Assessing the perceived effectiveness of suicide postvention in England, from the perspective of beneficiaries that utilise the service and key stakeholders.

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LIST OF ABBREVIATIONS

CEO	Chief Executive Officer
CGD	Complicated Grief Disorder
CORE-10	Clinical Outcomes in Routine Evaluation 10
GP	General Practitioner
ICD-10	International Classification of Diseases
NHS	National Health Service
PAG	Public Advisory Group
PTSD	Post-Traumatic Stress Disorder
NSPA	National Suicide Prevention Alliance
ONS	Office for National Statistics
SAIs	Sudden Adverse Incidents
SASP	Support After Suicide Partnership
SBSUK	Suicide Bereavement Support UK
SLOs	Suicide Liaison Officers
SPSS	Statistical Package for the Social Sciences
SOBS	Survivors of Bereavement by Suicide
SWEMWS	Short Warwick-Edinburgh Mental Wellbeing Scale
TOC	Theory of Change
WHO	World Health Organisation

ABSTRACT

Background:

Postvention services aim to support individuals bereaved by suicide, prevent further suicides and reduce adverse mental health in this at-risk population.

Aim:

The aim of this study was to evaluate the perceived effectiveness of postvention services in the UK and develop a model for anyone seeking to create a new postvention service.

Methods:

A mixed methods design was used to assess perceived effectiveness and develop recommendations. Fifty-eight interviews were conducted with nine services, including beneficiaries, commissioners, service Chief Executive Officers (CEOs), referrers, and Suicide Liaison Employees (SLOs). Interviews were analysed twice using thematic analysis, once to generate themes from each service and then again to create themes from each participant group. Two services' audit data on beneficiary demographics and evaluation outcome measures (CORE-10 and SWEMWBS) were analysed using paired samples t-tests.

Results:

This study found that well-being significantly improved between the initial assessment and recent assessment. Themes that emerged included: 1) “what do you need from us?”; 2) accessibility of postvention; 3) the ongoing debate surrounding data collection; 4) sustainability and longevity; 5) Shared learning of challenges and improvements for postvention services.

Conclusion:

Postvention services in England are having a positive impact on people bereaved by suicide and the wider community, by offering a tailor-made service that have adopted a public health approach to align postvention with suicide prevention programs. However, the longevity of these services was a concern due to funding and lack of evidence of their effectiveness. Evaluation would evidence their value and support the development of new services. Postvention services could be cost-effective in reducing the use of statutory services for people bereaved by suicide and reducing further suicides. A model for new services and further research is discussed.

DECLARATION

I declare that no portion of the work referred to in this thesis has been submitted in support of an application for another degree or qualification of this or any other university or other institute of learning.

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Chapter 1: Introduction

In this chapter, I will:

- Discuss the prevalence of suicide in the general population
- Outline the risk of suicide in individuals bereaved by suicide and the effects suicide has on those bereaved by suicide
- Outline suicide postvention, it's importance and suicide postvention services in the UK
- Outline the current policy on suicide and suicide bereavement in the UK

1.1 Introduction

Suicide bereavement, a phenomenon shrouded in the intricate interplay of grief, trauma, and societal stigma, has emerged as a poignant subject of academic inquiry within the broader field of bereavement studies. The aftermath of suicide presents unique challenges for individuals left grappling with the sudden loss of a loved one, as well as the communities and support networks surrounding them. This academic exploration sought to unravel the multifaceted dimensions of suicide bereavement, shedding light on the intricate processes of coping, mourning, and rebuilding that characterise this distinctive form of loss. It aimed to explore this process of coping, mourning and rebuilding, through the support known as 'postvention'.

The complexities inherent in suicide bereavement extend beyond the conventional parameters of grief studies. Unlike other forms of death, suicide introduces an additional layer of psychological turmoil for the bereaved, often intertwining grief with feelings of guilt, shame, and confusion. The stigmatisation associated with suicide compounds the already profound emotional distress, creating a distinct trajectory of bereavement that diverges from more conventional narratives.

Postvention, as a concept and practice, encompasses a range of strategies designed to mitigate the immediate and long-term effects of suicide on those bereaved. The term itself underscores the temporal aspect of intervention, emphasising actions taken in the aftermath of a suicide to promote healing, resilience, and prevention of further harm.

The academic study of postvention involved a multidisciplinary approach, drawing on psychology, social work and public health. Research within this domain spans a spectrum of topics, including the identification of risk factors for complicated grief, the development and evaluation of support programmes, and the examination of cultural variations in postvention practices. By delving into these diverse aspects, researchers aimed to contribute to a comprehensive understanding of the nuanced challenges posed by suicide bereavement and the varied responses that mitigate its impact.

This exploration examined the evolving landscape of postvention, scrutinising the intervention strategies. It aimed to do this through interviews with key stakeholders in postvention and beneficiaries who have direct experience of these services and the support they provide. Furthermore, the use of beneficiary demographic information and psychometric scales to measure well-being pre- and post- postvention support allowed for a deeper understanding of who these services support, gaps in service delivery and addressed the question of the perceived effectiveness of these services. From immediate crisis response to long-term therapeutic approaches, the academic discourse on postvention aimed to inform mental health professionals, policymakers, and communities about the multifaceted nature of suicide grief and the avenues available for constructive and empathetic support. As postvention is an unregulated sector, research is needed to provide an understanding of the landscape of postvention in the UK, how the support may contribute to a change in well-being and the short-term and long-term impact of this support. Ultimately, this academic inquiry aspired to deepen our comprehension of postvention's role in suicide bereavement and foster the development of evidence-based practices that promote healing and resilience in the aftermath of a suicide loss. This deeper knowledge played a vital role in ensuring postvention support is evidence-based and supported developing postvention programmes in establishing an effective service.

1.2 Background and Context

1.2.1 The prevalence of suicide worldwide

The World Health Organisation (WHO, 2021) reported that globally, 703,000 people die by suicide every year. Suicide is the fourth leading cause of death among 15 to 19-year-olds worldwide. WHO (2021) suggested that prior suicide attempts are the single most crucial risk factor for suicide. Furthermore, globally the most common methods of suicide include “ingestion of pesticide, hanging and firearms”. Soole, Kolves & De Leo (2015) published a systematic review on suicide in children aged under 14 years and found that suicide in children increases with age. Hanging by suicide was most frequent, however location correlated with methods as firearms suicides were more common in the United States and jumping from a height was more common in Hong Kong and Singapore. Suicides in female children were common at home, whereas suicide in male children were more frequent “elsewhere”. Like adults, previous suicide attempts were a crucial risk factor in children. Finally, parent-child conflict was the most common precipitant of a suicide death in children (Soole, Kolves & De Leo, 2015).

WHO (2021) suggested that suicide is preventable and identified four recommendations to prevent suicide. Firstly, access to methods of suicide should be limited such as pesticides, firearms and certain medications. Secondly, responsible reporting of suicide by liaising with all forms of media. Thirdly, supporting the development of “socio-emotional life skills” in adolescents who are increasingly at risk of suicide. Finally, early identification, assessment, management and follow-up for anyone who is affected by suicide is key (e.g., family members, friends, colleagues). WHO (2021) have suggested that collaboration between relevant authorities and organisations, which include health, education, labour, agriculture, business, justice, law, defence, politics and the media, is needed. Finally, efforts should include “situation analysis, multisectoral collaboration, awareness raising, capacity building, financing, surveillance and monitoring and evaluation” (WHO, 2021).

1.2.2 The prevalence of suicide in the UK

In England and Wales in 2021, there were 5,583 registered suicides, 10.7 deaths per 100,000 population (ONS, 2022). This was significantly higher than in 2020 where there were 5,224 suicides registered in the UK, a rate of 10.0 deaths per 1000,000 population (ONS, 2021). Whilst there was an increase in suicide deaths in 2021, it is believed that this was due to the result of a lower number of suicides registered in 2020 as the Covid-19 pandemic affected coroners' inquests. The 2021 rates were higher than in 2020, however they are consistent with the pre-Covid-19 rates in 2018 and 2019. The median registration delay for suicide deaths in England was 180 days in 2021 and 165 days in 2020. This was due to the disruption in inquests caused by the Covid-19 pandemic (ONS, 2021). Furthermore, the suicide rates highlighted do not account for suspected suicide deaths registered as misadventure, accident or open verdicts. Three-quarters of registered suicide deaths in 2021 were among men (n=4,129), 16.0 deaths per 100,000. Since 2010, males aged 46-64 years have the highest suicide rate. Males aged 10-24 years have the lowest rates since records began in 1981. Since 2010, men aged 45-64 have the highest age-specific suicide rates, 20.1 deaths per 100,000. Males aged 25 to 44 years had the highest suicide rates between 1995 and 2009, whereas males aged 75 years and above had the highest rates between 1981 and 1991. Male rates for all age groups were higher in 2021 than in 2020, except for those aged 75 years and over where the rate remained unchanged. However, none of these increases were statistically significant. See Figure 1 which shows the male suicide rates across multiple years.

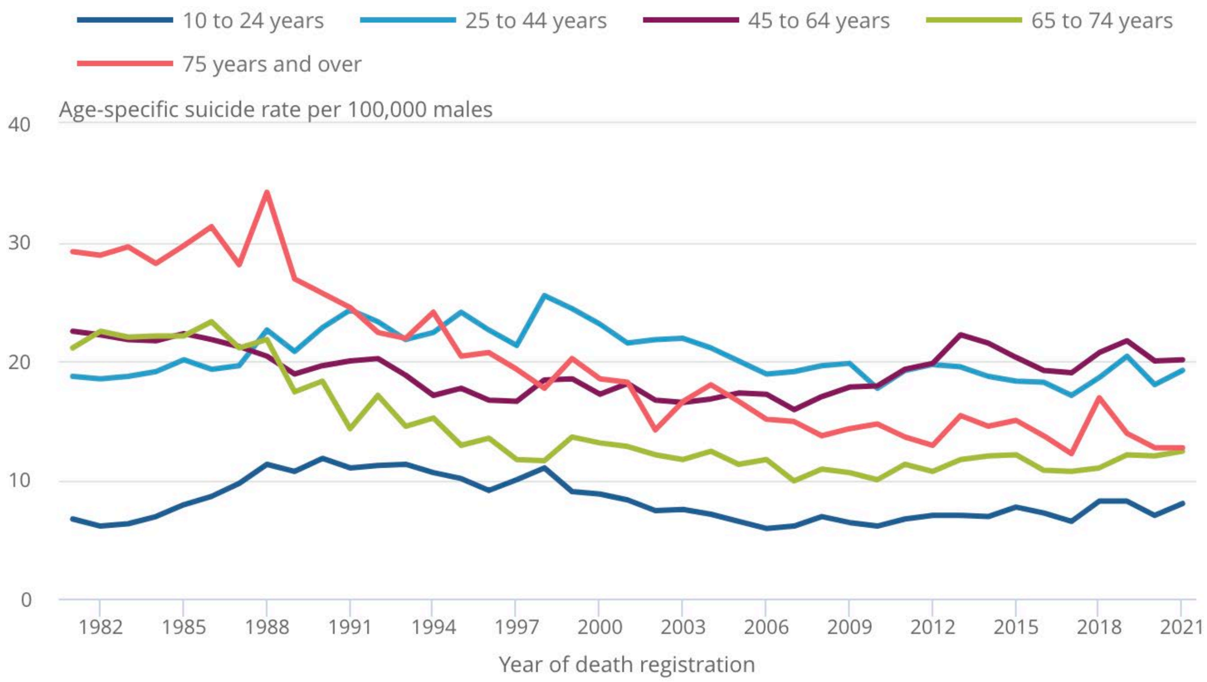


Figure 1: Age-specific rates for males in England and Wales, registered between 1981-2021 (Source: Office for National Statistics – Suicide in England and Wales).

To further illustrate Figure 2, which showed the female suicide rates, the female rates have risen, with 5.5 deaths per 100,000 population (ONS, 2022). Females aged 45- 49 years had the highest rate at 7.8 deaths per 100,000. Furthermore, females aged 24 years and under had the largest increase in suicide rate in 2021 since records began in 1981. There was also a significant increase in rates for females aged 10-24 and 25-44 years when compared between rates in 2015 and 2021.

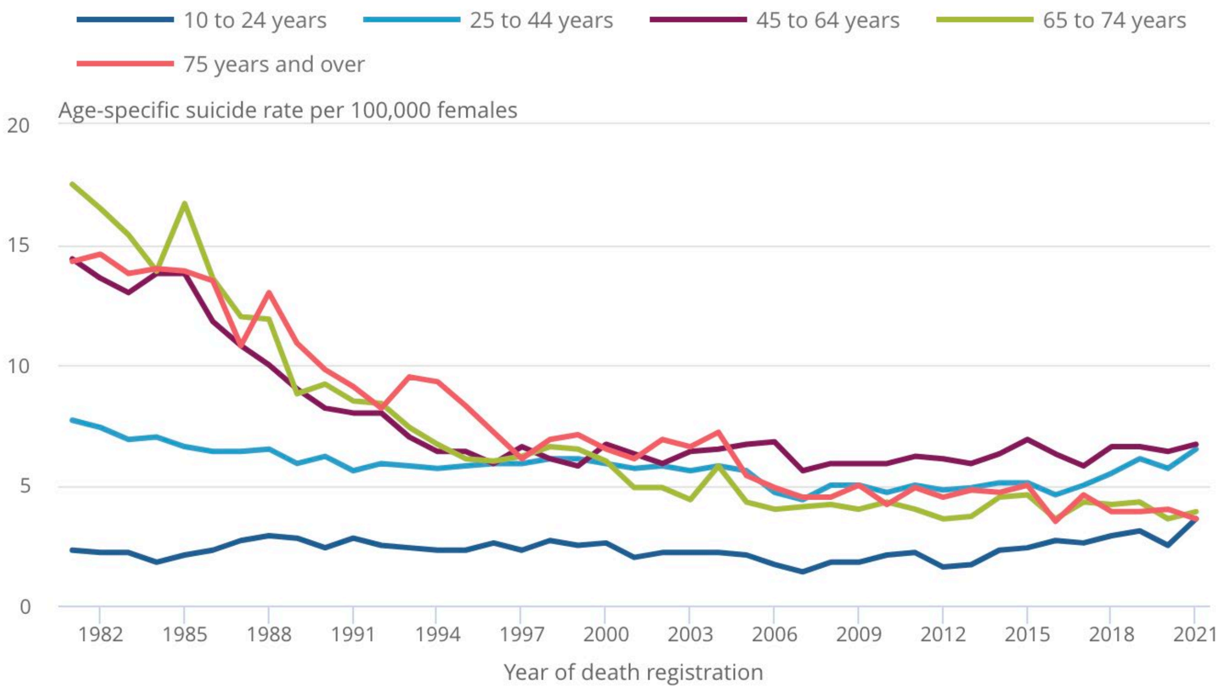


Figure 2: Age-specific suicide rates in females in England and Wales, registered between 1981 and 2021 (Source: Office for National Statistics – Suicides in England and Wales).

The age-standardised suicide rates for England and Wales by region in 2021 (see below) suggests that the Northeast, Northwest, Southwest and Wales have the highest suicide rates. Therefore, it's imperative that these local authorities have adequate prevention and postvention strategies. Furthermore, these rates have not improved from previous years, as the Northeast continued to have the highest suicide rates in England and Wales. This suggests a need for public health initiatives to target this population.

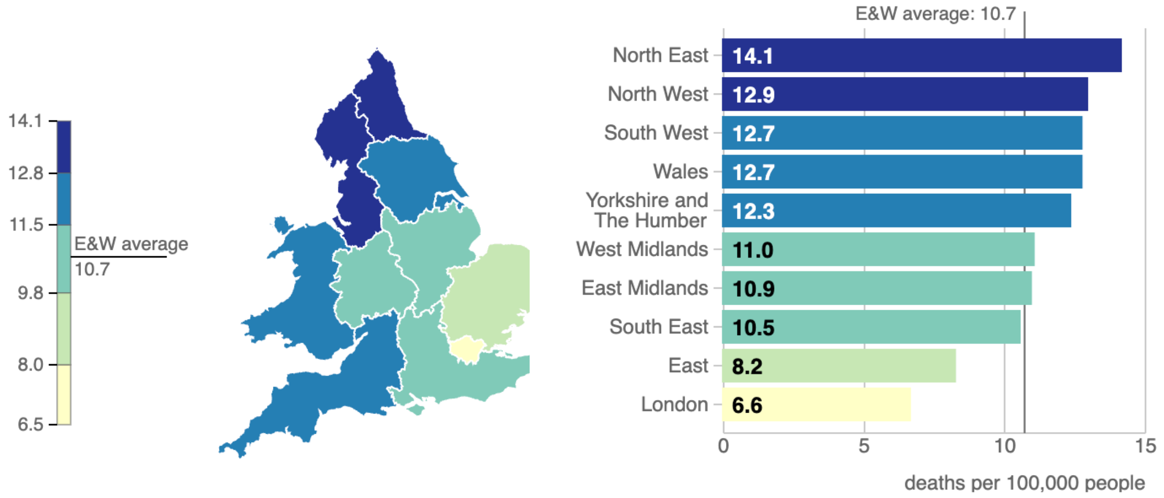


Figure 3: Northeast continues to have the highest suicide rates (Source: Office for National Statistics – Suicide in England and Wales).

