drive me to down to Edinburgh [5-hour round trip]. If you were by yourself, you might not feel up to doing that. Going to a support group by yourself or having to drive there yourself... it's just too much on top of everything else..."
Female, Bereaved by Suicide (Son)

"There's nothing here so you have to rely on support by telephone or get to the mainland for support... which is why I ended up on the internet..."
Female, Bereaved by Suicide (Partner)

"I went on to the National Suicide Prevention Alliance site and it's got a map of your area with all the support services, so you type in your postcode and it comes up with the support services in your area... but the nearest to me was Glasgow or Edinburgh... over 2hrs drive away!... that was the most depressing thing I found... I just thought great that makes me feel even worse..."
Female, Bereaved by Suicide (Daughter)

Self-Reliance / Lack of Acknowledgement

Some respondents in the research just felt they did not need support at the time. This was especially true for the some of the males we interviewed. There was a perception that they "just needed to get on with it" or they were embarrassed by what they felt was a weakness if they were seen to not be coping – and thus were less likely to open up to close family, friends or seek professional support without the intervention of someone else:

"I had to stay strong for the rest o f the family... so I didn't have time to worry about how I was feeling... or where to go anyway..."
Male, Bereaved by Suicide (Son)

"I was a bit embarrassed to be honest... I didn't know what to say and who to say it to...I just knew I wasn't coping and hiding it from everyone..."
Male, Bereaved by Suicide (Son)

'Not My Grief'

For some in the research – mainly aunts / uncles / close friends of the bereaved – there was a feeling that they had no right to feel the grief as heavily as the parents, siblings or partners of the loved one and this led to a reluctance to seek support from bereavement services:

"I felt like it was my sister who needed all the support… I just felt… it wasn't my grief it was my sister's grief whereas I was just in the background but I was really depressed and emotional and things were getting on top of me…"
Female, Bereaved by Suicide (Nephew)

"the school said we could talk to a teacher… I just wanted to be on my own… the family were obviously going through much worse…"
Male, bereaved by Suicide (Friend)

Inability to Verbalise Feelings

For some respondents the main barrier to seeking some type of formal support was the difficulty they had expressing their feelings. This made it challenging for them to pluck up the courage to call services in the first instance and any barrier reduced their likelihood to call again:

"I called… but got an answering machine message. You've got to build yourself up to it you know?… so, you call again… but you get the answering machine again… it takes you another week to build up to it again… you try again… you get the same thing. I thought, no, it's just not happening…"
Male, Bereaved by Suicide (Brother)

As well as the barriers identified by respondents who had been bereaved by suicide the following additional barriers were identified by organisations involved in the research:

Existence of, Awareness of and Type of Service Support

Some service respondents indicated that awareness of support available to those bereaved by suicide was a barrier. Other organisations raised that it was less about awareness of services and more about the lack of services and supports available universally across Scotland. This related to the ad-hoc presence of services within local areas.

This was evident within the national bereavement counselling service that had differing waiting lists in geographic locations due to lack of volunteers and capacity within more populated areas of Scotland. Among local supports many have developed in response to suicide rates or the experience of suicide within a family leading to them establish support networks. This meant that the development of support for people across Scotland are inconsistent with no rapid early response at all.

One organisation reflected on the bureaucratic barriers that prevented co-ordinated support being established. Another respondent raising that a barrier for them was when people thought they were a statutory provider. This was also raised more generally by others in terms of the benefits that emerge reputationally from being a charity, with the challenges of this being accessing adequate funding to run the service and promote it.

"I've been trying for fifteen, sixteen years for pathways and nothing... it gets so far... [Choose life co-ordinator] got the police, social work, them all round the table. They got caught up first of all with who would take the original phone call and I thought okay I'll take the original phone call, I don't have a problem with doing that. Right, so that was that. Now they're caught up in what data do we keep...?"
Service Manager, Service B

"When we ask how they hear of us 75% of the time the response is my GP told us to phone... The downside of that is then people assume that we're attached to statutory services... that's a weekly challenge for us sometimes."
Service Manager, Service F

Stigma

As above support service organisations felt that stigma continued to exist around suicide and mental health more generally.

Examples were given of this manifesting in the lives of those bereaved by suicide through people not knowing what to say to them after suicide or perhaps some people being reluctant to attend group based support, especially where it was for general bereavement, for fear of being judged.

"One of the guys was saying I thought he was my best pal and he's not spoken to me for three years. It's not that he's being bad, he just doesn't know what to say..."
Service Manager, Service E

"Folk bereaved hold onto that more than folk that aren't... because it's theirs, it their guilt. It's their stigma... you will always get the folk that are folk that complete a suicide are junkies or alcoholics. You can't change these people but... more importantly is the internalised stigma..."
Service Manager, Service B

Although there was recognition that stigma exists and can be a barrier there were mixed views around the extent to which this prevented people from coming forward for support. Some support services reflected on the high numbers of people they have supported over the years perhaps being an indicator that stigma has lessened, and people are more likely to come forward for support. Whereas other support services felt that as a society we are less likely to discuss grief and death than any previous time and this can make people feel very isolated.

"I think there is less stigma now around a death by suicide. Unfortunately, we live in an area that has one of the highest [rates] in the country. So as a region I think that this changed over time. I think the way in which we overcome that is people are aware of what we do and why we do it and certainly within the area that we're working in the stigma is lessening, because it's so frequent..."
Service Manager, Service D

"We live in a society that in terms of bereavement is more closed down that it's ever been... people in bereavement feel more and more and more isolated in their loss as society

becomes less caring of individuals within it and survivors of suicide is one example of that..."
Service Manager, Service A

Emotional Barriers and Readiness To Engage

The final and most commonly identified barrier raised by organisations working with those bereaved by suicide was the emotional readiness of people to engage with support. This included scenarios where people are provided with information about services immediately following the suicide and are not able to consider what their own support needs might be at that time.