The Office for National Statistics also reported on suicide by location. Whilst in 10 out of 11 previous years, London had the lowest suicide rate of any region in England (6.6 deaths per 100,000) when compared with England overall. The Northeast had the highest rate in England (14.1 deaths per 100,000) in 2021 which has been the case for 6 out of the 10 previous years. The Northeast is joined by the Northwest, Yorkshire and Humber and the Southwest regions as having statistically significantly higher rates when compared with England overall. The Northwest increased significantly in 2021 when compared to 2020 (ONS, 2022).

Whilst the ONS (2022) does not report statistics on suicide rates for other genders and sexualities, such as lesbian, gay, bisexual and transgender individuals (LGBT+), a meta-analysis of LGBT adolescents and young adults aged 12-25 years found clear links between minority stressors, suicidal ideation and suicide attempts (de Lange et al., 2022). These minority stressors suggest that victimisation, family rejection, internalised homophobia are additive to general stressors that may increase the risk for suicidal behaviours (de Lange et al., 2022). A Trevor Project study found that transgender and nonbinary youth were 2 to 2.5 times more likely to experience depressive symptoms, suicidal ideation and suicide attempts as compared to their cisgender and lesbian, gay, bisexual and queer peers (Price-

Feeney et al., 2020). Further research suggested that LGBTQ youth are four times more likely to attempt suicide than their peers (Johns et al., 2019; Johns et al., 2020). Additionally, a survey found that 45% of LGBTQ youth surveyed seriously considered attempting suicide in the past year, including more than half of the transgender and nonbinary youth (The Trevor Project, 2022). Additional stressors faced by the LGBTQ+ community are contributing to increased risk of suicide in this population. This increased risk highlighted the urgent need for societal change, identifying risk factors to reduce suicide rates and target prevention and postvention efforts. It is also amiss that the Office for National Statistics does not collect suicide data on the LGBTQ+ population as this would enable us to ascertain the true scale of the problem of suicide in the UK.

The Office for National Statistics does not include suicide deaths for persons aged below 10 years. However, a cohort study of n=10,103, a nationally representative sample of 17-year-olds in the UK conducted by Patalay & Fitzsimmons (2020) found that 10% of females and 4% of males had attempted suicide by the age of 17. Furthermore, 7% reported that they had attempted to end their lives and 24% reported that they self-harmed within the previous year (Patalay & Fitzsimmons, 2020).

In England and Wales, the most common method of suicide continued to be hanging, strangulation and suffocation, in both males and females (58.4%). The second most common method had also remained consistent as poisoning (20.5%). Hanging had been increasing since 2001, whereas poisoning had seen a slight decrease. Drowning, fall and fracture, jumping or laying in front of a moving object, and sharp object had remained consistent (ONS, 2022). A study assessing the methods used by the elderly in England and Wales found significant differences in gender and age. Hanging, strangulation and suffocation was found in 40.2% of males and 20.1% of females. Drowning and submersion was evident in 8.2% of males and 11.4% of females. The use of medication, drugs and the ingestion of biological substances was found in 8% of males and 20.4% of females. These figures present a stark difference in the methods used by men and women, as women are more likely to ingest substances compared to men (Shah & Buckley, 2011). Method availability and “method substitution” may enable a tailored response in reducing the use of means of suicide. Gunnell et al., (2015) found that suicides by gassing have reduced since 1950. However, suicide rates were partially offset by the increase in drug and medication overdoses. They term this as “method substitution”, as access to a certain method of suicide decreases, as another method takes its place. It was suggested by Berling et al., (2016) and Sarchiapone et al., (2011) that this may be due to the rise in prescriptions to barbiturates and tricyclic antidepressants. However, there was then a limit to medication packet size and the introduction of selective serotonin reuptake inhibitors (SSRIs) which were thought to be an effective method in treating depressive symptoms (Berling et al., 2016; Sarchiapone et al., 2011). Therefore, it is important to review and research method availability and access to prevent suicide.

1.2.3 Data Collection, Quality & the Registration of death

The World Health Organisation (WHO, 2021) reported that the quality and the availability of data on suicide was poor. They reported that only 80 out of 194 (41%) member states have acceptable quality data that could be used to estimate suicide rates. It may be that this under-reporting was due to the illegality of suicide in some countries. The WHO suggested that improving monitoring of suicide and suicidal behaviour is a prerequisite for effective prevention and postvention. They recommend that improvements in suicide registration, hospital-based reporting on suicide attempts and national surveys would impact prevention efforts. The absence of reliable and accurate suicide statistics presented a problem when attempting to assess targets such as the World Health Organisations’ Mental Health Action Plan target of reducing suicides. It also affected the ability to compare suicide rates and trends between years.

Furthermore, WHO (2019) found that suicide was the most commonly misclassified cause of death according to the codes of the International Classification of Diseases and Related Conditions (ICD-10). They are often misclassified as “deaths of undetermined intent”, “accidents”, “homicides” and “unknown causes”. One study on the military population found that under-reporting and misclassification errors accounted for 21% more suicides in the military (Carr et al., 2004). Another study found under-reporting of potential suicides that had been reported as “overdoses ruled indeterminate”. Overdose deaths may have been misclassified due to the reporting of suicidal thoughts, rather than suicidal intent (Bohnert et al., 2013). This then therefore affected the understanding of the true problem of suicide. Other research has suggested that cultural and religious attitudes may affect accurate reporting of suicide. Bertolote and Fleischmann (2002) suggested that suicide may be hidden and underreported for several reasons, such as prevailing social or religious attitudes. They reported that in some countries, suicide is underreported between 20% and 100%. Therefore, it may be that the worldwide suicide statistics were not a true reflection of suicide globally. Whilst it may be difficult to ascertain the true number of suicides across the world, under-reporting and misclassification may have also impacted the support received by individuals bereaved by suicide.

In the UK, the statutory process for reporting deaths in England is through the civil registration route. 23% of deaths are registered within two days and 77% within seven days of the death. Legally, there is an allowance of five days to register a death (NHS, n.d). However, there are some circumstances where a death must be reported to a coroner, and suspected suicide deaths are one of those circumstances. A coroner is an independent judicial officer. The coroner’s officers investigate a suspected suicide, gather evidence and arrange an inquest. To determine a suicide conclusion, there are two aspects, firstly the act taken by the deceased and secondly, their intention. As Lang (2013) put it succinctly, “in order to return a verdict of suicide, the coroner or jury must be sure (i) that the deceased intended his own death; and (ii) that he did an act with that intention which caused his death” (Lagos v R, 2013). In 2018, there was a significant change in how England determines whether a death was caused by suicide. Previously, coroners used a criminal standard of “beyond all reasonable doubt” that the deceased had acted with intent to die by suicide. After a Supreme Court ruling in the UK, this standard of proof was changed to a civil standard of “on the balance of probabilities” (ONS, 2020). This essentially lowered the standard of proof, as less evidence is required to meet this threshold. A Freedom of Information request (FOI,

2021) found that the amount of time it takes to hold an inquest causes a delay between the date of death and the date of death registration, which is known as the registration delay. Registration delays for suicides are estimated to be an average of five to six months. A death certificate is not issued for a suspected suicide until the inquest has been completed and a ruling on the cause of death has occurred (FOI, 2021). The Office for National Statistics (ONS) releases provisional suicide data for England on a quarterly basis. The FOI request states that “deaths that were registered from January to September 2020, this is for the deaths registered in 2020 and due to the registration delay... most of these deaths would have occurred in 2019”. Finalised suicide data from England and Wales in 2020 was published in September 2021 (FOI, 2021). These examples highlighted the delay in suicide data in the UK. This impacted the ability of researchers and professionals to understand the true prevalence of suicide and how suicide could be prevented. On review of this information, England and Wales saw an increase in suicide in 2021, however this is likely to be due to the delays in suicide registrations and inquests due to the Covid-19 pandemic. The pandemic had a significant impact on inquests during 2020 and 2021 (Blake, 2020). The ONS (2021) estimated that half of all suicide deaths registered each year will have occurred in the previous year. However, this delay increased due to Covid-19. Therefore, it may be difficult to truly ascertain how many suicides occurred in 2020 and 2021.

At present time, the coroner delay remains and is unlikely to change. To further our understanding of suicide prevalence, one potential avenue to be explored is known as Real Time Surveillance (or Real Time Data, RTD). On their Central Hub website, the Support after Suicide Partnership (SASP) characterised RTD as “either the collection of anonymous data from those who have died by suicide across a locality, and real time referral – the collection of (usually) a single person or family’s data for referral into a suicide liaison service, with the consent of the family. Both forms of RTD are vital to effective proactive suicide bereavement services” (SASP, n.d). SASP suggest that a system for RTD must include: i) identifying who is close to the person who has died by suicide; ii) identifying the level of risk to the bereaved; iii) sharing data consensually with other relevant agencies; and, iv) multiple agencies working collaboratively. They recommended that these agencies should include police and first responders, coroners, suicide liaison services, IAPT services, general practitioners, local hospitals, schools and education centres. The latter is particularly important to identify the potential for clusters and supporting young people affected by a suicide. The organisation responsible for RTD should be the organisation that is at the beginning of the bereavement pathway, which is usually the police or the coroners. Due to the sensitivity of this data, the responsible organisation must have a robust and secure system for storing and sharing confidential information. The use of real time data may enable researchers and professionals working in suicide postvention and prevention to firstly identify emerging trends as soon as possible and secondly, target interventions to particular methods of suicide, locations and current at-risk populations such as females aged 10-24 and 25-44 years.

1.2.4 Suicide bereavement

Approximately 135 people are directly affected by one suicide (Cerel et al., 2018). It is thought that exposure to suicide is on a continuum with some people exposed, some affected, and some bereaved, defining individuals exposed to suicide as “anyone who knows or identifies with someone who dies by suicide,” and stresses that the focus should no longer merely be on next of kin or those who were exposed to the trauma of the death itself (Cerel et al., 2014, p. 4). Thus, in England and Wales, 753,705 people may have been affected by suicide in 2021.

Pitman, Osborn, Rantell and King (2016) reported that people bereaved by suicide were 65% more likely to attempt suicide than people who were bereaved by natural causes, increasing the absolute risk to 1 in 10. Furthermore, regardless of whether the participants were blood-related to the deceased or not, the effects of suicide bereavement were similar. These findings suggest that bereavement by suicide is a risk factor for a suicide attempt and its effects are not confined to immediate family members and thus, suicide bereavement affects wider support networks.

Research has identified the need for support immediately after suicide bereavement as a lack of support can cause heightened grief experiences and mental health issues in those bereaved by suicide (Pitman et al., 2017; Maple et al., 2014; Houck, 2007). Bereavement by suicide increases the possibility of experiencing persistent negative grief effects, depression, and post-traumatic stress disorder (PTSD) (Kaltman & Bonanno, 2003; Murphy et al., 2003). Moreover, seeing the deceased's body is a significant predictor of distress and PTSD post-suicide (Callahan, 2000). An online survey (n=346) collecting data in the UK to assess the use of drugs and alcohol after a suicide bereavement found that increased use of alcohol and/or drugs after a suicide bereavement is a coping strategy (Eng et al., 2019). A systematic review of 11 qualitative and quantitative studies found that those bereaved by suicide reported feeling "shamed, blamed and judged", perceiving discomfort and "awkwardness" which contributed to their avoidance and secrecy surrounding the suicide. Furthermore, higher levels of perceived stigma were associated with symptoms of depression, psychological distress, acts of self-harm and suicidality. This study calls for evidence-based recommendations on support for this population (Evans & Abrahamson, 2020).

A large-scale national survey on suicide bereavement in the UK, conducted by McDonnell et al., (2022) found that out of 7,158 participants bereaved or affected by suicide, the suicide had a major impact on 77% of participants. Physical and mental health problems were reported in half of those surveyed. Over a third reported suicidal ideation and 8% had attempted suicide. Respondents also reported adverse social outcomes and engaging in high-risk behaviours. These outcomes were all believed to be linked to their suicide bereavement (McDonnell et al., 2022). Furthermore, this survey found that 67% of respondents were bereaved or affected by one suicide and 33% of participants had been bereaved or affected by more than one suicide. This ranged between one and 70 deaths and professionals experienced a greater number of suicide deaths. The most frequent relationship to the deceased was friend, and the second most common was parent. Two hundred and six bereaved individuals (4%) reported the death as being someone known to them through their occupation. Adverse health related and social consequences of suicide bereavement were most frequent in parents of the deceased, with the second most frequent being friend of the deceased (McDonnell et al., 2022).

Researchers and professionals working in the field of suicide have long proposed that suicide bereavement is different to other kinds of bereavement. Research has suggested that suicide bereavement increases the likelihood of developing Complicated Grief Disorder (CGD) (Jordan, 2008; Shear et al., 2011).
CGD is defined as a prolonged grief experience of a year after the loss, intrusive thoughts, heightened emotions, sleep disturbance, loss of interest in personal activities, distressing yearnings, feeling excessively alone and empty and excessively avoiding any activity reminiscent of the loss or deceased person (Horowitz et al., 2003). People experiencing CGD post-suicide loss had the highest rates of lifetime depression, passive suicidal ideation, self-blaming thoughts and impaired work and social adjustment compared to those who had lost someone through homicide, accident and natural causes (Tal et al., 2016). Violent deaths such as suicide increased the likelihood of experiencing long lasting and pervasive negative grief effects, PTSD and depression (Kaltman & Bonanno, 2003; Wu, Fan & Lohan, 2003).

Jordan (2001) suggested that suicide bereavement is distinct to other kinds of bereavement in three ways. Firstly, the thematic content of the grief may be different as family members attempt to make sense of the loss, search for meaning and question the reasons behind their loved one’s decision to take their own life. Furthermore, the study identified “high levels of guilt, blame and responsibility for the death” and intense feelings of abandonment, anger and rejection. Secondly the social processes surrounding the bereavement as negative feelings surrounding suicide “spills over” onto the family. Finally, the impact suicide had on the family systems was different from other kinds of bereavement as roles and identities changed, parents who had two children may now have one. Rynearson (2001) suggested that suicide bereavement sets itself apart from other types of bereavement as the nature of suicide is violent, self-injurious and willful on the part of the deceased person. It also challenged family and community morals and ethical attitudes which added to the complexity of suicide bereavement. It may be that it was the processes associated with suicide bereavements that contributed to the grief experience. Harwood et al., (2002) suggested that it is the need for an inquest and other factors associated with suicide which sets suicide bereavement apart. Those bereaved by suicide reported feeling distressed with the legal procedures, namely the coroner’s office and the inquest. Furthermore, the media reporting of the inquest added to this distress. Depression scores were similar in those bereaved by suicide and those bereaved through natural causes. However, those bereaved by suicide had higher scores of stigmatisation, shame, sense of rejection and unique grief reactions compared to bereavement through natural causes. This suggested that depression and low mood were common in all types of bereavement, however the additional mental distress due to a suicide caused a unique grief experience.

Bailley, Kral & Dunham (1999) found that those bereaved by suicide experienced more feelings of rejection, shame, stigma and responsibility for the death, with a higher level of grief reactions and more unique reactions to their grief than in accidental deaths, anticipated and unanticipated sudden deaths. “Naturalness” and “unexpectedness” of the deaths were less influential than the actual mode of death in the grief experience (Bailley, Kral & Dunham, 1999). Further research compared suicide bereavement to deaths by natural causes. Houck (2007) compared the grief experiences of people bereaved by cancer, HIV/AIDs and suicide, results showed that suicide showed the highest levels of stigma, loss of support, searching for an explanation and self-destructive behaviour. Suicide bereavement also had the highest levels for sense of guilt, responsibility, shame and rejection, as well as having more severe general grief reactions and unique reactions to suicide compared to HIV/AIDs and cancer bereavement. Finally, individuals bereaved by suicide were also most likely to purposefully conceal the circumstances of the deceased person’s death compared to HIV/AIDs and cancer bereavements. Kaltman & Bonanno (2003) found that violent deaths such as suicide predicted post-traumatic stress disorder and long-term depression than a bereavement due to natural causes which in turn may contribute to a more severe experience of grief. From this research, it can be concluded that suicide bereavement is different to other types of bereavement, perhaps due to the violent nature of suicide.

Bereavement by suicide was associated with more intense grief compared to bereavement by homicide, accidental death, natural anticipated death and natural unanticipated grief (Silverman, Range & Overholser, 1995). More recently, a longitudinal study compared suicide bereavement (n=142) to other sudden death (n=63) in adults in Australia at 6-, 12- and 24-months post-bereavement and found that individuals bereaved by suicide experienced significantly higher levels of rejection, stigma, shame and responsibility two years after the loss, when compared to the other sudden death group. However, the results suggested that rejection, stigma, search for explanation, somatic reactions and symptoms of depression and anxiety declined significantly over time in the other groups, but remained in the suicide bereaved group (Kõlves et al., 2020). A systematic review of suicide bereavement grief reactions and grief reactions, conducted by Sveen & Walby (2008) found that suicide bereavement produced specific grief variables which include rejection, shame, stigma, a need to conceal the cause of death and placing blame upon others. Therefore, it may be that levels of distress seen in suicide bereaved individuals was higher than other bereavements and these levels declined over time in other bereavements but did not decline in the suicide-bereaved.

It may be that relationships were an important mediator in how bereaved by suicide was experienced. Children who have lost parents may experience relationship problems, greater levels of unemployment and elevated risk of suicidal behaviour. Bélanger et al., (2022) found that those bereaved by parental suicide were at a greater risk of non- employment. Those who were employed at the time of bereavement were more likely to be unemployed five years after the death, suggesting that suicide bereavement could affect the ability to be in employment long term. A study investigating suicide deaths in 10–19-year-olds (n=595) between 2014-2016 using inquest information found that 9% (n=51) had been bereaved by suicide (Rodway et al., 2020). This study suggested an elevated risk of suicide in children bereaved by suicide, throughout childhood. Another study by Bartik, Maple & McKay (2020) of 18-year- olds who had experienced a friend’s suicide in rural Australia found that young people exposed to a friend’s suicide experienced significantly high levels of depression, anxiety and coping strategies such as alcohol use. Those identifying themselves as “close friends” were at less risk of suicide but displayed increased mental health concerns as a result of their friend’s death. Those identifying themselves as “peripheral friends” were at a greater risk of suicide. However, the limitations of this study suggested that the sampling was open to selection bias, there was a distinct lack of randomisation, and the sample was not re-tested and therefore, results only captured participant’s experience from one point in time (Barik, Maple & McKay, 2020). A study investigating parental death by suicide found that parental suicide is associated with an increased risk of suicide in bereaved children. This effect seemed to be higher for children who had a parent who died before they reached the age of six years, and this effect remained high for at least 25 years. During 25 years of follow-up, the absolute risk of suicide for girls bereaved by a parent’s suicide was 2 in 1000 and 4 in 1000 for boys, suggesting that parental suicide increases the risk of a child’s suicide for up to 25 years after the death (Guldin et al., 2015). This contrasted with the earlier discussed findings of Kõlves et al., (2020) who found that adverse mental health consequences and levels of distress caused by suicide bereavement may lessen after 24 months. However, this may be due the differences in relationships as Kõlves et al., included a variety of participant groups, whereas Guldin et al., studied children bereaved by a parent. Therefore, relationship to the deceased may be an important factor when assessing risk of suicide in the bereaved.

A review of the literature conducted by Ratnarajah & Schofield (2007) found that children’s adjustment to a parent’s suicide is influenced by the age of the child at time of the parent suicide, their personal attributes, family support, social environment, economic and environmental factors, and the process of ‘meaning making’ engaged in by the child. Another study found that risk of suicidal behaviour in children who lost a parent to suicide or an unintentional injury during childhood surpassed the adolescent groups' risk approximately five years after the death and for the youngest group (0-5 years) this risk continued to rise over decades. Children who lost a parent during adolescence or young adulthood were at greatest risk within one to two years after parental death, and risk declined over time. Children who lost a parent to suicide in childhood and young adulthood had earlier onset of hospitalisation for suicide attempt compared with offspring who lost a parent to an unintentional injury (Kuramoto et al., 2013). This suggested that the risk of suicide for children bereaved by suicide is long-lasting, particularly when comparing this to being bereaved by unintentional injury. Finally, children bereaved by a parent's suicide before the age of 13, had a 1.9 fold higher risk of self-harm than in children who did not experience a parent's suicide (Wilcox, et al., 2010).

A qualitative study of parents bereaved by the suicide of their child (n=23) and their experiences of support from primary care in the U.K found three main themes: the importance of not feeling alone; perceived barriers to accessing support; and the importance of signposting for additional support. Whilst some parents had good experiences of support, others described several barriers to accessing help, including formal triage processes. It was concluded that primary care was an important avenue of support, but participants often perceived the GP as “uncertain” of how to respond to a suicide bereavement. Parents felt that it was crucial for professionals working in primary care to have an awareness of suicide bereavement and an understanding of the needs of people bereaved by suicide. This included having knowledge of where to direct people for additional support (Wainwright et al., 2020).

One study compared stigmatisation experienced of parents bereaved by their child's suicide with other traumatic death and child natural death. Parents who encountered harmful responses and strained family relationships and non-kin interactions reported heightened grief responses. After controlling for time since the death and whether a child's death was traumatic or not, stigmatisation continued to be associated with grief, depression, and suicidal thinking. There were little differences in stigmatisation from other-traumatic-death, suggesting that child bereavement of any kind may be unique in terms of stigmatisation and grief responses (Feigelman, Gorman & Jordan, 2009). Another study compared parental experiences of bereaved by suicide, accident, and chronic disease. Feelings of guilt were reported by 92% of suicide bereaved parents, 78% of accident bereaved parents, and 71% of chronic disease bereaved parents. 34% of the suicide bereaved parents reported that guilt was the most distressing aspect of their grief, while none of the accident bereaved or chronic disease bereaved parents reported guilt as the most distressing aspect of their grief (Miles & Demi, 1992).

Studies have found a 22-fold increased risk of suicide in spouses bereaved by suicide during the first two years post-bereavement, this was also found in cohabiting partners (Agerbo, 2005). Furthermore, Erlangsen et al., (2017) found an increase in risk of suicide in bereaved partners, 3.7-fold increase in males and 4.7-fold increase in women, compared with people not exposed to bereavement by suicide. A study looking at the individuals bereaved by suicide and their emotional well-being three months after the suicide found that spouses and parents bereaved by suicide had similarly high rates of depression and complicated grief when compared to people bereaved by natural means (de Groot, de Keijser & Neeleman, 2011). This study highlighted the impact of spousal suicide bereavement, particularly in the initial stages of grief.

Siblings bereaved by suicide were at a 2.6-fold higher risk of dying by suicide (Qin et al., 2003). Another study, Tidemalm et al., (2011) found a 3.1-fold increased risk of suicide in bereaved siblings than in those not bereaved. However, this study did not control for extraneous variable such as previous psychiatric diagnoses pre-bereavement and therefore causation cannot be assumed. This study also found an increased risk for monozygotic twins and dizygotic twins. They also suggested an increased suicide risk for other family members including cousins and grandchildren. It has also been suggested that siblings bereaved by suicide are “the forgotten bereaved”. This term was used by Dyregrov & Dyregrov (2011) who found that bereaved siblings experienced post-traumatic stress, severe grief reactions, depression and anxiety. They found that siblings often felt that their grief was not as impactful as their parent's grief of losing a child. As social roles and identity changed within the family, siblings felt that they had to mature and support their parents and other family members.

In summary, research has suggested that a suicide bereavement affects approximately 135 people. Those bereaved by suicide were at increased risk of dying by suicide and self- harm behaviours. Bereavement by suicide increased the risk of depression, anxiety, and alcohol use. The prevalence of this may be affected by the relationship to the deceased. Suicide bereavement also increased the risk of developing Complicated Grief Disorder and prolonged grief, suggesting that suicide bereavement may be a different kind of bereavement, requiring specific intervention. This may be due to the processes involved in a suicide death such as an inquest and media reporting. Further to this, stigma, shame, rejection, and the unique grief reactions to suicide may also distinguish suicide bereavement as different to bereavement by natural causes. Lack of support has been identified as causing worsening grief experiences and mental health problems.

1.2.5 Suicide Postvention

The process of an intervention post-suicide was acknowledged by Edwin Schneidman, as “postvention is the prevention for the next generation” (Cain, 1972, pg. x). Therefore, postvention aimed to prevent suicide from happening again and affecting further generations. Postvention is a process which alleviates the effects of stress and aids in coping with a death by suicide. Andriessen (2009) proposed that effective postvention is prevention and further development of postvention support was needed. Professionals working with people bereaved by suicide noted that individuals bereaved by suicide characterised their grief as a unique experience which required specific intervention (Schuyler, 1973; Batzler, 1988; Knight, 1992). Harwood et al., (2002) reported that individuals bereaved by suicide felt highly distressed by legal procedures, specifically the coroner’s office and the inquest. Similar levels of distress were caused by the media reporting of their loved one’s suicide and postvention services should address these experiences. Therefore, it is crucial that suicide postvention recognises this bereavement as distinct and dissimilar to other kinds of bereavement, perhaps due to the legal process and media interest and as such, postvention services should consider how they can support the suicide-bereaved through these experiences.

Clark (2001) suggested that there is a growing need for appropriate frameworks and standards to guide postvention services. This would ensure that postvention services are meeting the needs of the community and ensures that they have a framework which specifies requirements that should be fulfilled by a service to establish its fitness for purpose. Dyregrov (2011) recommended that postvention support should be adapted to meet each individual bereaved person's needs, which further supported the notion that suicide bereavement is a unique experience, requiring specialist support. Furthermore, Andriessen et al., (2017) suggested that postvention research should focus on increasing intercultural collaboration and theory-driven research whilst encouraging the relationships between research and practice, therefore suggesting that research and practice should have a collaborative relationship, with each informing the other. One such study which had attempted to bridge the gap between research into postvention and practice, McDonnell et al., (2022), conducted a survey of n=7,158 people bereaved by suicide which found that most had not accessed support services and viewed local suicide bereavement support as "inadequate". Finally, Andriessen & Krysinska (2012) reported that postvention efforts were driven by those bereaved by suicide and that the bereaved should continue to be involved in the design and implementation of postvention services and research. They describe postvention as "an integral and indispensable component of prevention programs" (pg. 29). In conclusion, methodologically strong studies are needed to identify and meet the needs of individuals bereaved by suicide. Further research is needed, in particular, of postvention activities which include health-economic evaluations.

Furthermore, suicide postvention had been reported to be cost-effective if we consider the following studies. Comans, Visser and Scuffham (2013) found that an Australian postvention service called Standby was cost-effective as it found a cost saving of AUS $803 when compared to "usual care" by statutory services. They also found an increase in quality-adjusted life years of 0.02. The probabilistic sensitivity analysis found that there is an 81% chance of a postvention service being cost-effective in a range of possible scenarios. This showed that postvention services were effective in improving quality of life and were also cost-effective. In the UK, the Centre for Mental Health's 'Zero suicides' report suggested that "the economic and social cost of one suicide is estimated at £1.5 million" (Centre for Mental Health, 2015). The Support

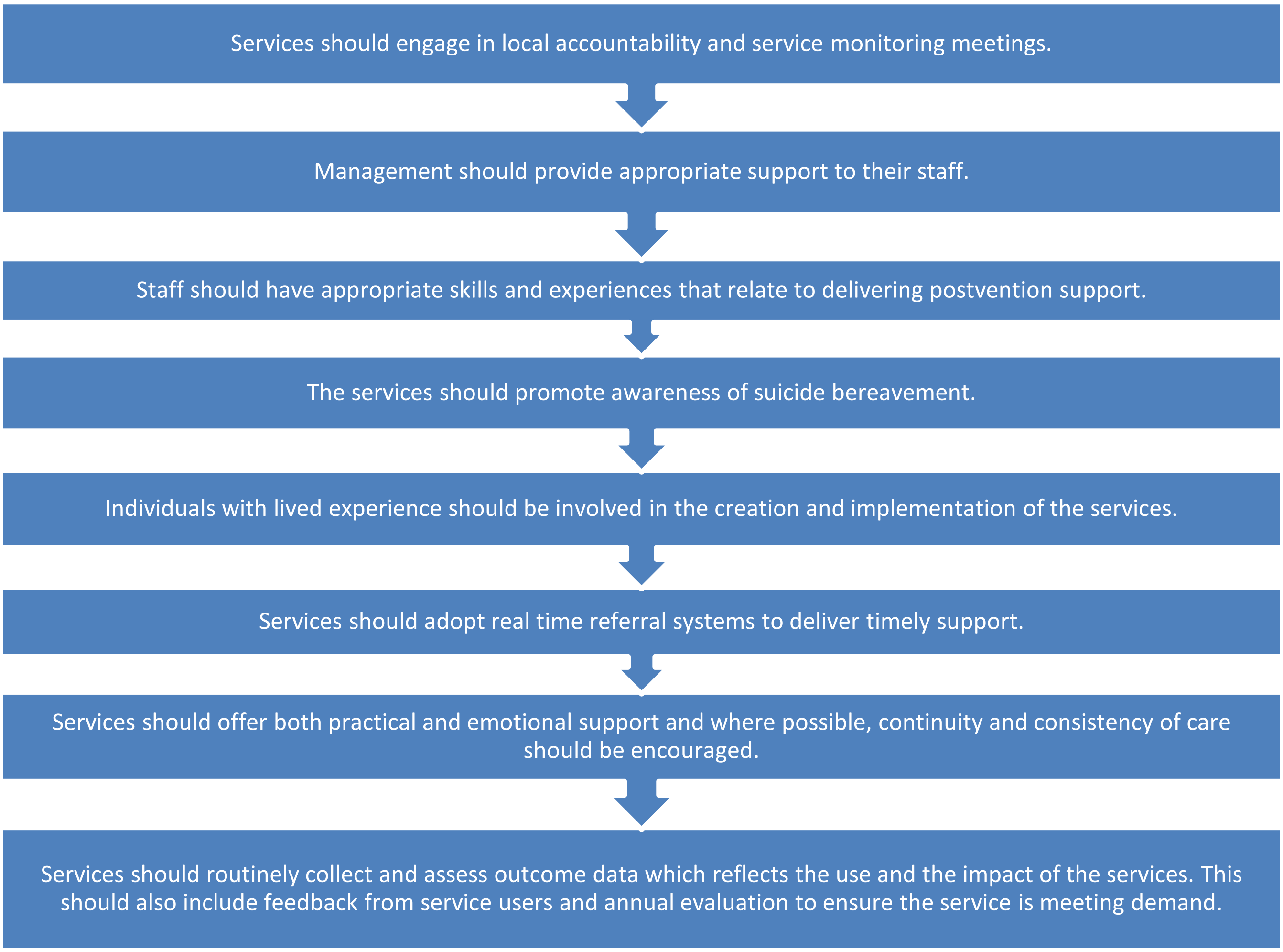
After Suicide Partnership (2019) estimated the national cost of suicide to be almost £10 billion per year. They suggested a local postvention service would cost approximately £200,000 a year, nationally this would be £10 million a year, suggesting that a national service "would only have to save six lives a year to pay for itself in less than a day". Therefore, research has suggested that suicide postvention services were cost-effective as it would be economically viable to prevent suicides in an at-risk population.

As discussed in the previous sections, suicide bereavement is thought to be a unique grief experience, requiring specific support. Suicide postvention has attempted to address this. Research had also examined the potential benefits of support for those bereaved by suicide. A realist evaluation of a social support group for (n=6) individuals bereaved by suicide found that effective social support provided building meaningful connections with like-minded individuals, in a safe space that encouraged self-expression and personal relationship maintenance. In addition, they found that societal and cultural stigma surrounding suicide, self-stigma and blame, and gender norms, affected the impact on the well-being of participants. Mechanisms which influenced support seeking behaviours included not wanting to be a burden on loved ones, judgement of others and lack of understanding by others. This research concluded that adequate support would reduce the demands on healthcare and statutory services (Adshead & Runacres, 2022). Indeed, belongingness, self-disclosure and social support were facilitators of increased posttraumatic growth after a suicide bereavement, suggesting that support and a sense of belonging played an important role after a traumatic bereavement (Levi-Belz, 2019). Furthermore, a study examining social isolation and bereavement by suicide found that the availability of support could decrease depression (Spino et al., 2016). Social support may also help individuals bereaved by suicide to make meaning and sense of the death, rather than ruminate on feelings of responsibility, suggesting that support may be an important facilitating factor in the process of healing (Hunt et al., 2019). Providing further evidence of the specific needs of those bereaved by suicide, a qualitative study by Ross et al., (2021) found that participants reflected on the difficulty navigating services involved in a suicide death and how their support needs changed, which included the need for proactive and practical support. The impact of stigma, social isolation and connecting with others were important factors. Some concerns were highlighted, such as support group facilitators who dominated group discussions with their personal experience, however support groups were thought to be helpful as they created a sense of connectedness and shared experience (Ross et al., 2021). These findings suggested the need for support to alleviate mental distress and promote making sense of the death. However, the aforementioned research focused on the experiences of those bereaved by suicide and did not discuss the experience of suicide on finder of the body, irrespective of their relation to the deceased. Additionally, front-line professionals who may be exposed to suicides through their work, such as police officers, coroner's, GP's, and emergency responders, may require support following a suicide. ONS (2017) reported that 430 health professionals died by suicide between 2011 and 2015. First responders, ambulance staff, police, firefighters and nurses were also at higher risk of dying by suicide (Nelson et al., 2020; Jones et al., 2018; Milner et al., 2017; Vigil et al., 2019). One study assessing the impact of suicide on frontline staff highlighted the need for ongoing support and training, as well as the development of specific post-suicide protocols. Participants reflected on the highly distressing impact of the suicide of a patient which contributed to burnout as professionals then became very concerned about the family of the bereaved, feelings of responsibility for the death and making meaning of the death (Gaffney et al., 2004). In support of this, Draper et al., (2014) found that being a female healthcare professional and the suicide occurring within a week of contact between the professional and the patient were predictors of professional and personal impact. Furthermore, having less than five years of experience within the role predicted professional impact and receiving support and/or counselling predicted personal impact. These findings suggested that everyone involved in contact with the person who died by suicide such as the bereaved, those working in suicide prevention and individuals exposed to suicide due to their employment roles, would benefit from support.