This led one service respondent based within a rapid early response service to suggest that an 'opt out' consent process may be better than an 'opt in' approach. This would mean that those bereaved by suicide would all be provided with information about services rather than asked if they want the information – and letting them make the decision themselves at such a time.

There was a view that it could take months and sometimes years for people bereaved by suicide to recognise that they need support to manage and deal with their grief. It was also raised that some people don't feel worthy of support, often due to the feelings of guilt they are dealing with.

"They don't really understand when the coroner's talking to them, not because they don't have the cognitive skills, it's just the kind of chaos that they're in at the initial

disclosure of a suicide of a close family member... when we do finally get in contact with them they'll say, oh, I don't remember saying yes to that..."
Service Manager

"single most biggest barrier is the feeling of non-self-care... it's almost like they're not worthy of having any care... I don't need support, I'm alright, when it's quite clear that they are not."
Service Manager, Service C

8.4 Facilitators to Seeking Support

The research identified a number of facilitators that assisted some respondents in reaching out to professional support services:

Awareness of Support Services

Respondents who were previously aware or had past experiences of support services were more likely to be more pro-active in seeking support. This was especially true of those who worked within the NHS:

"through my work I had heard of them... knew what they did... and when it got really bad I knew where I could go... I was lucky really... others may not be aware and you're not in the right frame of mind to go searching gall over the internet..."
Female, Bereaved by Suicide (Partner)

Encouragement from Others

Those who spoke to friends and / or family about how they were feeling were also more likely to seek support. Those closest to them may be more likely to observe their struggle and in some cases investigated possible support services for them.

Perception of Being a 'Burden'

For a few respondents the push to seek more professional support to deal with their grief came from their perception that they were becoming a burden to others. One respondent spoke of feelings of guilt that their family had to deal with all their support needs. Another respondent stated:

"I just didn't want to burden them anymore with the mess I'd become... I had to find another outlet for my grief..."
Female, Bereaved by Suicide (Son)

Facilitators identified by respondents were echoed by service manager with some additional factors highlighted. Key facilitators identified by service respondents included:

- Having clear referral pathways established with statutory services and first point of contact agencies – examples given included with police, coroner's office and local funeral directors

- Having a strong profile nationally or locally which supported referrals from statutory agencies, especially GPs, and word of mouth.

- Running groups in secular, community-based spaces which are easy to access in terms of transport

Case Study 1: Veronica

Veronica's son Alex was just 20 years old when he took his own life. Due to the shock, disbelief and overwhelming sadness she felt – and in the absence of being offered any formal support – she relied solely on her close family and friends to help her cope at the time. She said: "Obviously, I didn't know what to expect, nobody does. But there was nothing from my GP...nothing from the university...even his GP...no phone call or anything from them. No support at all."

Acknowledging that she needed help to deal with her grief, she contacted a national grief counselling service but was disappointed to learn that services were only available six months after a death. She managed to find a national suicide bereavement support service and made the four-hour round trip from her semi-rural location to the nearest group.

"You knew immediately you walked in that they had been through the same and that was very important for me... to sit and talk to other people who had been through the same.". Sadly, the distance meant she could not attend on a regular basis.

After six months she contacted the national bereavement organisation but didn't feel a connection with her counsellor. However, finally a work colleague put her in touch with a specific murder and suicide bereavement counselling service which she says helped her tremendously.

Today she no longer feels she needs support on a regular basis, but would really benefit from the opportunity to tap into a local support group – if one were available – at 'trigger' times such as birthdays and anniversaries of the death. In the absence of any such support nearby, she has set up a Facebook Messenger support group to allow those in similar circumstances to chat with others.

Although Veronica was able to eventually access some support that helped her, she says that it would be have been so beneficial to have had some signposting to where she could have accessed some support much earlier in the grief journey – "I spent a lot of time looking for something when some information at the beginning could have been so useful."

9. Experiences of Support

This section examines those bereaved by suicide experiences of different support services. It looks at three different types: One-to-one counselling services; group support services; and online support services. No respondent involved in the interviews had experience of rapid early response as this model of support is not available in Scotland.

9.1 Group Support Services for Those Bereaved by Suicide

From the discussions we had with those bereaved by suicide it was clear that those who had attended support groups had differing experiences. There could be several reasons for this. For example, such groups can vary in terms of the type of culture they develop with some very positive in outlook and attempting to move people through a continuum of support focussing on different ways to deal with grief. This could be through ensuring that the group had a clear structured programme for the bereaved to go through. Other groups lacked such structure and members of the group were supported in more informal ways over an unspecified period.

Consequently, we found that such group support services for those bereaved by suicide were an incredible help for some respondents but not others. Furthermore, some respondents were uncomfortable about attending a support group as they would not be at ease talking about either their bereavement or associated feelings, nor their loved one themselves in such a forum.

A number of respondents had attended at least one support group for those bereaved by suicide and those that had a positive support group experience felt that overall they had been instrumental in helping them heal and move forward. Their perceptions of the benefits of a support group for those bereaved by suicide were as follows:

Non-Judgemental: People spoke of the non-judgemental atmosphere of the support group where others listened to them and accepted what they had to say in an environment where they felt able to be open and honest without fear of being judged about the death of their loved one, as everyone was in a similar position:

> *"...everyone in the group has a similar tale with similar feelings of guilt and shame...so it's a safe space to open up without fear of judgement..."*
> Female, Bereaved by Suicide (Son)

Strongly Supportive Environment: Although respondents in all cases had family and friends that had been supportive throughout their grieving process many felt the supportive environment of the group – due to the

shared experiences of other members – provided another layer of support that reduced their feelings of isolation:

"...we've all been traumatised by a suicide so we're all members of a club nobody wants to be a member of..."
Male, Bereaved by Suicide (Son)

"...you know immediately you walk in there that they've been through the same and that was very important to me... to sit and talk to other people who had been through the same thing..."
Female, Bereaved by Suicide (Son)

Coping Strategy Development: Some respondents mentioned that other group members and the group facilitator had taught them how to deal with their grief in a more positive way by learning how to adapt to their new 'normal' with a variety of coping strategies. So, members learn from other experiences:

"...she's [the facilitator] has taught me to be more aware of my feelings some days...and how to deal with them... it's been invaluable this group..."
Female, Bereaved by Suicide (son)

Social Aspects: Many of the respondents who had joined a local support group for those bereaved by suicide commented widely on how membership had also brought new friends and more social activities.