1.2.6 Organisations working in Suicide Postvention

The National Suicide Prevention Alliance (NSPA) launched in 2011 and worked to bring together public, private, and voluntary organisations to reduce suicide and support those affected by suicide. The Support After Suicide Partnership (SASP) was created in 2013 to bring together national and local organisations that were involved in delivering suicide bereavement support across the UK. They aimed to support new and existing suicide postvention services to ensure that all areas of the UK have local bereavement support services. They published resources to support individuals bereaved by suicide, such as the following resources: “Help is at Hand”, “Finding the Words”, “Suicide Safer Universities”, “Inquests - A Factsheet for Families” and many others (SASP, n.d).

SASP recently created “Core Standards” (2020) for bereavement support services. These standards highlight recommendations for postvention services. These include:



Services should engage in local accountability and service monitoring meetings.

Management should provide appropriate support to their staff.

Staff should have appropriate skills and experiences that relate to delivering postvention support.

The services should promote awareness of suicide bereavement.

Individuals with lived experience should be involved in the creation and implementation of the services.

Services should adopt real time referral systems to deliver timely support.

Services should offer both practical and emotional support and where possible, continuity and consistency of care should be encouraged.

Services should routinely collect and assess outcome data which reflects the use and the impact of the services. This should also include feedback from service users and annual evaluation to ensure the service is meeting demand.

Figure 4: SASP Core Standards

Finally, the Zero Suicide Alliance is an organisation created by the Mersey Care NHS Foundation Trust which aimed to break the stigma surrounding suicide and enable community leaders to create meaningful action to prevent suicide in the UK. They provided suicide awareness training, develop evidence-based resources and understand factors that contribute to suicide. Adequate and timely support for those bereaved by suicide was a key objective in the NO MORE Zero Suicide Alliance Strategy (2017) for Cheshire & Merseyside.

1.2.7 Government Policy

In Andriessen et al., (2019) review of postvention guidelines, they recommended that adopting a public health approach to postvention that allowed service delivery to be tailored to the needs of the bereaved individuals. The UK adopted that approach, by viewing suicide as a public health issue, that required national, regional and local responses. The Department of Health (2012; 2014) outlined supporting those bereaved and affected by suicide was a key area for action, as was supporting research and encouraging support for those bereaved by suicide both locally and nationally. The National Suicide Prevention Strategy, titled "Preventing Suicide in England: A Cross-Government Outcomes Strategy to Save Lives," was a pivotal framework established by the UK government to tackle the issue of suicide comprehensively. This strategy encompassed six key areas for action, ensuring a holistic and coordinated approach (See Figure 5). These areas included improving the understanding of suicide and implementing effective prevention measures, providing high-quality and accessible services for individuals at risk, offering better support to those bereaved by suicide, reducing access to means of suicide, promoting responsible media reporting, supporting research and data collection, and monitoring progress through robust data analysis. The government published annual progress reports on each of these areas, ensuring transparency and accountability. These reports highlighted achievements, challenges, and future goals, driving continuous improvement in suicide prevention efforts. By implementing the National Suicide Prevention Strategy and monitoring progress annually, the UK government demonstrated its commitment to saving lives, promoting mental health, and creating a society where suicide is prevented.

Reduce the risk in key high risk groups
- Young and middle aged men
- People under the care of mental health services and/or the criminal justice system
- People with a history of self-harm
- Specific occupations (doctors, nurses, veterinary workers, farmers

Tailored approaches to improve mental health in specific groups
- Tailored measures for groups with particular vulnerabilities and increase access to support services
- Individuals or groups of people who may have higher rates of mental health problems

Reduce access to means of suicide
- Reduce acccess to high-lethality means of suicide
- Targeted interventions in psychiatric inpatient and criminal jusice settings, high risk locations and rail and underground networks

Information and support to those bereaved or affected by suicide
- Timely and effectve support and information for those bereaved or affected
- Local response in the aftermah of suicide
- Information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

Support the media in a sensitive approach
- Promoting the responnsible reporting and portrayal of suicide in the media
- Supporting the internet industry to recognise and remove content that encoirages suicide and provide signposting to suicide prevention services

Support research, data collection and monitoring
- Further development of existing research and other souirces of data
- Expand and improve the gathering of data
- Monitor progress against the stated objectives

Making it happen locally and nationally
- Each priority area for action set in the above 1-6 areas for action suggests local and national activities to deliver change
- Public Health England to take a leadership role across public health services
- Collaborative woorking between health and wellbeing boards, local councillors, Clinical Commissioning Groups, directors of public health, adult social services, childrens social services and wider partners such as police, safeguarding and community organisations

Figure 5: The six key areas for action, with the additional guidance on local and national actions.

The All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2015) reported that local suicide prevention plans were varying and inconsistent, with 30% of local authorities reported having no suicide prevention plan. Police, coroner, and GP involvement at a local level was inconsistent and 40% of local authorities reported not having a multi-agency suicide prevention group; thus, suggesting little collaboration between key agencies. The Mental Health Taskforce to the NHS in England (2016) recommended all local authorities should have a multi-agency suicide prevention strategy in place by 2017.

The Five Year Forward View for Mental Health (2016) set out clear recommendations for suicide and aimed to reduce suicides by 10% nationally by 2020/21. In 2018-2019, local communities that were the worst affected by suicide were to be given funding to develop suicide prevention and reduction schemes. This investment was to be the start of a five-year programme worth £25 million, which aimed to reach the whole country by 2021. This funding was allocated to eight areas most affected. However, the Progress of the Five Year Forward View: on the road to parity, reported that NHS Clinical Commissioners felt that progress had “waned” (All-Party Parliamentary Group on Mental Health, 2018). The inquiry found that various organisations were concerned that local government budget cuts were impacting public health initiatives. The Association of Directors of Public Health reported in this inquiry that they “have reached their limit of available efficiencies.” This report also highlighted that one to two percent of local authority public health budgets have been devoted to mental health.

In October 2018, the UK appointed Jackie Doyle-Price as minister for suicide prevention. This new role aimed to focus on raising the profile of mental health issues in Britain to prioritise mental health as much as physical health. To date, there have been five different ministers for suicide prevention.

In 2019, The Suicide Prevention: Cross-Government Plan was created. This was a comprehensive and crucial initiative aimed at addressing the urgent issue of suicide prevention. Developed by various government departments and agencies, this plan outlined a coordinated approach to tackle the complex factors contributing to suicide and promote mental well-being across the population. The plan emphasised the importance of collaboration and partnership among healthcare providers, community organisations, educational institutions, and other stakeholders. It focused on early intervention, improved access to mental health services, and increased public awareness and education. Through targeted interventions, the plan aimed to reduce stigma, enhance support networks, and enhance the capacity of healthcare professionals to identify and respond to individuals at risk of suicide. With a strong emphasis on evidence-based strategies and continuous evaluation, the Suicide Prevention: Cross-Government Plan was a crucial step forward in ensuring the well-being and safety of individuals across the nation.

Collaboration between governmental bodies and the NSPA have resulted in guidance for how to support people bereaved by suicide. One such guidance (Public Health England, 2016) was a practical resource, aimed at providing local services with information. This guidance suggested that postvention was essential, as suicide affects a wide range of people, with a wide-reaching impact. Due to this, support needs vary. It suggested that postvention could be cost-effective and has the potential for improving well-being and preventing further suicides. Finally, evaluating the potential for this was crucial, and postvention services should engage in evaluating their outcomes (See table 1).

Table 1: 10 key considerations for postvention (Public Health, 2016)

Key Considerations	Further information
1. Postvention is an essential part of public health	Suicide bereavement was more likely to result in suicide, poor social functioning, decreased ability to cope with everyday activities (work, relationships, social).
2. The scale of the problem	Wide-reaching impact of those bereaved or affected/impacted by suicide.
3. Suicide affects a wide range of people	Relationship to deceased was key: close family (parents, spouses/partners) were most vulnerable, as well as a risk for friends, family and colleagues. Support needed for health professionals and others exposed to suicide.

4. Unmet needs for support	Raise awareness of support and resources available.
5. A case for health and economic	Cost of suicide thought to be £1.67 million. Suicide postvention thought to improve social functioning, mental well-being, physical health, whilst reducing stigma and perhaps reducing further suicides. Research should explore the potential benefits of postvention.
6. Postvention supports wider social issues	Providing support may encourage social inclusion, reduce health inequalities, promote employment and education retention.
7. People want different types of support	The type and duration of support required varied. The time point an individual seeks support differed, it could be immediately after the time or months or even years after the death. Some people may benefit from group support or seek individual support. Difference between counselling and postvention liaison support was highlighted. Different models of support should be considered.
8. We can learn from what others are doing	Australia and USA have established postvention programmes and a range of other support available. UK postvention programmes should learn from these programmes. Evidence based training also needed to support GP's and other mental health professionals.
9. Local postvention programmes rely on strong partnerships	Postvention programmes should collaborate with commissioners, coroners, police, health and mental health services, as well as other organisations providing bereavement support. Effective collaboration enabled local services to act quickly in response to a potential suicide and provide timely support.
10. Evaluating outcomes are	Incorporating evaluation into postvention was essential for indicating effectiveness and cost-effectiveness. Evaluation

important	frameworks should include collecting and analysing information on their clients and their needs, the systems within the service, and make improvements to the service.

In addition to this, the Suicide Prevention in England: five-year cross-sector strategy (Public Health, 2023) suggested suicide postvention was a national governmental effort, requiring collaboration from the NHS, local government, voluntary, community and social enterprises, employees and members of the public. Key priorities for action included improving evidence that effective, evidence-informed and timely intervention should be developed. Furthermore, support to priority groups should tailored and targeted to ensure a bespoke package of support available to those who were higher risk. Finally, effective bereavement support to those affected by suicide should be provided. These key objectives set the tone for national and local public health efforts in preventing suicide and improving support for those bereaved by suicide.

1.2.8 Summary

Data collected by the ONS showed that suicide is a national problem within the UK and indeed world-wide. Research has suggested that suicide is a different kind of bereavement, requiring specialist support tailored to the experiences of those bereaved by suicide. Furthermore, people bereaved by suicide were at an increased risk of adverse mental and physical health issues, whilst also being at an increased risk of suicidal ideation and suicide. Postvention services were created to prevent further suicides in this at-risk population. These services could be both effective and cost-effective, as suggested by evaluations conducted on postvention services in other countries. To understand how to prevent suicides in the UK and support the bereaved, researchers and organisations should investigate the postvention efforts across the world. Despite the ongoing postvention efforts in the UK, there was a lack knowledge and understanding on their effectiveness. Governmental policies have highlighted the need for suicide prevention and reduction; however, funding had fallen short of impacting services and individuals bereaved by suicide. It may now fall to voluntary and private sector organisations to support those bereaved by suicide.

1.3 Aim of the research and research questions

1.3.1 Problem statement

Very little research had been conducted on suicide postvention in the UK. As this sector is unregulated, it was important to understand how these services were supporting vulnerable people, and the impact they were having. From this, a model and recommendations could support new and existing services in ensuring they are delivering an appropriate service.

1.3.2 Statement of Purpose and Research Questions

The thesis aimed to evaluate the perceived effectiveness of suicide postvention efforts in England, considering the viewpoints of both beneficiaries utilising the service and key stakeholders engaged in suicide prevention. To do this, the current suicide postvention service landscape in England is explored, as was the existing state of suicide postvention services in England, elucidating the range of programmes and initiatives in place. Secondly, the thesis discussed the perceived effectiveness in reducing suicides and enhancing well-being by scrutinising the effectiveness of these services in terms of their capacity to prevent subsequent suicides and enhance the overall well-being of the individuals they assist. Psychometric scales were used to assess the impact on mental health and well-being. The qualitative data described the impact postvention has on beneficiaries, other organisations and the wider Community. Finally, the thesis investigated the broader ramifications of these services on other organisations and the community at large in the respective geographical areas and therefore examined how these efforts influenced and collaborated with other entities in the mental health and community support ecosystem. See table 2 outlining the aims, research questions and methods for the thesis.

In summary, this evaluation sought to provide insights into the effectiveness of suicide postvention services by considering the perspectives of beneficiaries and key stakeholders. It aimed to assess not only the direct impact on suicide rates and well-being but also the broader repercussions on organisational and community dynamics.

To support the development of these research questions and aims, a systematic review was conducted to assess postvention in other countries and models of postvention.

Table 2: The study aims, research questions and methods.

Study aims	Research Questions	Methods
Assess the perceived effectiveness of suicide postvention in England, from the perspective of beneficiaries that utilise the service and key stakeholders involved in suicide.	• What is the current suicide postvention service provision in England? • Are the services perceived to be effective in reducing further suicides and improving the wellbeing of the people they support? • What impact do these services have on other organisations and the wider community in the areas they are located?	Quantitative – secondary data analysis using i). demographic data and ii). psychometric scales measuring well-being. Qualitative - semi-structured interviews with service users (beneficiaries), key stakeholders, service CEOs and suicide liaison support workers.

1.4 Overview of the research approach and positionality of the researcher

With the involvement of suicide postvention services and the Support after Suicide Partnership (SASP), the researcher studied the experiences and perceptions of people bereaved by suicide accessing postvention support, key stakeholders who were involved with and referred into these services, individuals who created and managed these services, and individuals who delivered the support. Furthermore, demographic data explored who was accessing these services and psychometric well-being scales aimed to explore whether these services improved well-being. This investigation was therefore a mixed methods study.

Fifty-eight in-depth interviews were conducted. Interview questions were created in consultation with a public advisory group and were based upon previous research in this area conducted by the primary researcher. Each interviewee was identified by a pseudonym, and all interviews were tape recorded and transcribed verbatim.

Demographic data and well-being scores were accessed from two services. These services collected this data and this was then analysed by the researcher. The use of this data supported the aims and research questions in understanding who was supported by these services, any gaps in service provision and attempted to understand whether these services improved well-being.

The researcher, Laura Abbate, was a PhD student and qualified counsellor, working as a grief counsellor. This study aligned with a pragmatic perspective by leveraging personal and professional experiences with suicide and bereavement as a basis for investigating the support provided to those who have lost someone to suicide. The belief was that researchers should actively incorporate their personal worldview into their work, shaping their approach to research design. Consequently, a mixed methods approach, grounded in pragmatism, was considered optimal, aiming to address key questions: In England, are suicide postvention services perceived to be effective by beneficiaries? Are they perceived to be effective by key stakeholders who are exposed to suicide, such as coroners, police officers and general practitioners? However, the researcher used key concepts from Person Centred counselling such as Rogers (1961, 1975) work on empathy and unconditional positive regard to understand that the participants are the experts in their own lives and the researcher is to remain impartial to allow the participants to tell their stories. In essence, whilst the researcher had some understanding of suicide, suicide bereavement and grief, the researcher was not an expert in each of the participants experiences and it was for the researcher to learn from them.

The researcher also attempted to use theoretical frameworks in understanding suicidality. Whilst there is a lack of theoretical framework for suicide postvention, some theories on suicide may facilitate an understanding of suicidal behaviour and therefore, the risk of suicide for those bereaved by suicide. The Interpersonal Theory of Suicide (Van Orden et al., 2010) posited that the most critical manifestation of suicidal behaviour arose from the interaction between two interpersonal constructs – thwarted belonginess and perceived burdensomeness. Thwarted belonginess was the belief of being alone, and perceived burdensomeness manifested in the belief of being a burden. The capability to engage in suicidal behaviour was separate from the desire for suicide. For some, the presence of the desire and capability for suicide combined, to produce an increased risk of suicide. One such risk that increased the probability of desire for suicide was a family history of suicide.

The integrated motivational-volitional model of suicidal behaviour (O'Conner & Kirtley, 2018) proposed that defeat and entrapment drive suicidal ideation. A group of factors known as volitional moderators encouraged suicidal ideation to transition to suicidal behaviour. These factors included means of suicide, exposure to suicide, capability for suicide (fearlessness about death and increased physical pain tolerance), planning for suicide, a proclivity for impulsiveness and past suicidal behaviour. Therefore, it may be reasonable to suggest that those bereaved by suicide have been exposed to suicide, and in their grief, they develop a fearlessness about suicide as they may desire to be with their deceased relative or friend.

Cramer and Kapusta (2017) proposed a comprehensive social-ecological framework for understanding suicide, highlighting risk and protective factors across multiple levels, from societal to individual. This theory emphasised the importance of community involvement, effective support systems, and psychological resilience in suicide prevention and postvention efforts. It underscored the significance of tailoring interventions to address specific risk factors, such as stigma and social isolation, while promoting protective factors like social support and coping skills. By providing a multi-level perspective on suicide, this theory offered valuable insights to develop targeted prevention strategies and support services. Incorporating such a multi-level approach into suicide prevention and postvention initiatives would enhance their effectiveness in addressing the complex factors associated with suicide.

These theories explain suicidal behaviour, which can be expanded to explain the risk of suicide in those bereaved by suicide. The question then arose, what can be done to prevent suicidal thoughts in those bereaved by suicide from transitioning to suicidal behaviour? The Theory of Change (Weiss, 1995) posited why a desired change was expected to happen in a particular context. It focused on mapping out or filling in what has been described as the “missing middle” between what a programme is and what change it wished to initiate. This included the programmes activities or interventions and how these led to desired goals being achieved.
The first step or task within this theory was identifying the desired long-term goals. The second step was to identify all the conditions or outcomes that must take place. How these conditions relate to one another must be considered. These are then mapped onto the outcomes framework. This then provided a basis for identifying what type of activity or intervention will lead to the outcomes identified as preconditions for achieving the long-term or ultimate goal. Developing a theory of change is thought to be useful in evaluation (Church & Rogers, 2006). It could be an opportunity to engage with programme staff and intended beneficiaries, which could aid in the following: formalising knowledge and experience, establishing a shared vision for the programme and finally, identifying key enablers and barriers for a successful programme (Aromatario et al., 2019; Funnell & Rogers, 2011).

This study was rooted in pragmatism, drawing on both personal and professional experiences related to suicide and suicide bereavement. The motivation to investigate the support received by those bereaved by suicide stemmed from the belief that researchers should integrate their personal perspectives into the research process, shaping their approach to research design. Consequently, this study adopted a mixed methods approach founded on pragmatist principles. This approach enabled the researcher to address key questions, such as assessing the perceived effectiveness of suicide bereavement support services from the perspective of beneficiaries and those exposed to suicide due to their occupation. This study adopted an inductive Thematic Analysis orientation, emphasising the exploration and development of themes directly from the collected data. This is discussed more thoroughly in Chapter 3.

1.5 Contribution to knowledge

It was hoped that a theory of change, model and recommendations would support SASP in developing a standardised support package that suicide postvention services used to ensure that all individuals bereaved by suicide received an acceptable standard of support. A study on the perceived effectiveness of postvention had not been conducted before in the United Kingdom. This research was seen as a stepping stone for policymakers, postvention services and further research. As improving mental health and preventing suicide are key public health objectives in Public Health England's strategy 2020-2025 (Public Health England, 2019), this thesis aimed to provide important information and guidance on the support given to vulnerable people who have experienced a suicide loss. Furthermore, this thesis aimed to support the Public Health England (2023) objectives in improving data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted and providing effective bereavement support to those affected by suicide. Finally, this thesis supported the notion that suicide should be a public health priority so that collectively, we can maximise impact and support to prevent suicides.

1.6 Overview of thesis

This thesis highlighted the experiences of those bereaved by suicide and the support provided by suicide postvention services. This thesis endeavoured to assess the perceived effectiveness of suicide postvention efforts in England, delving into the diverse perspectives of beneficiaries and key stakeholders. A systematic review was also conducted to assess the feasibility and acceptability of postvention services across the world and models used for postvention. Then, the thesis explored the current landscape of suicide postvention services, detailing the existing services and the support they provided. Subsequently, it critically examined the perceived effectiveness of these services in reducing suicides and improving well-being, utilising psychometric scales to gauge mental health impact. These psychometric scales were the Clinical Outcomes in Routine Evaluation 10 and the Short Warwick-Edinburgh Mental Wellbeing Scale. This data was collected by two postvention services and analysed by the researcher. Furthermore, demographic data was used to assess who was supported by these services. Qualitative data vividly depicted the influence of postvention on beneficiaries, organisations, and the wider community. Lastly, the thesis investigated the broader implications of these services on organisational and community dynamics. The qualitative data was analysed twice, once by service and secondly by participant type. This ensured the researcher developed themes from the perspective of the services and then from the different participants. For example, what are key stakeholders experience of these services? In essence, this thesis aimed to provide comprehensive insights into the multifaceted impact of suicide postvention services. Semi-structured interviews involving 58 participants from nine postvention services yielded five overarching themes. These encompassed the support provision for individuals affected by suicide loss, the accessibility of postvention services, the ongoing discourse on effective data collection, the sustainability and durability of services, and insights gained from delivering suicide support. The overall conclusion was that suicide postvention in England is perceived to be effective by beneficiaries, communities and organisations involved in suicide. A theory of change was included, as are recommendations and a model. These recommendations are for policymakers, new and existing postvention services and for future research.

Chapter 2: Systematic Review

In Chapter two, I will include a systematic review with the following aims. This systematic review was published 5th July 2022 in the Journal of Death and Dying.

The following systematic review aimed to build upon the work of McDaid et al., (2008) and Andriessen et al., (2019). McDaid et al., (2008) conducted a review of n=8 controlled studies assessing interventions for people bereaved by suicide, which were bereavement groups and cognitive-behavioural interventions. None were qualitative nor UK-based. This review concluded that there was some benefit of interventions aimed at people bereaved by suicide but called for more robust, methodologically sound research. Andriessen et al., (2019) reviewed n=11 studies and found some evidence that postvention may be effective for people bereaved by suicide. The review compared a variety of interventions including supportive, therapeutic and educational approaches. Similarly to McDaid et al., (2008) this review did not include any UK-based postvention services, suggesting a limited evidence base for UK postvention. Both reviews concluded that further research was needed. Furthermore, the existing reviews did not include non-controlled and qualitative studies within their analysis. This would have allowed for an exploration of the voices and experiences of those working in postvention or receiving support from postvention services. Including other methods would help to determine whether non-controlled approaches yield a stronger quality of studies to gain insight into whether these services meet the needs of the people supported and communities. Therefore, this review aimed:

- To assess evaluations of current postvention services globally that are supporting the suicide-bereaved;
- To examine the acceptability of methods of postvention services such as community support, peer support, group support and internet support;
- To identify gaps in the literature to inform the research questions and aims for the current study.

This review informed the research question and aims within this thesis as it became clear that the current research on postvention was of low quality due to issues with how data was collected, analysed and reported. This raised further questions as to whether the services were effective. Furthermore, the previous systematic reviews conducted by Andriessen et al., (2019) and McDaid et al., (2008) could not compare studies due to intervention variation and a lack of standardised measures being used. The findings from this review informed the development of the study design and materials for this thesis. This also led to the decision to analyse the qualitative findings twice, once by services to allow for an understanding of the different services in the UK and the difficulties they face, and secondly by participant type, to gain an understanding of the different experiences of the beneficiaries and key stakeholders. In terms of the quantitative data, it was important to assess well-being pre- and post-intervention. As the previous reviews and the current systematic review discovered, there was a lack of qualitative and mixed-methods studies in postvention and therefore, the present thesis aimed to address this gap.

Evaluating Postvention Services and the Acceptability of Models of Postvention: A Systematic Review

2.1 Abstract

Background:

Suicide is a major public health issue that increases the risk of suicide for those bereaved by suicide themselves. There is a lack of evaluation of the effectiveness and acceptability of suicide postvention services supporting those bereaved by suicide.

Aims:

This review aimed to assess evaluations of postvention services supporting those bereaved by suicide and the acceptability of methods of postvention.

Methods:

Searches of peer-reviewed literature identified 36 studies for inclusion. 22 studies evaluated specific postvention services, 14 evaluated models of postvention.

Results:

Using the Mixed Methods Appraisal Tool, mixed-methods and qualitative postvention evaluation and acceptability research produce high-quality studies. Studies rated as low quality reflect poor reporting, rather than ineffective services.

Conclusion:

Further evaluation of community-based postvention services within the UK is needed. This would evidence that services in the UK are effective in supporting those bereaved by suicide. Evaluation would benefit services in accessing funding, improve service development and provide holistic support.

Keywords

suicide, postvention, bereavement, evaluation, systematic review

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2.2 Introduction

Globally, 800,000 people die by suicide every year – one death every 40 seconds (World Health Organisation, 2019). According to the most recent published data in England and Wales in 2019, there were 5691 registered suicides, 11 deaths per 100,000 population (Office for National Statistics, 2020). The Centre for Mental Health's 'Zero suicides' report suggested that "the economic and social cost of one suicide is estimated at £1.5 million" (Centre for Mental Health, 2015). For every suicide, it has been estimated that 135 people are directly affected (Cerel et al., 2019). It is thought that exposure to suicide is on a continuum with some people directly exposed or witness to a suicide, some directly or indirectly affected, and some bereaved (Cerel et al., 2014). The continuum defines individuals exposed to suicide as "anyone who knows or identifies with someone who dies by suicide," and stresses that this no longer merely just focuses on kin or those who were exposed to the trauma of the death itself but focus on all of those who may be affected by a suicide (Cerel et al., 2014, p. 4). Pitman et al., (2016) found that people bereaved by suicide are 65% more likely to attempt suicide than people who are bereaved by natural causes, increasing the absolute risk to 1 in 10. Furthermore, regardless of whether the participants were blood-related to the deceased, the effects of suicide bereavement were similar. These findings suggest that bereavement by suicide is a risk factor for a suicide attempt and its effects are not confined to immediate family members and thus, suicide bereavement effects wider support networks.

A study investigating suicide deaths in 10–19-year-olds (*n* = 595) between 2014-2016, using inquest information found that 9% (*n* = 51) had been bereaved by suicide (Rodway et al., 2020). Bartik et al., (2020) study of 18-year-olds who had experienced a friend's suicide in rural Australia found that young people exposed to a friend's suicide experienced significantly high levels of depression, anxiety and maladaptive coping strategies such as alcohol use. Those identifying themselves as "close friends" were at less risk of suicide but displayed increased mental health concerns as a result of their friend's death. Those identifying themselves as "peripheral friends" were at a greater risk of suicide. However, the limitations of this study suggest that the sampling was open to selection bias, there was a distinct lack of randomisation and the small sample size had insufficient statistical power to meet requirements of quantitative method deduction, and the sample were not re-tested and therefore, results only capture participant's experience from one point in time. Pitman et al. (2014) found an increased risk of psychiatric admission for parents bereaved by the suicide of their child. Additionally, the suicide of a child places parents at greater risk of psychological morbidity and physical health problems such as poor diet and smoking, compared to other causes of death (Erangsen & Pitman, 2017; Pitman et al., 2014). The process of an intervention post-suicide was acknowledged by Edwin Schneidman, as "postvention is the prevention for the next generation" (Cain, 1972, pg. x). Postvention is a process which alleviates the effects of stress and aids in coping with a death by suicide. Professionals working with people bereaved by suicide noted that people they characterise their grief as a unique experience requiring specific intervention (Schuyler, 1973; Batzler, 1988; Knight, 1992). Harwood et al., (2002) reported that individuals bereaved by suicide felt highly distressed by legal procedures, specifically the coroner's office and the inquest. Similar levels of distress were caused by the media reporting on the suicide, therefore postvention services should address these experiences. Dyregrov (2011) recommended that postvention support should adapt to meet each individual bereaved person's needs. Andriessen et al., (2017) suggested that postvention research should focus on increasing intercultural collaboration and theory-driven research whilst encouraging relationships between research and practice. Furthermore, Campbell et al. (2004, p. 31.) suggested that "an essential ingredient for successful implementation... is acceptance or buy-in by various police departments... and coroners", therefore it is crucial that services collaborate with statutory services that are involved in suicide bereavement. McGeechan et al., (2018) compared police and coroner-led postvention strategies and found that coroners were more consistent at identifying suspected suicides however cases were filed quicker by the police. Bereaved individuals were more willing to share contact details and consent to referrals with police, which led to increased referrals. This research highlighted a need to look at components of successful postvention services, such as referral sources and collaboration. McDaid et al., (2008) conducted a systematic review into the interventions for adults and children bereaved by suicide. They included support groups, self-help, volunteer-led groups and therapeutic interventions led by health professionals. This study exclusively included randomised controlled trials and studies with a control or comparison group such as cohort studies. Eight studies were identified, none being UK-based. Findings suggested that when compared with no intervention, there was evidence of effectiveness for four sessions of cognitive-behavioural family interventions with a psychiatric nurse. They also found that a psychologist-led 10-week bereavement group intervention was beneficial for children. Finally, an 8-week group therapy delivered by a mental health professional or volunteer was beneficial to adults. They concluded that all but one study had “substantial methodological limitations”.

More recently, Andriessen et al., (2019) conducted a systematic review into the effectiveness of interventions for people bereaved through suicide. The studies included (*n* = 11) were controlled studies of grief, psychosocial and suicide-related outcomes. The inclusion criteria included: study population consisting of people bereaved by suicide, studies needed to provide empirical data on grief, mental health and/or suicide-related outcomes, studies involving a controlled intervention and finally, studies needed to have been published in a peer-reviewed journal. This review excluded studies without a control group, case studies and review papers. No qualitative studies met the inclusion criteria. Location of origin included USA (*n* = 8), the Netherlands (*n* = 3), Australia (*n* = 3) and Belgium (*n* = 3). Across the studies, intervention modalities vary. The quality of studies was weak as evidence of the effectiveness of complicated grief interventions was lacking. The diversity of intervention settings, populations and measures used contributed to the overall quality of the studies. Furthermore, the studies had limited replicability and none of the studies looked at suicidal behaviour as an outcome. Studies that did have an interview follow-up period utilised short time points. Studies had small sample sizes, were female dominated samples, and it is unknown if studies controlled for effects of other treatments. This review highlighted concerns of selection bias, blinding and high withdrawal and dropouts as the weakest components across the studies. However, there was some evidence of the effectiveness of interventions for uncomplicated grief (Andriessen et al., 2019).

The majority of postvention research is conducted elsewhere in the world, and rarely conducted in the UK despite multiple postvention services supporting people bereaved by suicide in the UK, suggesting a need for postvention research in the UK. Two studies highlighted that mixed methodology studies were more effective in identifying insights through qualitative interviews that cannot be discovered using quantitative methods (Jordan, 2001; Jordan & McMenamy, 2004). Quantitative methods are limited in teasing out how contexts of postvention impact the outcomes. Qualitative methods, specifically the phenomenological approach, which seeks to understand the lived experience of the respondents, are inherently designed to assess a phenomenon in its natural setting and context (Moustakas, 1994). Andriessen and Krysinska (2012) posed essential questions on suicide bereavement and postvention and conclude that “the voice of survivors should be included in public health policies related to suicide prevention as well as involved in design and implementation of postvention programs and studies” (p. 29). Therefore, conducting a systematic review that considers non-controlled studies that assess the effectiveness of suicide bereavement support interventions is crucial. This will help to determine whether a non-controlled approach yields stronger quality of studies that also allow us to gain insight into the experience of being bereaved by suicide, creating services that provide a good standard of support. No recent reviews have included non-controlled and qualitative studies.

This systematic review has two aims, firstly to assess research which evaluates postvention services supporting those bereaved by suicide and secondly it aims to assess the acceptability of methods of postvention in terms of community support, peer support, group support and internet support.

The objectives in this review are to:

1) Identify and assess international research which evaluates postvention services and methods of postvention
2) Examine evidence for suicide postvention services that aim to prevent suicide
3) Examine and identify outcomes used to evaluate the effectiveness of suicide postvention services
4) Identify components of effective suicide postvention services

2.3 Method

2.3.1 Review Questions

1) How do suicide postvention services support those bereaved by suicide?
2) What outcomes are used to assess the effectiveness of postvention services?
3) How effective are suicide postvention services in supporting those bereaved by suicide?
4) Can effectiveness of these services be measured and quantified?

2.3.2 Literature Search

Electronic databases were searched to identify relevant published studies that met the inclusion criteria for this systematic review. The databases included were: PSYCINFO, CINAHL, MEDLINE, Scopus, Web of Science, Science Direct, EMBASE, TRIP, Cochrane Library, AMED and Google Scholar.

General searches were then supplemented with more specific searches for postvention services or interventions. Lateral search techniques were then implemented to search through citations used in primary studies and other systematic reviews.

2.3.3 Search Terms

1) Suicid* OR “taking your own life”
2) Postvention OR support OR counselling OR counseling OR “peer support” OR “support service*” OR “self-help group” OR “postvention liaison service*” OR liaison
3) Bereave* OR grief OR mourning
4) Effectiveness OR impact OR acceptability

2.3.4 Inclusion Criteria

Qualitative and quantitative peer-review studies. This included interviews, focus groups, intervention studies, and experimental designs and process evaluations. Studies focusing on suicide postvention were included. No geographical restrictions were applied. Postvention services offering support to adults and children were considered. Any relationship to the deceased was included, such as studies that evaluate services that offered support to any relative or friend. As those accessing support services may be experiencing mental health issues, studies including those individuals as participant groups were included. Studies were included if they reported on suicide postvention services and their effectiveness and the acceptability of a method of postvention. As the goal of most suicide postvention services is to prevent suicide, suicide-related outcomes were the primary outcome of interest, postvention studies will also be included if they measure other mental health or well-being change such as self-harm, psychological factors. Peer support groups were also considered.

2.3.5 Exclusion Criteria

Studies reporting on prevention services and therapeutic interventions were not included, as this review focuses on postvention services. Studies and grey literature written in other languages that had not been translated into English were not considered.

2.3.6 Comparator/Control

Some studies included within this review compared intervention outcome with a control group or treatment-as-usual, another intervention or no intervention group.

2.3.7 Screening

Electronic search results were downloaded into Microsoft Excel (*n* = 2808). Duplicates were then removed (*n* = 890). Titles and abstracts were screened against the inclusion criteria (*n* = 1918). Systematic reviews and policy/practice guidance documents were screened for primary studies. One researcher then screened full papers, with the rest of the research team screening 1/3 of the full papers each. Any disagreements at this stage were blindly assessed by a different member of the research team and discussed. Full papers were then screened (*n* = 315). The final number (*n* = 36) of studies included were then agreed upon, rejecting studies which were not written in English, evaluated counselling interventions and prevention services, and did not evaluate postvention support services (See Figure 6). At this stage, results were divided into papers which were evaluations of a specific postvention service, and papers which looked at the acceptability of methods of postvention.