This had the dual benefit of widening their social circle and giving them another distraction from their grief and increasing their wellbeing. This was true with both peer-led local groups and counsellor-led groups:

"...It's all the comradeship we all have with one another which is really good..."
Female, Bereaved by Suicide (Nephew)

"...having our nights out makes me feel less alone..."
Female, Bereaved by Suicide (Son)

"...it's just a voluntary group run by other mums...It's run on a weekly basis... they just meet for coffee one night every week...it's just the fact of sitting with other people who have been through the same as you helps...just chatting..."
Female, Bereaved by Suicide (Son)

Although many of those who had attended support groups were positive about their experiences, it was clear from our interviews that support groups for those bereaved by suicide were not for everyone. Some of the respondents felt that their encounters with grief support groups were not so constructive and shared some of their experiences during the research:

Dominant Characters: For two respondents their support group experience was rather daunting due to the group being monopolised by one or two people. In addition, it was felt that the facilitator of the group (in both cases a trained counsellor) did little or nothing to move the conversation on or reduce the negativity that the dominant characters brought to the group. Neither respondent returned to the support group.

Persistent Victimhood: One respondent felt that at the support group she attended the members perceived

themselves as victims and rather than discuss strategies to move forward everyone tended to wallow in their grief. Consequently, the group itself felt rather intense in atmosphere and negative in thought and she had the feeling that people were 'competing' to recount their bereavement in the saddest terms:

> *"...I felt worse coming out than when I did when I arrived... everyone was just so sad all the time"*
> Female, Bereaved by Suicide (Son)

Clique: Rather than be a distraction from their grief or offer them tangible ways of dealing with it, for another respondent who attended a support group the group she joined was long-standing with many friendships already cemented. This – they commented – made them feel even more isolated and uncomfortable and thus they discontinued attendance:

> *"...there were people that had been there for ages...I struggled with the fact that it was a clique... people knew each other too much. It wasn't that they didn't give me a welcome, but I felt very out of it ... yet there were people there that would walk in late... you know, they'd been there forever, everybody knew who they were...."*
> Female, Bereaved by Suicide (Daughter)

Issues Around Confidentiality: For one respondent, living in a small town there was also the worry around confidentiality, and she feared that some of things she wanted to speak about around the suicide may be passed on to others in her local community.

9.2 Counselling Services

Some of the respondents in the research had accessed one-to-one counselling to help them deal with their grief. In most cases this had been within the first year of their bereavement.

All had reached counselling services through different routes:

- Self-referred through employer private healthcare package

- Informed of organisation through friend

- Fast-tracked to NHS counselling due to severity of mental ill-health

- Support group facilitator recommended one-to-one counselling

- Pro-actively searched online for specific bereavement counselling

Only one of the respondents, however, had sessions with a professional 'bereaved by suicide' counsellor. The others only had access to a general counsellor or general bereavement counsellor and one respondent had one-to-one sessions for a period of time in conjunction with attending a support group.

For some respondents the counselling was a positive experience with a variety of benefits (for them) over group support services:

Moving Forward: For some the one-to-one counselling they received was instrumental in helping them move forward in a positive manner and assisting in accepting their loss:

"...it was challenging but good...it helped me process my emotions..."
Female, Bereaved by Suicide (Son)

Coping Strategies: For some respondents the counselling was invaluable for teaching them strategies for coping with their grief when it overwhelms them.

Processing Guilt and Anger: Many of our respondents spoke of their anger both at themselves for not noticing the pain their loved one was in and anger at the loved one for taking their own lives. It was felt that their sessions with a counsellor helped them manage and process that anger and guilt:

> *"I had bottled up so much guilt that I thought I would actually just start screaming at some point..."*
> Female, Bereaved by Suicide (Nephew)

Easier to Talk to a Stranger: Another benefit for the respondents was that they felt they could be more open and honest talking to a counsellor than they could be with their family and friends:

> *"There is just no way I could burden my friends and family with some of the awful thoughts I was having... they would've been so worried..."*
> Female, Bereaved by Suicide (Son)

More Time: By talking in a one-to-one environment those dealing with a bereavement could go at their own pace with more time to explore the various facets of their grief that was difficult to do within a support group environment.

Although for the majority of respondents one-to-one counselling helped them immensely it was not without it challenges:

Waiting Lists: For those that had been referred through the NHS there tended to be a long waiting list. This was a challenge when someone was emotionally distraught and needed help as soon as possible. In such cases other strategies needed to be employed in the short term. For one respondent this was an online forum for those bereaved by suicide.

Lack of Bereaved by Suicide Specific Counsellors: Respondents all felt they would have preferred talk to a counsellor who specialised in helping those bereaved by suicide. They felt they would have better understood the nature of their loss. However, this was not to denigrate the support that one-to-one counselling gave them.