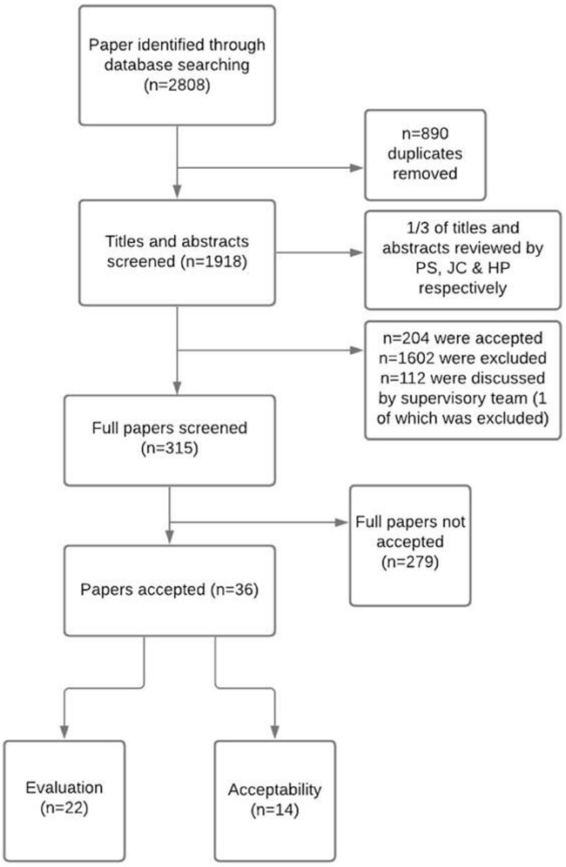

Figure 6: Flow diagram depicting the flow of information through the different phases of a systematic review.

2.3.8 Data Extraction

Data extraction from all studies were conducted by the primary author to a Microsoft excel database. Study types were classified as: outcome evaluation, process evaluation, economic evaluation, methodological evaluation, intervention development, protocols, descriptive, qualitative studies, and systematic or literature reviews. The research team conducted a data extraction quality assurance check and 2/3 of the research team blindly rated 10% of evaluation papers and 10% of acceptability papers.

The data which was extracted from each study is highlighted below:

1. Study characteristics: Author, publication year, location of study, study design, age range of participants, gender of participants, time since

bereavement and relationship to deceased

2. Intervention characteristics: Type of intervention, setting, characteristics of intervention, duration/frequency of contact
3. Study outcomes: Outcome measurement approach used (e.g., qualitative and/or quantitative), baseline mean (SD) for intervention group and any comparison group if used (e.g., control), endpoint mean (SD) for intervention group and comparison group if applicable (e.g., control group) and intervention effect as reported within the paper. Outcome measures and timepoints.
4. Secondary study outcomes/process outcomes: acceptability, feasibility and satisfaction

2.3.9 Strategy for Data Synthesis

Data was collected and analysed according to type of study design and outcomes. A narrative synthesis was conducted which included ‘evidence statements’ as this summarised the results of the studies taking into account the key issues relevant to the review questions.

2.3.10 Risk of Bias Quality Assessment

Methodological quality was evaluated by the primary researcher using guidelines stipulated in the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018). Two members of the research team then blindly assessed 10% of the papers in each group. Discrepancies from independent screening, data extraction, and quality assessment were resolved through discussion and where appropriate by a third reviewer within the research team.

2.4 Results

Thirty-six studies were included. These studies were then divided into (1) research evaluating specific postvention services (*n* = 22) and (2) research evaluating the acceptability of models of postvention (*n* = 14). From this point onwards, we will discuss the results of each of these categories separately.

2.4.1 Studies Evaluating Specific Postvention Services

Twenty-two studies met the inclusion criteria (see Table 3). Table three details study characteristics. Included studies involved services from UK (*n* = 2), USA (*n* = 6), Australia (*n* = 6), New Zealand (*n* = 1), Canada (*n* = 3), Italy (*n* = 1), Ireland (*n* = 1), the Netherlands (*n* = 1), and Korea (*n* = 1). Where participant demographics such as ages and genders were discussed, this was included in the table. Nine of the studies used mixed methods. One study was a secondary analysis. Three studies were qualitative. A further nine studies were quantitative. The most common type of postvention intervention was community-based services (*n* = 13), one of these was a cost-effective analysis of a community-based evaluation. Two of the community-based interventions were an art community-based service and a further one was a writing and performative community-based intervention. Other types of interventions included group interventions (*n* = 6), internet resource (*n* = 1), school-based intervention (*n* = 1), and an internet-based forum (*n* = 1). The most common service to be evaluated was the Standby service in Australia, with four studies evaluating this service, one of which being the cost-effective study. Standby is a community-based postvention service that is funded by the Australian government and offers twenty-four-hour, 7 days a week support to anyone bereaved or affected by suicide. The Local Outreach to Suicide Survivors (LOSS) service in the USA featured in two of the studies. A LOSS Team is an active model of community-based postvention. The team is made up of suicide survivors who have been trained to assist the bereaved at the scene of a suicide by providing support.

Table 3: Characteristics of studies evaluating specific postvention services.

Study ID & Location	Study Design	Type of Intervention	Participant Information	Outcomes measured	Summary of results
Ali & Lucock (2020), UK	Qual - interviews	Group Intervention - SOBS	N=22, 16 were females and six were males.	The impact of SOBS groups, questions based on life before the suicide, the suicide, and life after suicide.	Make sense of the suicide through meeting likeminded people. SOBS helped participants gain a greater understanding of their own experience through the process of sharing and hearing other's stories. Put experience into perspective. Helped to find resolution that they could not have prevented the death.
Gehrmann et al., (2020), Australia	Quant – A retrospective cross-sectional study	Community - based intervention - StandBy	N=545. 84% female. 121 intervention group participants, and 424 control group participants	Compare outcomes between people bereaved by suicide who had accessed StandBy (intervention group) and those who did not access StandBy (control group). Suicidality (SBQ-R), grief reactions (GEQ) and social isolation (DLS) measured.	Participants in recent loss <12 months significant group differences on four of the outcome variables, with the intervention group scoring significantly lower on the SBQ-R, the grief reaction of loss of social connections, and social loneliness, but significantly higher on the grief reaction of responsibility compared with the control group. No significant difference between participants with: loss >12 months; risk of suicidality; outcome variables based on type of support received.
Maple et al., (2019), Australia	Mixed Methods – Descriptive quant data & interviews	Community - based intervention - Standby	Quant N=2,748 service users. Qual N=6 Standby female staff	The impact of Standby on service users and individuals providing the support measured through service usage data routinely collected by Standby, and semi-structured interviews.	The numbers of people accessing StandBy demonstrates the continuing and increasing need for suicide postvention support, as prevention. StandBy coordinators evidenced that working with people bereaved by suicide impacted the workers but negative feelings did not last long. The importance of consistent and appropriate support and external supervision for workers cannot be underestimated. Workers were passionate about supporting people through suicide bereavement. Appropriate organisational mechanisms that allow for time away from work and the ability to effectively "switch off."

Peters et al., (2015), Australia	Mixed Methods – surveys and interviews	Community-based art	Quant n= 82 bereaved individuals. Qual n=30 bereaved individuals interviewed.	Satisfaction with the project and themes reflecting the experience	Scores indicated that the Quilt was helpful in assisting participants in their bereavement. Interview data highlighted 4 themes: healing, creating opportunities for dialogue, reclaiming the real person and raising public awareness.
Kramer et al., (2015) The Netherlands	Mixed Methods - pre and post study & innterviews	Two web-based forums	N=270 forum users. 87% female. Mean age of 42.9 years.	Baseline, 6-month and 12- month follow-up questionnaire for depression, well-being and grief. Frequency of use, and expectations and benefits from using the forum were also assessed.	At 12 months, there were small to medium-sized significant improvements in well-being and depressive symptoms ($p < .001$) and nearly as much for grief ($p= .08$). About two thirds reported benefit from visiting the forum. There was no significant change in risk of suicide.
Veale (2015), Ireland	Mixed Methods- Longitudinal & interviews	Group intervention	N = 5, children aged 8-12 years. N=3 children took part in follow up focus groups 4 years post-intervention	Child behaviour checklist, social relationships, functioning, and interviews.	Meaning making: participation in the group helped them to remember and to construct a narrative of the suicide. Follow up focus group showed how children: took leadership roles in their schools on suicide, suicide bereavement and prevention; contacted a national leader on youth mental health; raised funds and set up a school-based programme running a drop-in in the school for young people affected by suicide or to gain support if they are having problems; took an active role in suicide awareness and prevention in school. The group intervention had a multiplier effect as these adolescents reached out to their peers and mobilised adults to engage with them on suicide-related interventions. This was an unanticipated outcome. All former participants said they found the intervention very positive and timely.

Aguirre & Terry (2013), USA	Mixed Methods	Community-based intervention - LOSS	Quant N=68 bereaved familial and social network. Qual N=8 survivors, 2 team members and 1 counsellor from a referring police department.	The impact of the LOSS Team services delivered in TC was measured in two ways: (1) time elapsed between death and access of services—measured quantitatively through case notes of those receiving a LOSS Team contact; and (2) an examination of the role of the LOSS Team in the grief process—investigated through phenomenological interviews	The LOSS team serves an important role in helping survivors connect to life- saving resources, encouraging belongingness. The LOSS Team helped participants connect with therapy, grief support services and with other survivors. Findings included that time elapsed between the suicide and accessing services did decrease from an estimate of 4.5 years without an Active Postvention Model like the LOSS Team to an average of 34 days. Significant impact of the LOSS Team on survivors' grief processes.
Visser, Comans & Scuffham (2014), Australia	Quant – A retrospective cross-sectional study	Community - based intervention – Stand-by	Intervention N=90. Control N=360. Intervention participants were matched with controls in a ratio of 4:1 to maximize the power of the study to detect differences between groups.	Health outcome variables K6, SBQ-R, EQ-5D and ICECAP	StandBy clients scored higher than the control group on all four measures. Only one difference reached statistical significance – level of suicidality ($p = 0.006$).StandBy clients and control group participants at high risk for suicidality (SBQ-R score above 7; 48% and 64% respectively) showing that StandBy clients were significantly less likely to be at high risk ($p = 0.005$). Participants of both groups had high rates of absenteeism. Those not employed were more impacted than those employed, with participants from both groups reporting they were unable to perform their usual activities for around 6 of the previous 28 days. Both groups averaged approximately one GP visit in the past 4 weeks.
Ryan, Lister & Flynn (2013), Australia	Mixed Methods – questionnaire including open	Performative community-based intervention	N=20 writing workshops. N=15 completed both writing and performance components.	Quantitative measure – the Kessler psychological distress scale which measures well- being, and a number of open- ended questions designed to elicit qualitative responses.	Mean scores on the Kessler psychological distress scale improved overall i.e., there was a significant decrease from 21.36 to 16.36, ($p= 0.05$). Participants' feedback via responses to open-ended questions in the three evaluation questionnaires and in the interviews was highly positive.

	ended Questions				
Hawton et al., (2012), UK	Mixed Methods	Online resource	N=12 completed questionnaires were returned.	Descriptive of individuals accessing the resource, rating the resource and general feedback.	Large numbers of copies of *Help is at Hand* were obtained by a range of organisations, but far fewer directly by individuals, although the resource was extensively accessed online. Most respondents were positive about the format and content, specifically sections on experiencing bereavement and practical matters relating to the death. The main complaint was delay in gaining access to *Help is at Hand*.
Barlow et al.,(2010), Canada	Mixed Methods – interviews and surveys	Community - based peer intervention	N=16 (13 women, 3 men), 7 clients and 9 peer supporters. 16 completed one or both of the checklists; 13 completed the pre- and post-measurement.	Hogan's Grief Response Checklist and the qualitative data. Initial assessment interviews and post-meeting surveys.	Both the supporters and clients reported benefits from this intervention. Strengths of intervention included being matched with a peer supporter who experienced a similar bereavement. Before the intervention, the peer supporters generally had higher functional scores in all six behavioral aspects than their counterpart clients. After the intervention, clients scores had improved in three out of six means were statistically significant ($p < 0.05$): despair, detachment, and disorganisation.
Comans, Visser & Scuffham (2013), Australia	Quant- Cross-sectional	Cost-effectiveness of a community-based intervention - Standby	Control group N=670. Intervention N=90. Match ratio of 4:1.	A Markov model was constructed to estimate the health outcomes, quality-adjusted life years, and associated costs such as medical costs and time off work.	The StandBy service dominated usual care with a cost saving from providing the StandBy service of AUS $803 and an increase in quality-adjusted life years of 0.02. Probabilistic sensitivity analysis indicates there is an 81% chance the service would be cost-effective given a range of possible scenarios.

Cha et al.,(2018), Korea	Quant - cohort study	School-based intervention	N=956 (506 girls, 450 boys). Participants divided into two groups according to scores on the Child Report of Post-Traumatic Symptoms scores at baseline assessments. Students with a score of 19 or higher were classified as ‘trauma group’. Scores of less than 19 were classified as ‘non-trauma group’.	Post-traumatic symptoms, PTSD diagnostic criteria, Beck Anxiety Inventory, Beck Depression Inventory, symptoms associated with loss	At baseline and five months follow-ups, 8.6% and 2.9% of the students showed post-traumatic stress symptoms. At five months follow-up, there was a statistically significant decline in the post-traumatic stress symptoms, anxiety, depression, and complicated grief among the ‘trauma group’ (p=0.00). A higher proportion of the female students showed post-traumatic stress symptoms after the incident of peer suicide than the male students.
Scocco, et al., (2018), Italy	Quant – Longitudinal prospective study	Community-based weekend retreats	N=61, 14 of whom took part in 2 or more retreat weekends (multiple participation). 80% women. Mean age of 49.5 years.	Sociodemographic data, The Five-Facet Mindfulness Questionnaire, The Self-Compassion Scale, The Profile of Mood States (POMS)	A significant reduction in all dimensions of the POMS (except Vigor-Activity) and lower levels of overidentification were observed after the retreat.
Bowden (2011), New Zealand	Mixed Methods	Community-based intervention - WAVES	Not included	End of programme questionnaire and focus interviews on service user satisfaction.	Value given to the structured programme, the expertise of the facilitators in creating a safe and supportive environment, and the opportunity to connect with and gain support from a community of fellow grievers. Some changes were initiated by the facilitators following reflection on process evaluation, delivery and new emerging research.

Cerel & Campbell (2008), USA	Secondary data analysis	Community-based intervention - LOSS	Differences in those who received an Active Model of Postvention (APM) (N=150) and those who received a traditional passive postvention model (PP) (N=206)	Current and lifetime symptoms, history of psychological and prior mental health treatments. Suicide attempts. Information on deceased,	APM presented for an intake sooner than PP. APM were more likely than PP to attend any support group meetings and attended more groups than PP. APM were no more likely than those who did not have received mental health treatment before the death, to report current suicidal ideation at the time of their intake or to have a history of suicidal ideation or attempt prior to the death.
Mitchell et al., (2003), USA	Qual	Group intervention	N=7 individuals bereaved by suicide attended a group for all or 6/8 sessions.	Both agentic and victimic narratives are identified in accounts of loss each member shares within the suicide bereavement group.	Participants in the suicide survivor support group frequently reported heightened well-being and a personal sense of community through sharing their narratives of loss with each other. Observations of how participants responded to and modified narratives in the group intervention suggest that Polkinghorne's (1996) paradigm has value as a therapeutic tool.
Pfeffer et al., (2002), USA	Quant	Group intervention	52 families (75 children) were eligible and assigned in alternating order to receive (27 families, 39 children) or not to receive (25 families, 36 children) the intervention	Changes in anxiety and depressive symptoms, using the Beck Depression Inventory, the Childhood Posttraumatic Stress Reaction Index, The Children's Depression Inventory, The Revised Children's Manifest Anxiety Scale and the Social Adjustment Inventory for Children and Adolescents.	Non-intervention children had poorer social adjustment than children assigned to the intervention ($p<.005$). Significantly higher dropout rates in Non-intervention children ($<.0001$). Greater reduction in anxiety ($p<.01$) and depression ($p<.0006$ for children in intervention group than non-intervention children.

Constantin o, Sekula & Rubinstein (2001), USA	Quant	Group intervention	N=60 widows randomly assigned to Bereaved Group Intervention (BGP) or Social Group Postvention (SGP).	Changes in depression, psychological distress, grief and social adjustment.	Statistically significant changes were found on all measures when the SGP and the BGP were combined for analyses on posttreatment assessments 3 to 5 days after completion of the group intervention, and 6 months and 12 months after the intervention (p<.0001). Participants experienced a significant reduction in 6 of the 9 subscales, depression, psychological distress, and grief, as well as an increase in social adjustment (p<.0001).
Strouse, Hass-Cohen & Bokoch (2021), USA	Mixed Methods	Art intervention	N=39 adults	Quant – social validation, developing new possibilities, relating to others. Qual – themes of bereavement processing, sharing, collaboration, relaxation and positive contributions to the art experience.	Social sharing of meaning-making was particularly impactful, as evidenced by the significant improvements in social validation and invalidation scores. There was a decrease in feelings of interpersonal invalidation. There was a significant increase in new possibilities; two aspects of posttraumatic growth; relating to others; feelings of validation. No significant results for total PTGI scores; personal strength; spiritual change. Qualitative themes provided insight into the significance of validation, bereavement processing and sharinng and collaboration. Sharing with the studio facilitators was more frequently reported as a key aspect of the studio than sharing with peers.
Rogers (1982), Canada	Quant	Community-based intervention and group intervention	N=53 adults, 47 were female. The median age of 40.3 years. N=33 responded to the follow up Survey	Rating a list of 8 program goals. Rating social support.	Participants reported that the program helped by putting the suicide in perspective, so it does not drain energy and emotions; providing a safe space to express feelings without being judged; and talking about the suicide. 2 out of 33 follow up survey respondents reported being uncomfortable with the format of the meeting with 2 volunteers.
Renaud (1995), Quebec, Canada	Quant	Group intervention	N=8	Anxiety, depression. Ability to meet own goals and objectives.	Significant decreases in depression and anxiety. Individuals were able to meet their own goals and objectives.

2.4.2 Studies Evaluating the Acceptability of Models of Postvention

14 studies met the inclusion criteria (see Table 4). Table 4 details study characteristics. Included studies originated from Canada (*N* = 1), Sweden (*N* = 2), USA (*N* = 5), Australia (*N* = 1), Ireland (*N* = 1), Norway (*N* = 1), the UK (*N* = 1), New Zealand (*N* = 1), and Finland (*N* = 1). Three of these studies were mixed methods, 8 were qualitative and 3 were quantitative. These studies did not evaluate a specific service but did assess the acceptability of a method of postvention. These methods include general support (*N* = 2), health services (*N* = 2), peer support (*N* = 1), teachers (*N* = 1), community providers (*N* = 3), internet support (*N* = 3), group support (*N* = 1) and Critical Incident Stress Debriefing (*N* = 1).

Table 4: Characteristics of studies evaluating acceptability.

Study ID & Location	Study Design	Type of Intervention	Participant Information	Outcomes measured	Summary of results
Ligier et al., (2020), Montreal, Canada	Mixed Methods	Medical/pharmacological, information, support and outreach	N=29. Mean age of participants 57.7 years. 23 were women.	Emotional experiences post suicide death notification and how long they lasted. General physical health, mental health and problems/difficulties post suicide. Personal or family history of suicide. Semi- structured interview guide from the five items of the Brief Grief Questionnaire. Usefulness of resources. Depression and anxiety (Patient Health Questionnaire, PHQ-9 and GAD-7.)	Interviews revealed that those who did not receive professional help post suicide felt they might have benefitted from such help, they would have liked to receive a call from a professional within 66 days after the suicide. At the time of the death notification, participants felt shocked by the death, sad/discouraged, and angry. At the time of being surveyed, participants felt at peace, sad/anxious, and loss. Recommendations included: support from physicians and/or nurse practitioners; first responders should be responsible for signposting support resources; access to support groups and other services; outreach needs for resources and practical support within the first 6 months; a need for suicide pre/postvention training and delivery.
Pettersen et al., (2015), Sweden	Qual	Health services	N=18 suicide-bereaved siblings (13 women). At the time of the interview, two participants were between 15–20 years old, seven were between 21–30 years old, and nine were between 31– 38 years old.	Indepth interviews, narrative of important events and experiences related to the sibling's suicide. Two questions asked at the end of the interview surrounding experience of health services support after the suicide.	Participants reported needing professional support after their loss, and most sought help. The professional support included a one-time appointment with a physician in an emergency unit to consecutive sessions with a psychologist, psychiatrist, school nurse, or counselor. Reasons for seeking help from health services included: to cope with grief responses; facilitate social relationships; and search for reasons leading to the suicide. Reasons for not seeking help included: lack of trust in health services, inability due to overwhelming grief responses, and no need for help. Recommendations included: immediate and repeated contact, empathic and personal meetings,and information and grief-related support.

Bartone et al., (2018), USA	Qual	Peer support	N=10 individuals with experience in managing peer support programs for bereaved in military, law enforcement, and emergency responder communities. 6 women and 4 men. Age ranged from 41 to 75	Experts were asked to present their views on what makes for a successful program providing peer support for bereaved survivors.	Findings indicated that effective peer support programs for the bereaved should be easily accessible; confidential; provide a safe environment; use peer supporters with similar shared experiences to clients; select peer supporters carefully; partner with professional mental health providers; train peer supporters thoroughly; and provide care and monitoring for peer supporters.
Feigelman, Sanford & Cerel (2020), USA	Quant	Primary care physicians	N=146 bereaved respondents reporting suicides as causing them severe emotional distress. Mean age of 52 years. 83% female.	Grief experience questionnaire, mental health functioning, perceptions of responses from physicians.	48% of the respondents encountered positive, help-offering responses from physicians, compared to 10% whose responses were deemed as negative. Experiences included: doctor expressed a negative opinion about loved one or the way they died, said things that were hurtful or dismissive, offered medication to help, suggested a referral to mental health resources, suggested resources in the community such as a support group, doctor told patient about a similar loss they had experienced. Physicians' positive and help rendering responses greatly outnumbered negative and dismissive responses.
Farragh	Qual	Teachers	N=6 retired teachers.	Interview questions	Teachers reported: feeling unprepared to support students who

(2019), USA				surrounding teachers' preparedness to support students affected by the death of a classmate, policies and procedures within the school, how the policies are implemented and how does a school counsellor influence teacher support and impact the response to students who return to school after a death by suicide.	returned after a death by suicide; that the school counselor is critical/essential to supporting them in the classroom with crisis response; that the school counselor demonstrated expertise and leadership when dealing with a critical incident such as a death by suicide. Emergent themes indicated teachers were: unaware of policies related to supporting students after a death by suicide; unaware of policies that directly influenced the crisis response of a death by suicide; aware that a school crisis committee existed, but it was questionable about who or how the school crisis plan, if existent was implemented; supporting students after a death by suicide, with or without policy. Although a culture of caring existed, there were inconsistencies in how individual teachers responded to students after a death by suicide and that a formal plan did not exist.
Goodwin-Smith et al., (2013), Australia	Qual	Community support aimed at Aboriginal suicide	Throughout 2011, focus groups were held with Aboriginal service providers and health workers in four regions of metropolitan Adelaide (North, Central, West and South, with six, six, five and 10 participants respectively). Fifteen individual semi-structured interviews were also held with Aboriginal people who have been personally bereaved by suicide	Questions surrounding the support the community needs, the experience of suicide within the family, what aspects of the service would appeal to Aboriginal people, how services could be improved, what support is already in place and what other kinds of support would be helpful. Cultural considerations and barriers to accessing services are asked about.	A valuable suicide postvention service that would be significantly enhanced if postvention work was harnessed to serve Aboriginal people and communities who suffer disproportionately from suicide bereavement. Themes indicated: the usefulness that the service can offer bereaved Aboriginal people and lessons learnt from Aboriginal people about service delivery. In partnership and through a service delivery model which involves Aboriginal input, these assets are capable of constructively mitigating Aboriginal grief. This potential enhancement of postvntion as a social service demonstrates the utility of a genuine process of 'walking together'.

Trimble, Hannigan & Gaffney (2012), Ireland	Qual	General postvention support (social support, support groups).	Ten participants, five male and five female bereaved by the suicide of a close family member.	Questions guided participants to report on experiences accessing social, community and professional support networks	Themes included helpfulness of social support, support groups as a vehicle to contextualise and normalise feelings, desire for understanding and knowledge from professionals, acknowledgement of traumatic nature of bereavement. The study showed that trauma focused interventions benefited survivors who also reported the desire for greater access to networks and the further development of proactive networks of support.
Dyregrov (2002), Norway	Mixed Methods	Community-based local authority	A questionnaire developed for this study maps the extent of professional community support as reported by parent survivors (N =128). Additionally, 41 survivors described the quality of the assistance through in-depth interviews	Extent of professional community support and quality of assistance. Another questionnaire assessed the provisions and the organisation of intervention strategies in the local communities.	85% of the parent survivors reported that they had experienced contact with community professionals. The communities reported that the medical doctor, the psychiatric nurse, and the public health nurse were common helpers, however survivors reported the undertaker to be a significant helper, more than what is reported by the local authorities. Supportive counseling was received most, followed by support groups. Local authorities reported differently on service use than survivors following bereavement by suicide.
Tiatia-Seath, Lay-Yee & von Randow (2019), New Zealand	Mixed Methods	Community-based	Pacific communities and service providers. Online survey component n=70 Pacific service providers included professionals, social workers, nurses, spiritual leaders.	Survey used a structured questionnaire consisting of close-ended (quantitative) and open-ended (qualitative) items.	Service providers were no more aware of postvention resources available than community respondents. Provider respondents were unaware of group discussions (or fono) as a resource. Over a quarter of provider respondents were dissatisfied with resources available, while almost a quarter felt the materials had limited or no effectiveness. These findings indicated that suicide postvention support could be improved by training service providers to be more informed of resources and particularly of fono as a culturally appropriate resource. Provider respondents reported that health professionals, churches, and community leaders were best placed to lead suicide postvention initiatives.

Chapple & Ziebland (2011), UK	Qual	Internet support	N=40 narrative interviews. 28 women.	Narrative interviews with a semi-structured interview guide which was used to explore relevant issues that did not emerge in the first part of the interview. This included where they found help and support.	A few people preferred not to use the Internet for this purpose or had no access to a computer. Few adverse consequences of Internet communities were mentioned. In conclusion it was found evidence that the Internet transformed the experience of bereavement by suicide, most dramatically through providing access to other people's experiences.
Feigelman et al., (2008), USA	Quant	Internet support groups	Taken among parents who sustained the loss of a child to suicide this study explores the participation of parents in Internet support groups, comparing their demographic and loss- related characteristics (N = 104) to other parent survivors participating in face-to- face support groups (N = 297).	The Grief experience questionnaire, the family/social strain scale, the family unhelpful response scale, the social unhelpful response scale.	Similar levels of Internet use were reported in under-served rural areas, urban, suburban, small city and rural residents for both Internet and face-to-face subsamples. Several factors contributed to interest in Internet grief support including: 24/7 availability and opportunities to invest more time into this type of support group experience. Compared to their face-to-face group counterparts, Internet users experienced greater suicide stigmatisation from their families and other associates. Unable to find comfort and support from their personal communities, Internet users—and especially highly depressed survivors—sought and obtained valuable help from the Internet support resource. Only six respondents remarked that the Internet support group contributed to worsening their feelings of depression, while 14 others commented that they perceived this group as their lifesaver, helping them to stay alive after having come to their lowest point of depression and despair.

Pietilä (2002), Finland	Qual	Group interventions	N=16 interviews with bereaved parents and (adult) children, half of whom had attended a bereavement support group after their family member's suicide.	Ethnomethodological study of 16 qualitative interviews with parents and (adult) children concerning their experience of a (respective) family member's suicide.	Half were in bereavement support groups, acting as storytellers and recipients of other people's stories, influencing their understanding of their family member's suicide and bereavement. Interviewees appreciated talking in support groups, sharing with peers had validated their own experience. They described how group members had formed a 'safety net' amongst themselves. They did not have the need to defend themselves, but did with people outside the experience, or to protect them as they had done with their families. In an 'anonymous' group, the interviewees had found it easier to be just one of the many, particularly in contrast with their family in which they had to perform other social roles and show attendant feelings. Only in support groups was it possible for them to talk about their suicide bereavement as individuals, without taking into account the emotions and experiences of their intimate circle.
Juhnke & Shoffner (1999), USA	Qual	Adapted Critical Incident Stress Debriefing	N= 11 families and older siblings. No further information is given.	General comments and anecdotal evidence. No further information is given.	Anecdotal evidence gathered from surviving parents and older sibling survivors suggested that the process has been helpful. The Family Debriefing Model provided a forum where they could discuss the suicide and its effects on the family. Prior to the Debriefing Model experience, many family members would isolate themselves and grieve individually without openly discussing their feelings of guilt, anger, and fear of future family suicides, which appeared to have inhibited familial interpersonal support and communications. The Family Debriefing Model encouraged members to mutually discuss these feelings and perceptions, suggesting that following the Family Debriefing Model, family members experienced reduced feelings of anger, anxiety, depression, guilt, and fear of familial suicide.

Westerlund (2020), Sweden	Quant	Internet based individual support	N= 327 suicide bereaved responded to the survey.	21 questions with fixed response alternatives and one open-ended question. Demographic information perceived psychosocial consequences that following the loss, satisfaction with current psychosocial health, evaluation of the different resources that were used.	The results showed that psychosocial ill-health was severe among the suicide bereaved participants and that a majority used digital resources. The propensity to engage in online support groups or memorial websites was not predicted by the severity of psychosocial consequences following the suicide. However, multiple regressions showed that higher online support group activity predicted more satisfaction with current psychosocial health, while memorial websites seemed to have the opposite effect. Some digital resources, for example, online support groups, may be an effective way of coping with grief related to suicide loss, but also suggesting that memorial websites may increase rumination and cause emotional distress.

2.4.3 Quality Assessment

Evaluating Specific Postvention Services

The quality of all the 22 studies was assessed using the Mixed Methods Appraisal Tool (MMAT) (Hong et al., 2018), using the corresponding tool for the methodology of each study. Studies scoring 1 or 2 out of the 7 questions were rated as low quality. Studies scoring 3, 4 and 5 out of 7 questions were rated as medium quality. Finally, studies scoring 6 or 7 out of the 7 questions were rated as high quality (Hong et al., 2018).

Of the 22 studies evaluating a postvention service, four were rated as low quality (Aguirre & Terry, 2013; Bowden, 2011; Renaud, 1995; Rogers et al., 1982). This was due to studies not having explicit research questions and not clearly stating how the collected data addressed the research questions. The mixed methods study (Aguirre & Terry, 2013) did not adhere to the quality criteria for each tradition of the methods involved. Furthermore, it was difficult to assess whether there was an adequate rationale for using a mixed methods design and whether each component of the study was effectively integrated to answer the research question. The research questions were also unclear. The qualitative study (Bowden, 2011) was unclear in all questions relating to the qualitative methodology as it did not clearly state the evaluation aspect of the paper but was more of a descriptive paper on the service. The two quantitative papers rated as low (Rogers et al., 1982; Renaud, 1995) did not have a sample that was representative of the target population and had high nonresponse rates. There were five studies that were rated as medium quality. Two were mixed methods (Veale, 2014; Strouse et al., 2021) and they had issues in reporting on the risk of nonresponse bias, addressing the rationale for using a mixed methods approach and integrating the different components of the study effectively. Furthermore, inconsistencies between the quantitative and qualitative results were not discussed and the quality criteria for the qualitative methods was not wholly adhered to. One qualitative study was rated as medium quality (Mitchell et al., 2003) due to not clearly stating the research questions and whether the data collected would address the research questions. There was a lack of clarity as to whether the qualitative approach chosen and data collection methods were appropriate to answer the research question. One quantitative study was rated as medium quality (Gehrmann et al., 2020) due to incomplete outcome data, low response rate and the intervention group (*n* = 121) being significantly smaller than the control group (424). Finally, there were 14 studies assessing a postvention service that were rated as high quality; six were mixed methods (Maple et al., 2019; Peters et al., 2015; Kramer et al., 2015; Ryan et al., 2013); Hawton et al., 2012; Barlow et al., 2012). They were rated because they had adhered to the quality criteria of both the qualitative and quantitative methods and integrated these aspects to address the research questions. There was also explicit and adequate rationale for using a mixed methods approach. Seven studies rated as high were quantitative (Cerel & Campbell, 2008; Scocco et al., 2019; Cha et al., 2018; Visser et al., 2014; Comans et al., 2013; Pfeffer et al., 2002; Constantino et al., 2001). One study rated as high was qualitative which evaluated the SOBS group intervention (Ali & Lucock, 2020). These studies met six or all the methodological quality criteria. The studies that met six of the criteria had some issues with confounding variables (*n* = 2; Scocco et al., 2019; Comans et al., 2013) and the sample was not representative of the target population (*n* = 1; Constantino et al., 2001).

Of the 14 studies included in the acceptability section of this review, one study was rated as low quality, two studies were rated as medium quality and 11 were rated as high quality. The study rated as low quality (Juhnke & Shoffner, 1999) had insufficient empirical data, relying on general comments and anecdotal evidence for the efficacy of a debriefing model for postvention support. It did not outline clear research questions, data collection methods or analysis. Therefore, further research is needed to assess the acceptability of a debriefing model as postvention support. Both of the general postvention models were rated as high quality (Ligier et al., 2020; Trimble et al., 2012). Similarly, both of the health models of postvention support were also rated as high quality (Pettersen et al., 2015; Feigelman et al., 2020). Of the studies assessing the acceptability of web-based models of postvention support (*n* = 3), one was rated as medium quality due to its inability to assess the risk of non-response bias and the sample not being representative (Feigelman et al., 2008). The remaining two studies assessing web-based models were rated as high quality (Chapple & Ziebland, 2011; Westerlund, 2020). One study assessed a postvention model which was led by teachers was also rated as high quality (Farragh, 2018). A study evaluating a peer-led postvention model was rated as high quality (Bartone et al., 2018), as was the group postvention model (Pietilä, 2002). Of the three studies evaluating community-based models of postvention, two were rated as high quality (Goodwin-Smith et al., 2013; Tiatia-Seath et al., 2019). The third study was rated as medium quality (Dyregrov, 2002) (Tables 5 and 6).