Only one respondent – after attending sessions with a general bereavement counsellor – found a specific suicide bereavement specialist:

> *"...it helped me a great deal knowing that they were specifically for suicide [bereavement]...they've been trained to help with the bereavement process with suicide which is quite different to any other bereavement..."*
> Female, Bereaved by Suicide (Son)

Lack of Connection / Not for Everyone: For a couple of respondents the lack of a connection with their counsellor meant they felt that the counselling was unproductive:

"...we just didn't click really...they weren't specialised in my sort of grief... I felt that it wasn't doing me any good..."
Female, Bereaved by Suicide (Son)

"...I came away thinking wee bits of it were really useful but really...bits of it...what was that all about...?"
Male, Bereaved by Suicide (Brother)

9.3 Online Support for Those Bereaved by Suicide

The internet tended to be the first port of call for all respondents who proactively searched for support services. In some cases, this led them to a national support service which they could call for either telephone support or face-to-face support nearest to their home. For a few however the internet led them to other online support outlets. Three respondents uncovered online forums or Facebook support groups for those bereaved by suicide which they subsequently joined. All acknowledged there was a number of benefits of such support:

In-Home Support: For respondents the main benefit of being a member of an online support group was the easy access to support as everyone can receive support without leaving their home – which for some could be difficult – or they lived in a remote area:

"...there's nothing round here... I was really struggling... no one would see me for counselling for another 3 months and I thought... I'm not going to last 3 months... I need to talk to someone"
Female, Bereaved by Suicide (Partner)

Accessibility: Support was usually available 24 hours a day so there was always someone available to talk to online.

Anonymity: The ability to open up about their grief, express their truth in an environment where they are essentially anonymous made respondents feel more comfortable:

"...the best help I got was by finding a Facebook page... American page... I just typed in "I've just picked up a knife and I'm scared..." and they came back to me and said no its normal to feel like that...I wouldn't have said any of that to my friends or family"
Female, Bereaved by Suicide (Partner)

Reduces Feelings of Isolation: Connecting with others online reduced their feelings of being isolated – both physically and emotionally in some cases – and by helping support others distracted them from their own grief:

"...at the time I just felt alone... completely alone... and I couldn't even get out the house... the people on the group became my friends... we all understood what each other was going through so we could help each other..."
Female, Bereaved by Suicide (Partner)

Online forums and Facebook support groups also had some downsides however:

No Focus on Recovery: One respondent was conscious that such groups – although supportive – did nothing to help members move forward but rather the chat focussed on the ways in

which their grief was impacting on their everyday life with other members more likely to offer their own bereavement issues rather than focussing on strategies to help them to move on:

> *"...what I found was that there wasn't an emphasis on recovery, it was just wallowing in grief and I struggled with that...because you'd get people on there that were eight years down the line that were... like... I'm never going to recover from this, I'm struggling with this and I was thinking, I have to recover from this to survive..."*
> Female, Bereaved by Suicide (Daughter)

Misinformation / Bad Advice:
Following on from above, there was concern that where advice was offered in some cases this could be damaging to recovery. This was especially true if the site had no moderator and comments were not screened.

Fluid Nature of Membership: Due to the nature of informal online support groups, members may utilise the site at particular points on their grief journey and then drop out. This can cause upset where a respondent has felt they had made a connection with a member and then they disappear from the group:

> *"...it wasn't just that I missed her... you do worry... and of course being Facebook I didn't have her number... she just didn't come back on..."*
> Female, Bereaved by Suicide (Son)

9.4 Other Means of Managing Grief

For many respondents – with the lack of support services available to them – or because they felt they did not require such 'formal' support – they found other ways of dealing with their grief:

- Writing a blog
- Helping set up an informal support group
- Massage and mediation
- Driving to quiet areas
- Supporting other charities
- Visiting others bereaved by suicide
- Reading books and articles around suicide bereavement
- WhatsApp group support from friendship group of the bereaved

Case Study 2: Laura

Laura lost her nephew John 5 years ago. At just 20 year's old, he was her sister's only child and her whole family was in complete shock, consumed with grief and despair. Laura spent a lot of time helping support her family both in practical terms and emotionally.

In addition, she was dealing with several other personal issues across this first year of the bereavement and began to feel very low and emotional: "It felt like I'd fallen into a deep hole and would never get out"

Lack of knowledge about where to access help and support, as well as feelings of guilt for needing support, prevented her initially from reaching out to help her cope with her feelings. She said: "It was my sister's grief... I shouldn't be thinking about myself... I had to think about everyone else..."

When she did feel able to reach out to her local GP, they eventually arranged for counselling who felt she would benefit from specific suicide bereavement support.

This led her to further one-to-one specialist counselling sessions and eventually to Laura joining a local suicide bereavement support group, which has been a huge step forward for her.

Despite having to travel to the group, it's really helped her come to terms with her loss by offering her companionship and understanding from those experiencing similar loss and giving her permission to grieve.

The support group has also given her a sense of belonging which has made a big difference to her her mental wellbeing. She said: "It's all the comradeship we all have with one another...it makes you feel you're not alone."

Laura wishes she had known of the suicide bereavement support group much earlier to help her manage her feelings around John's death – "This place has been a lifeline to me... I wish I had known about it in the beginning."

10. The Ideal Support Service

10.1 Introduction

We asked respondents what would have been their ideal support service to help them considering their needs at that time. Their thoughts can be categorised as follows:

- Early advice and assistance
- A named contact
- Quick assessment of need
- Lived experience support availability
- Flexible ongoing support available as required

These are discussed below:

10.2 Early Advice and Assistance

Almost all our respondents in the research struggled in the early days to deal with the myriad of arrangements and details to be dealt with after a suicide. Although their family and friends were there to help them, in most cases, they also needed help and advice around registering the death, financial issues, how to cancel a mobile phone contract, how to deal with the deceased's social media accounts etc.:

"someone to say this is what's going to happen next"
Female, Bereaved by Suicide (Partner)

"even if they had handed me a booklet that would've done... we were just so lost, and everybody
was struggling with all the stuff that needed done... but we were all grieving too."s
Female, Bereaved by Suicide (Son)

10.3 A Named Contact

Only one respondent was given a family liaison officer after the death but nearly all respondents had wished they had someone they could call to ask several questions – especially in the first few weeks when it was clear all respondents felt extremely lost and needed help to deal with a number of issues – both practical and emotional:

"It's just someone to talk to really... even if it's just at the end of the phone to ask 'what happens now'..."
Female, Bereaved by Suicide (son)

"I would've just liked some more support when he died...because it was so sudden...I just needed someone that would help with everything... I really struggled..."
Female, Bereaved by Suicide (Partner)

"It would've been good if I'd somebody at the beginning... that could talk me through the practicalities...because your head is everywhere... it would've been great if I had somebody that had said...or the police had said...here's a leaflet...phone that number...and they'll help you now..."
Male, Bereaved by Suicide (Son)

10.4 Early Assessment of Need

As detailed earlier, for all our respondents friends and family were their main source of emotional support in the beginning and many highlighted the toil being such an emotional support can have on their loved ones. Many wished to have someone outside this 'bubble' to speak to.

For those respondents who felt in desperate need of professional help in the first few months they commented on the lack of services who would assess their state of mind at this point:

"I wasn't well...its clear now that I was in a dangerous state of mind... but there was nothing...no one... other than my family and I couldn't worry them anymore. I was online all night screaming for help in my head..."
Female, Bereaved by Suicide (Son)

"What I needed was the doctor to say...you need help to get through this...so instead of offering me pills he offered me someone to talk to. He's my doctor! He should've realised that I needed help..."
Female, Bereaved by Suicide (Son)

"The thing is...everyone is different... so they different support don't they at this time... but if you've lost someone to suicide no one is there to figure out what you need... you have to figure that stuff out for yourself... and how can we?"
Female, Bereaved by Suicide (Partner)

10.5 Lived Experience Support

For all our respondents one of their main requests was that support came from someone who had lived experience of losing someone to suicide. It was felt that because this type of bereavement resulted in so many unique issues and emotions than only someone with such experience could understand what they were going through at the time. All expressed a wish for someone for some support in this way:

"Somebody that's been there and done that... that's lost their mate... and knows how it actually feels? "
Female, Bereaved by Suicide (Friend)

"I just think... in those first few weeks and months...what I would've given to speak to someone who'd been through this... someone who could understand what I was going through and say... you need to do this or that... you'll feel this and that but that's ok..."
Female, Bereaved by Suicide (Son)

10.6 Flexible ongoing support

All respondents identified the individual nature of grief and how people processed their grief in different ways and at different times. For some this meant only being ready to access support months or years after the suicide whilst others needed support more immediately. The importance of having flexible ongoing support was recognised as important to account for ongoing support needs and people's 'readiness' to engage with support.

11. Discussion and Recommendations

Our research has clearly highlighted the lack of equity in access to support services for those bereaved by suicide in Scotland and it was evident that what is called for is a holistic, Scotland wide approach to supporting people bereaved by suicide.

Theoretically – for those that require it – access to one-to-one counselling should be available across the country However, the reality is that waiting times differ depending on where the bereaved person resides and in most cases counselling cannot be accessed until a set period has passed since the loss.

Support through a bereaved by suicide support group is even more inequitable and may require long drive times to attend – if one is available within an acceptable travel distance at all. Others may have a support group in their local area but there is still limited awareness of such services.

Although the focus of this report is about experiences of support, it should be acknowledged that a great deal of time was spent with those bereaved by suicide discussing the initial experiences of their loss and immediate aftermath. This described a period of intense pain, messiness, numbness, anger, guilt, devastation – essentially an incredibly complex and difficult time.

Although none of the respondents described this using the language of trauma, what they were describing was exactly that. This means that services need to be informed by the core principles that underpin a trauma-informed approach: namely individualised support provided through compassionate and empathetic people.

Recommendation 1

All newly developed support services must take into account the significant grief and trauma of those they are working with and tailor support to individual needs.

Recommendation 2

More equitable access to support for people bereaved by suicide across Scotland.

There were strong opinions held around requirements in the early days of a death, in terms of desiring someone to navigate them through that time. However within Scotland there is a complete gap in this type of support. However the rapid early response model of service that are available in parts in England would seem to be an appropriate starting point.

As many of those affected by suicide have a lack of trust in statutory services, we recommend this rapid response should come from trusted sources within the third / voluntary sector however it is recognised that strong referral pathways with statutory services are essential.

Recommendation 3

A rapid early response service to provide practical support and advocacy in the early days following a suicide.

It was clear from our research that very few of those bereaved by suicide proactively sought support until a crisis point, so any service designed must allow for periodic 'check-ins' with those who may need support but are reluctant to ask for help.

Respondents were clear that they wanted a service that was broad enough for those requiring support to refer themselves if necessary (e.g. at 'trigger' points such as birthdays or anniversaries).

Recommendation 4

Support group-based options that can provide longer-term and flexible support when needed.

Those bereaved by suicide mentioned during the research that one of the barriers to seeking support was their lack of awareness of services and the types available and were unsure where to find such information.

In addition, many had unhelpful experiences with some of the statutory services and so could be reluctant to return for support. This – in some cases – resulted in not asking for help at all.

Recommendation 5

Flexible access to support, with several referral pathways but also allowing for self-referral.

We acknowledge that general bereavement counselling is available in Scotland, and for those who accessed such counselling they found it beneficial. However, those bereaved by suicide felt strongly that such support should be from a specific suicide bereavement counsellor. In addition, some went further and desired support from those that had lived experience of losing someone to suicide. For respondents, this was the most important requirement of any support service offered.

Recommendation 6

Access to lived experience support and a named contact.

Given the sometimes negative experiences that many of those bereaved had with statutory services, there was a wariness of accessing support on a regular basis from such agencies and conversely many spoke in positive terms about their encounters with third sector and voluntary services.

Recommendation 7

Third / Voluntary sector management of any support model due to a lack of trust in statutory services.

Due to the emotional toll that supporting people can have it is also important that staff and volunteers themselves are supported with both regular supervisory meetings and self-care plans.

Recommendation 8

Clear guidelines around the skills of staff / lived experience and support for all those staff and volunteers working to support those bereaved by suicide.

It is important to note the limitations of the study itself where the focus was on individual adult support services it must be noted that community-level responses were mentioned by some respondents. Furthermore, the support needs of children and young people were highlighted by some respondents.

Recommendation 9

Further research is necessary to investigate the support needs required for children and young people; community level support including schools and specific groups particularly equality groups such as black and minority communities who we were not able to engage as part of this study.

Appendices

A. General Bereavement Support: Group Work	
Who	For adults (18+).
Access/referral	Open referral with specific referrals from Funeral Directors.
What	6 week course with group facilitators and input from range of experts covering sharing of loss, importance of nutrition and self-care in such times, finance etc. Builds peer connections among people who have experienced a bereavement.
Stage	Primarily aimed at people within first year of loss with some flexibility within this.
Onward referrals	To external counselling (often with cost), local suicide specific support groups (such as Survivors of Bereavement by Suicide – SoBS) – where available.
Facilitators	Staff facilitators with input from specific experts i.e. nutritionists, GPs.
Reach	Working within a local area in Scotland.

B. General Bereavement Counselling: One-to-One	
Who	For adults and children (12plus).
Access/referral	Self-referral with many people informed about service through GP. Initial inquiry can be made via phone, email or webchat.
What	Contact helpline (phone or email) who collect some basic details including type of bereavement, if young person living at home, area living in Scotland etc. This enables person to be allocated to nearest local office. Local office sends tailored information about other local services (relevant to type of bereavement) and overview of what this service provides. If people want direct support, they get back in touch with local service where volunteer then carries out an assessment (face to face or over phone). This identifies levels of risk and type of support which is likely to be best suited. Bereavement counselling offers initial 6 sessions with scope to offer another 6 sessions and then a final 2.
Stage	Bereavement counselling is offered to those only after 6 months of loss with no upper limit on time since bereavement. For those who have experienced bereavement within 6 months they receive a different assessment (early assessment) and can be offered early support sessions. This is essentially listening and holding.
Onward referrals	Range of referrals made depending on need. Includes suicide specific group work (SOBS) for longer term support where this exists locally; trauma counselling; social supports including befriending. In some areas of Scotland have additional services including drop-in group work, closed therapeutic groups, memorial events. Availability of this is restricted to two areas in Scotland.
Facilitators	Volunteer led. High standard of training provided depending on what role they have i.e. listening support, helpline or One-to-One counselling. Minimum is counselling and psychotherapy in Scotland (COSCA) 4 modules in counselling. All volunteers receive management and clinical supervision.
Reach	Provided across Scotland with varying levels of provision (depending on number of volunteers locally).
Waiting list	Differs depending on area and number of volunteers operating. Up to 1 month (approx.) in larger areas like Glasgow and 1 week (approx.) in less populated areas.

C. Suicide Specific Postvention Support Service	
Who	Families and individuals bereaved by suicide.
Access/referral	Open referral with specific pathway in cases of suspected suicide where police or coroner make a direct referral (with consent). Initial contact is then made with family within 24 hours.
What	This is a non-clinical service that provides early rapid response to families and individuals bereaved by suicide. They offer practical support and advocacy depending on needs of person/family. This can include understanding of coronial system, accessing financial support for funeral, welfare rights, inquest process, serious investigation process etc. In some areas also provide wider supports including memorial events (at Christmas, suicide prevention day), community response plans (mainly in schools) and real time surveillance where clusters are suspected.
Stage	Rapid response service that generally offers support (as minimum) up to inquest. Can provide some support beyond this mainly via advocacy to access other services.
Onward referrals	To SoBS and other suicide specific group work that offers longer term support. Also, a wide range of social support services including befriending etc. In some areas postvention service operates within a broader service where internal referrals can be made i.e. domestic abuse service, general counselling, youth counselling etc.
Facilitators	Paid staff with counselling background but not working as counsellors. Offered within a hub and spoke model with central phoneline who allocate cases to flexible home-based staff. Staff provided with all technical equipment such as phones, laptop, shredder and monthly clinical supervision and monthly management supervision.
Reach	Not operating in Scotland.
Waiting list	None.

D. Suicide Specific Postvention Support Service (Lived Experience Led)

Who	Families and individuals bereaved by suicide.
Access/referral	Open referral with specific pathway in cases of suspected suicide where police make a direct referral (with consent). Contact is then made with family within 48 hours.
What	Support provided by people with their own experience of loss due to suicide. This is a non-clinical service that provides practical support and advocacy depending on needs of person/family. This include understanding and navigation of coronial system, accessing financial support for funeral, welfare rights, inquest process, serious investigation process etc. Also provide emotional support via groups and specific memorial events (at Christmas, suicide prevention day, online) and can refer internally to specialist services such as trauma counselling, general counselling, aromatherapy, sleep specialists etc as needed.
Stage	Specific focus on early support but people can access service at any time. There are no parameters on this.
Onward referrals	Most often internal referrals but also can direct and support into longer term support as and when required such as befriending, etc.
Facilitators	Staff with own experience of loss due to suicide. All receive high standard of training including PABBS (Evidence-based Suicide Bereavement Training), suicide prevention, safeguarding, managing aggression, self-harm, youth mental health first aid, crisis, drug and alcohol. Staff receive monthly supervision from clinical supervisor and monthly aromatherapy.
Reach	Not operating in Scotland.
Waiting list	None.

E. Suicide Specific Postvention Support: Self-Help Groups

Who	Adults (16+).
Access/referral	Open access.
What	Monthly self-help groups facilitated by volunteers (or staff member) who have own experience of loss due to suicide. Can also provide some One-to-One support mainly via phone outside of groups.
Stage	No limitations as to when people can access support or duration of support.
Onward referrals	Yes.
Facilitators	Volunteer led with one paid staff member. Volunteers receive training and regular supervision and must have own experience of loss due to suicide (this is within constitution).
Reach	14 groups that run mainly in central Scotland.
Waiting List	None.

F: Suicide Specific Group Work Part of Broader Mental Health Support Service

Who	Adults bereaved by suicide.
Access/referral	Open access.
What	Monthly drop in support group facilitated by staff member.
Stage	No limitations as to when people can access support or duration of support.
Onward referrals	Can refer into broader support available within other parts of the service including counselling, mindfulness.
Facilitators	Staff member with no experience of bereavement due to suicide.
Reach	Locally operated.
Waiting list	None.

References

1. Scotland's Suicide Prevention Action Plan: Action 4: p12.

2. https://www.gov.scot/groups/national-suicide-prevention-leadership-group/

3. https://www.nrscotland.gov.uk/statistics-and-data/statistics/statistics-by-the/vital-events/deaths/suicides

4. Pitman, A. et al., 2014. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry 1(1), pp. 86-94.

5. McKinnon, J. M., and Chonody, J. 2014. Exploring the formal supports used by people bereaved through suicide: a qualitative study. Social Work in Mental Health, 12(3), pp. 231-248.

6. Platt, S. et al., 2006. Evaluation of the first phase of Choose Life: the national strategy and action plan to prevent suicide in Scotland. Edinburgh: Scottish Executive Social Research.

7. Visser, V. S. et al., 2014, Evaluation of the effectiveness of a community-based crisis intervention program for people bereaved by suicide. Journal of Community Psychology, 42(1), pp. 19-28.

8. Pfeffer, C. R., et al. 2002. Group intervention for children bereaved by the suicide of a relative. Journal of the American Academy of Child and Adolescent Psychiatry, 41(5), pp. 505-13.

9. Shneidman E. Postvention: The care of the bereaved. In: Pasnau RO, editor. Consultation-liaison psychiatry: Seminars in PSYCHIATRY. 1. New York, NY: Grune & Stratton; 1975. pp. 245–256.

10. Dyregrov, K., 2011. What Do We Know About Needs for Help After Suicide in Different Parts of the World? Crisis. 32(6), pp. 310-8.

11. Pitman, A. et al., 2018. Support Needs and Experiences of People Bereaved by Suicide: Qualitative Findings from a Cross-Sectional British Study of Bereaved Young Adults International Journal of Environmental Research and Public Health, 15 (4), e.666.

12. Scotland's Suicide Prevention Action Plan: Action 4: p12.

13. https://www.gov.scot/groups/national-suicide-prevention-leadership-group/

14. Shneidman, E. (1972). Foreword. In A. Cain (Ed.), Survivors of Suicide (pp. ix-xi). Springfield, IL: Charles C. Thomas.

15. Cerel, J., Brown, M. M., Maple, M., Singleton, M., van de Venne, J., Moore, M., & Flaherty, C. (2018). How Many People Are Exposed to Suicide? Not Six. Suicide and Life-Threatening Behavior, 1-6. doi:10.1111/sltb.12450.

16. Berman, A. L. (2011). Estimating the Population of Survivors of Suicide: Seeking an Evidence Base. Suicide and Life-Threatening Behavior, 41, 110-116.

17. Andriessen, K., Rahman, B., Draper, B., Dudley, M., & Mitchell, P. B. (2017). Prevalence of exposure to suicide: A meta-analysis of population-based studies. Journal of Psychiatric Research, 88, 113-120.

18. Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. Suicide and Life-Threatening Behaviour, 38(1), 13-29.

19. Erlangsen, A., & Pitman, A. (2017). Effects of Suicide Bereavement on Mental and Physical Health. In K. Andriessen, K. Krysinska, & O. T. Grad (Eds.), Postvention in Action: The International Handbook of Suicide Bereavement Support (pp.3-16). Boston, MA, US: Hogrefe Publishing.

20. Pitman, A., Osborn, D., King, M., & Erlangsen, A. (2014). Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry, 1, 86-94.

21. Joiner, T. (2005). Why people die by suicide. Cambridge, MA: Harvard University Press.

22. Klonsky, E. D., & May, A. M. (2015). The Three-Step Theory (3ST): A new theory of suicide rooted in the "ideation-to-action" framework. International Journal of Cognitive Therapy, 8, 114-129.

23. O'Connor, R. C. (2011). Towards an Integrated Motivational-Volitional Model of Suicidal Behaviour, In O'Connor, R. C., Platt, S., & Gordon, J. (Eds.), International Handbook of Suicide Prevention: Research, Policy and Practice (1st ed., pp. 181-198). UK: John Wiley & Sons, Ltd.

24. O'Connor, R. C., & Kirtley, O. J. (2018). The integrated motivational-volitional model of suicidal behaviour. Philosophical Transactions B, 373, 20170268.

25. Young, I. T., Iglewicz, A., Glorioso, D., Lanouette, N., Seay, K., Ilapakurti, M., & Zisook, S. (2012). Suicide bereavement and complicated grief. Dialogues in Clinical Neuroscience, 14, 177-186.

26. Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. Crisis, 25, 12-18.

27. Wilson, A., & Marshall, A. (2010). The Support Needs and Experiences of Suicidally Bereaved Family and Friends. Death Studies, 34, 625-640.

28. Andriessen, K. (2009). Can postvention be prevention? Crisis, 30(1), 43-47.

29. Mitchell, A. M., Kim, Y., Prigerson, H. G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. Crisis, 25, 12-18.

30. Andriessen, K., Krysinska, K., Hill, N. T. M., Reifels, L., Robinson, J., Reavley, N., & Pirkis, J. (2019). Effectiveness of interventions for people bereaved through suicide: a systematic review of controlled studies. BMC Psychiatry, 19:49.

31. Farberow, N. L. (1992). The Los Angeles Survivors-After-Suicide program: An evaluation. Crisis, 13, 23-34.

32. De Groot, M., de Keijser, J., Neeleman, J., Kerkhof, A., Nolen, W., & Burger, H. (2007). Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: cluster randomised controlled trial. BMJ, 334, 994.

33. De Groot, M., Neeleman, J., van der Meer, K., & Burger, H. (2010). The effectiveness of family-based cognitive-behavior grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. Suicide and Life-Threatening Behavior, 40, 425-437.

34. Zisook, S., Shear, M. K., Reynolds, C. F., Simon, N. M., Mauro, C., Skritskaya, N. A., ... & Qiu, X. (2018). Treatment of Complicated Grief in Survivors of Suicide Loss: A HEAL Report. Journal of Clinical Psychiatry, 79, 17m11592.

35. Constantino, R. E., & Bricker, P. L. (1996). Nursing Postvention for Spousal Survivors of Suicide. Issues in Mental Health Nursing, 17, 131-152.

36. Constantino, R. E., Sekula, L. K., & Rubinstein, E. N. (2001). Group Intervention for Widowed Survivors of Suicide. Suicide and Life-Threatening Behavior, 31, 428-441.

37. Kovac, S. H., & Range, L. M. (2000). Writing projects: lessening undergraduates' unique suicidal bereavement. Suicide and Life-Threatening Behavior, 30, 50-60.

38. Pfeffer, C. R., Jiang, H., Kakuma, T., Hwang, J., & Metsch, M. (2002). Group intervention for children bereaved by the suicide of a relative. Journal

of the American Academy of Child & Adolescent Psychiatry, 41, 505-513.

39. Sandor, M. K., Walker, L. O., & Sands, D. (1994). Competence-Building in Adolescents, Part II: Community Intervention for Survivors of Peer Suicide. Issues in Comprehensive Pediatric Nursing, 17, 197-209.

40. Battle, A. O. (1984). Group therapy for survivors of suicide. Crisis, (5), 45-58.

41. Ibid.

42. Ibid.

43. Hazell, P. & Lewin, T. (1993). An evaluation of postvention following adolescent suicide. Suicide and Life-Threatening Behavior, 23, 101-109.

44. Ibid.

45. Wittouck, C., Van Autreve, S., Portzky, G., & van Heeringen, K. (2014). A CBT-Based Psychoeducational Intervention for Suicide Survivors: A Cluster Randomized Controlled Study. Crisis, 35, 193-201.

46. Ibid.

47. Ibid.

48. Linde, K., Tremi, J., Steining, J., Nagi, M., & Kersting, A. (2017). Grief interventions for people bereaved by suicide: A systematic review. PLoS ONE, 12, e0179496.

49. Ibid.

50. Szumilas, M., & Kutcher, S. (2011). Post-suicide Intervention Programs: A Systematic Review. Canadian Journal of Public Health, 102, 18-29.

51. Callahan, J. (1996). Negative effects of a school suicide postvention program--a case example. Crisis, 17, 108-115.

52. Grossman, J., Hirsch, J., Goldenberg, D., Libby, S., Fendrich, M., Mackesy-Amiti, M. E., Mazur, C., & Chance, G. H. (1995). Strategies for school-based response to loss: proactive training and postvention consultation. Crisis, 16, 18-26.

53. Cerel, J., & Campbell, F. R. (2008). Suicide Survivors Seeking Mental Health Services: A Preliminary Examination of the Role of an Active Postvention Model. Suicide and Life-Threatening Behavior, 38, 30-34.

54. McDaid, C., Trowman, R., Golder, S., Hawton, K., & Sowden, A. (2008). Interventions for people bereaved through suicide: systematic review. The British Journal of Psychiatry, 193, 438-443.

55. Cerel, J., McIntosh, J. L., Neimeyer, R. A., Maple, M., & Marshall, D. (2014). The Continuum of "Survivorship": Definitional Issues in the Aftermath of Suicide. Suicide and Life Threatening Behavior, 44, 591-600.

56. To be as inclusive as possible, search terms included variations of the terms: (Bereave* OR grief OR griev* OR mourn*) AND (Suicid*) AND (Postvent* OR interven* OR prevent* OR treatment OR therap* OR counsel* OR support* OR service*). Searches on some websites were restricted by geographical location (UK and/or its constituent countries) or publication type (excluding peer-reviewed publications to avoid overlap with previously reviewed evidence)

57. Saini, P., Chantler, K., While, D., & Kapur, N. (2016). Do GPs want or need formal support following a patient suicide?: A mixed methods study. Family Practice, 33, 414-420.

58. Chapple, A., & Ziebland, S. (2011). How the Internet is changing the experience of bereavement by suicide: A qualitative study in the UK. Health, 15, 173-187.

Mental Health Foundation
Scotland

✉ **Mental Health Foundation Scotland**
30 George Square
Glasgow G2 1EG

📞 **0141 572 0125**

@ **scotlandoffice@mentalhealth.org.uk**

🐦 **@MHFScot**

🖱 **mentalhealth.org.uk**