Table 5: Quality assessment of studies evaluating specific postvention services.

Study ID	Main threats to validity	MMAT Score
Ali & Lucock (2020)	The sampling and recruitment strategy. The majority of participants were white British females or parents who had lost a son. Recruitment was for individuals who attend peer support groups which excludes those bereaved by suicide who do not access this support.	6 - Medium
Gehrmann et al., (2020)	Use of a cross-sectional design, it was not possible to determine changes in outcomes over time. The low response rate among StandBy clients, the use of convenience sampling, and selection bias towards females may have resulted in a sample that might not be representative of all people bereaved by suicide. Likewise, the intervention group (StandBy clients) willingly accessed StandBy after their loss. It is possible that individuals who seek support may have better coping skills than individuals who do not access support, which may have contributed to improved outcomes of StandBy clients compared with the control group. The use of an online survey may have led to self-selection bias	4 - Medium
Maple et al., (2019)	The variability of the data was a significant limitation of the study, in some areas there were high levels of missing data. For example, some of the fields with high levels of missing data include ‘time between suicide and support session’, was not recorded for 46% of clients, “Clients exposed to prior suicide” not recorded for 44%, “Location postcode” 23% not recorded.	6 - High
Peters et al.(2015)	Sampling bias as it was mainly women who participated. A further limitation to this study was that people who participate in Quilt projects are not necessarily representative of all suicide survivors.	6 - High
Kramer et al., (2015)	The 270 participants were mostly female, low in well-being, with high levels of depressive symptoms and complicated grief. Suicidal risk was high for 5.9%. Because of the pre–post design we cannot determine whether a causal relationship exists between the form and changes in mental health.	6 - High
Veale (2015)	Only 3 children took part in the follow up. Relatively small sample size for the study n=5. The 3 children at follow up reported it would have been nice to have a male facilitator as all facilitators were female. Lack of control group.	4 - Medium
Aguirre & Terry (2013)	First year evaluation, which doesn't show long-term effects of the service. Not a quant evaluation as it is an audit of beneficiaries' information.	2 - low

Visser, Comans & Scuffham, (2014)	The observational design of this study means that bias may be present, and the direction of this bias is difficult to assess. Respondents were self-selected and there may have been systematic differences between those who chose to be included and those who did not. This means that the results may not be transferable to all people bereaved by suicide. The low response rate by StandBy clients (23%) may also have influenced the results. Despite matching the samples of the two groups on two variables (i.e., relationship to the deceased and time since bereavement), there were some significant demographic differences between the intervention and control groups and these differences may have influenced the results. However, based on the direction of these differences, it could be hypothesized that the control group would be expected to be faring better than the intervention group, which was not shown in the results. Use of other types of bereavement support was not measured in this study. As such, it is possible that the control group had accessed support from other bereavement support services, which may have affected their health and social outcomes. Finally, although the results of this study show a significant reduction in self-reported suicidal thoughts and behaviours by StandBy clients, it is extremely difficult to unequivocally prove that the intervention reduces actual suicide numbers or rates for people bereaved by suicide. The relatively low incidence of suicide as an event means that very large sample sizes are required to have sufficient statistical power to reveal a significant effect (Gunnell & Frankel, 1994; Mann et al., 2005). In addition, because of the observational study design, it is difficult to remove the potential effects of confounding variables.	7 - High
Ryan, Lister & Flynn (2013)	(1) there was a self-selection bias amongst the participants in that all of them had volunteered to participate in the project; (2) the number of participants was small with only 15 completing the entire project; and (3) there was no comparison intervention or control group.	6 - High
Hawton et al., (2012)	Low number of questionnaire respondents and the small sample of participants of the focus group and interview study, all of whom came from the same geographical area.	6 - High
Barlow et al., (2010)	The cohort presented as a small sample; several additional tests were conducted to determine if the results were sufficiently robust to warrant future research on peer support.	6 - High
Comans, Visser & Scuffham (2013)	The cohort in this study was self-selected in both arms and, therefore, there may be systematic differences between this group of people and all those affected by suicide bereavement. It could be the case that those more affected by unresolved complicated grief were more likely to volunteer for this study. Differences were evident between the StandBy group and the control group. The control group subjects were more likely to have fewer close relatives and were more likely to have been friends with the deceased compared to the StandBy group. Control subjects also had on average, a longer period of bereavement. These differences are more likely to bias the results against StandBy, since it could be expected that grief is worse if the deceased is a close family member, and that grief naturally resolves over time. Therefore, these factors are not expected to alter the conclusions of the study.	6 - High

Cha et al.,(2018)	It was difficult to conduct a long-term follow-up study because the timing of the follow-up was determined according to the circumstances of the schools. Second, various psychosocial factors were not examined. Third, the level of intimacy between the student who committed suicide and the suicide survivors was not assessed. It may affect the post-traumatic stress symptoms and depressive symptoms. Finally, we could not assess any preexisting psychopathology prior to the peer suicide.	7 - High
Scocco et al., (2018)	Selection bias since enrolment in the course was voluntary/self-initiated. The cohort is also small, and there is no control group or follow-up data. At present, only 14 participants attended more than one retreat. More data and patients are needed to establish the role of specific interventions versus non-specific factors in this type of setting. Another limitation is that no grief-specific scale was utilized to assess grief intensity and its qualities, or the presence of complicated grief. Our study focused primarily on mindfulness dimensions and mood states, but to evaluate the effectiveness of these retreats, it would clearly also be important to focus on grief and how it changes over time. Moreover, no specific scale was used to evaluate and measure the presence of depression, and satisfaction level was not assessed.	6 - High
Bowden (2011)	Does not discuss participant numbers. Doesn't fully outline evaluation and results. Poor quality of reporting the evaluation.	1 - Low
Cerel & Campbell (2008)	Sample not representative, overwhelming Caucasian. Self-referred sample of individuals seeking help following a suicide. Does not evaluate users' opinion of the service and functioning. Does not utilise follow ups and long-term effects.	7 - High
Mitchell et al., (2003)	The use of narrative theory and structural analysis resulted in the discourse of group members being subjective. Only 1 group was assessed, making the results different to generalise to other groups.	3 - Medium
Pfeffer et al., (2002)	Higher dropout rates in nonintervention children caused there to be 9 retained non-intervention children as compared to 32 retained children in the intervention group, leading to the intervention children being significantly younger. Small sample size. Codependence effects as there were multiple children from the same family. Children with diagnosed mental health problems were excluded.	7 - High
Constantino, Sekula & Rubinstein, (2001)	No control group. Self-selection bias, small sample size. The effect of time can't be ruled out.	6 - High

Strouse, Hass-Cohen & Bokoch (2021)	The posttraumatic growth measure is usually intended to measure change over longer periods of time with treatment and was not designed for complex grief. It was a challenge to find measures for brief art therapy interventions and complex grief. One third of the participants completed the follow-up survey. While this is considered an acceptable response rate, there is a possibility that those participants felt more positively about the studio, and therefore chose to share their feedback.	3 - Medium
Rogers (1982)	Low turnout for group sessions. Not all participants completed the follow up questionnaire which calls into question the results, did those who returned the questionnaire have a better opinion of the intervention than those who did not.	2 - Low
Renaud (1995)	Small sample size. Did not measure outcomes including functioning and grief.	2 - Low

Table 6: Quality assessment of acceptability of models of postvention.

Study ID	Main threats to validity	MMAT Score
Ligier et al., (2020)	Retrospective study prone to memory and reconstruction biases. Interviews were recorded but not transcribed. The study focused only on SBS mentioned in police reports; other family members, friends and colleagues were neither identified nor contacted.	6 - High
Pettersen et al., (2015)	The participants were all under the age of 38 and the fact that the majority are female. Study was carried out in Sweden where healthcare is universal and tax funded, results may not reflect what is experienced in other healthcare systems which may narrow the transferability of our findings. The perceived quality of the professional help received may have been influenced by psychological phenomena like the projection of unwanted emotions (I.e., blame) onto others or identification with the deceased sibling's experiences as a way of coping with the loss.	7 - High
Bartone et al., (2018)	The sample of experts interviewed for this study is somewhat small (N = 10), and thus may not represent the entire field of experts providing peer support services to bereaved survivors. Results may not be a true reflection of the experience of being bereaved by suicide as they did not interview those bereaved by suicide.	7 - High
Feigelman, Sanford & Cerel (2020)	The study sample was predominately white, female, highly educated, and seeing an established physician after the loss. It is unclear how physician responses are perceived by men, people of color, and those who are not seeing an established physician after the loss. The sample also came primarily from a suicidology listserv and survivor of suicide loss support groups, which may indicate that respondents are already involved in prevention/postvention efforts and may be comfortable with help-seeking behaviours.	6 - High
Farragh (2019)	Selection bias, researcher choosing participants. Past teachers, not current teachers, may result in participants not being up to date with postvention plans and emerging data.	6 - High
Goodwin et al., (2013)	Small sample size for both providers and individuals bereaved by suicide.	6 - High
Trimble, Hannigan & Gaffney (2012)	No real evaluation, small sample size, no comparison between groups.	6 - High
Dyregrov (2002)	The response rate was only 50% of the total population. However, the researcher’s contact with 30% of the non-participants left the impression that the latter were even worse off, concerning psychosocial health and lack of help, then the participants. Hence, the need for assistance among those bereaved by youth suicide might be even greater, and the provisions even poorer, than data from this study reflect.	4 - Medium

Tiatia-Seath, Lay-Yee & Randow (2019)	The findings are descriptive and indicative only as our sample of respondents was purposively identified through networks in the absence of a specific sampling frame, and thus may not represent the target population of people who work for service providers of postvention support.	6 - High
Chapple & Ziebland (2011)	Limited recruitment as participants needed access to the internet. As a narrative interview study these data cannot inform us about effects on people's health status or use of services.	7 - High
Feigelman et al., (2008)	Cross-sectional survey data does not enable us to identify the chain of causal forces affecting the differences in grief difficulties. Participants include parents who have lost a child to suicide, which may make it difficult to generalise to other suicide losses.	5 - Medum
Pietilä (2002)	Interviews with parents and (adult) children concerning their experience of a (respective) family member's suicide and therefore not generalisable to other experiences	6 - High
Juhnke & Shoffner (1999)	Insufficient empirical data has been collected to suggest efficacy. Additional investigation is needed. 10 out of 11 families were Caucasian.	0 - Low
Westerlund (2020)	Cross sectional design, no follow up of the anonymised bereaved participants was possible. Risk for memory biased reporting by the participants. Self-selection bias as it was advertised on Facebook groups, websites relating to suicide organisation in Sweden, filtering out other suicide bereaved individuals that do not use these websites or use the internet. Women seem to use these websites more and therefore there is a gender bias.	7 - High

2.4.4 Quality Assessments of Components of Effective Postvention Services

Where adequately reported in the studies, components of postvention services are discussed in this section. Group interventions such as Survivors of Bereavement by Suicide (SOBS) in the UK have been supporting people bereaved by suicide, offering peer-led support groups, a national telephone helpline, email support, online virtual support groups and online community forum. Ali and Lucock (2020) evaluated SOBS support group members who reported experiencing difficulties adjusting to the suicide, which motivated them to meet others in a peer suicide bereavement group who had shared a similar experience. This helped them to normalise their grief experiences and share ways of coping with the death. Veale (2014) evaluated a group intervention for children and found that groupwork enhanced connectedness, emotional expression, family communication, memory and meaning making. Groupwork also enabled active coping. Furthermore, measures of emotional and behavioural problems and social competence showed improvements 6 months post-intervention. Mitchell et al., (2003) also evaluated a group intervention for children and found that participants reported heightened well-being and a sense of community through sharing their narratives.

These findings suggest that group interventions should attempt to foster the development of agentic narratives, rather than victimic narratives as this empowers the bereaved to feel in control. Pfeffer et al., (2002) studied children's group intervention and reported that children who received the intervention had significantly lower scores for anxiety ($p < .001$) and depression ($p < .006$) than those who did not receive the intervention. Constantino et al., (2001) evaluated a group intervention for widows. When comparing a bereavement group postvention and a social group they found that when these interventions were combined, significant changes were found on all measures, seeing an improvement in 6 of the 9 grief subscales, depression ($p < .0001$), and psychological distress ($p < .0001$). There was also a significant improvement in social adjustment. ($p < .0001$). Another study looking at adults participating in a support group (Renaud, 1995) found that there was a significant decrease in depression ($p < .001$) and situational anxiety ($p < .001$). Rogers et al., (1982) evaluated a community and group-based intervention and found that participants reported that the intervention helped by putting the suicide into perspective as it provides a "safe space" to talk about the bereavement without feeling judged.

Four studies rated the Standby service in Australia which is a community postvention service. Gehrmann et al., (2020) found that participants with a bereavement in the last 12 months who received the intervention had significantly lower scores in suicidality, experience a loss of social support and social loneliness compared to those who did not receive the intervention. However, participants who received the intervention whose bereavement was more than 12 months showed no significant difference, suggesting that it is crucial for postvention support to be timely. Maple et al., (2019) found that postvention workers believe that appropriate and timely support reduces the negative effects associated with suicide bereavement. They also state the importance of maintaining their own well- being through external supervision. Visser et al., (2014) compared those who received the intervention with those who did not and found that Standby improves well-being across four measures. It also significantly reduced suicidality. Those that received the Standby intervention had significantly less healthcare usage than those in the control group, suggesting that Standby is effective in improving well-being and may also be cost- effective. Comans et al., (2013) found that Standby was far more cost-effective than usual care with a cost saving of $803AUS and an increase in quality-adjusted life years of 0.02. Probabilistic sensitivity analysis indicated there was an 81% chance the service would be cost-effective. However, none of the other studies were evaluated in terms of cost- effectiveness, this is the only cost-effective evaluation included in this review.

The LOSS service based in the US, a community intervention was evaluated by Aguirre and Terry (2013), and they found that the service helped them to feel supported and create a community around themselves, by connecting them with resources and other bereaved people. Furthermore, Cerel and Campbell (2008) found that those receiving the support were more likely to access additional support such as support groups. Bowden (2011) evaluated the Waves service, a community-based intervention in New Zealand and reported that participants find the features of the intervention “highly valued”, however this study was rated as low in quality as it did not outline any participant information, methodology or results. Barlow et al., (2010) evaluated a Canadian peer support intervention and found that peer supporters can be effective in supporting people recently bereaved. This study also assessed the functioning of the peer supporters as well as the clients. Peer supporters had higher levels of premeasurement functioning compared with the clients, suggesting that peer support can be delivered effectively by trained individuals who have grieved sufficiently in order to support others. Scocco et al., (2019) found that weekend retreats reduced all dimensions in the Profile of Mood states, suggesting that these can be beneficial to individuals bereaved by suicide. School-based interventions may also support younger people bereaved by suicide. Cha et al., (2018) found that at 5 months follow-up there was a significant decrease in post-traumatic stress symptoms, anxiety, depression and complicated grief in the ‘trauma’ group.

Art and performative postvention support were also represented in this review. Peters et al., (2015) found that the quilt project was helpful in assisting participants in their bereavement by giving them an opportunity to reflect and grieve without fear of negative social reactions. Participants rated themselves as having high satisfaction with the project. Ryan et al., (2013) found that a writing and performative postvention improved psychological distress. Participants gave highly positive feedback in interviews. Strouse et al., (2021) found that art can enable meaning-making as supported by significant improvements in social validation and invalidation scores. Qualitative themes highlighted the significance of validation, specifically, bereavement processing and sharing and collaboration. Participants reported that sharing with the studio facilitators was more frequently reported as a key aspect of the studio than sharing with peers.

Non-face-to-face support was also represented in this review. Resources given to those bereaved by suicide to provide information and practical support may alleviate associated anxieties concerning the legal process that occurs when there has been a death by. suicide. Hawton et al., (2012) evaluated a UK online resource, Help is at Hand and found that organisations were more likely to access the resource than bereaved individuals. Participants reported that the overall format and content of the resource was appropriate. Web-based forums may also be effective in supporting people bereaved by suicide. Kramer et al., (2015) evaluated two sister forums, one in Belgian and one in Dutch and found that at 12 months there were significant improvements in grief, depression and well-being. Two thirds of participants reported some benefit from using the forums. These studies suggest that online resources can be useful in supporting people bereaved by suicide.

In summary, these findings suggest that postvention support for individuals bereaved by suicide is effective in reducing various health and psychological outcomes associated with being bereaved by suicide. One of the significant findings is that a mechanism that seems to be most effective is for suicide bereaved individuals to have some kind of access to others, creating a sense of community and belonging around themselves. This may be through peer support, group support, contact with those previously bereaved by suicide who are now in a supportive role or indeed through trained postvention support workers. Studies have also shown that postvention can be cost-effective in monetary value but also in psychological facts and life expectancy.

2.4.5 Quality Assessments of Components of Effective Models of Postvention

There is an ongoing debate as to which model of postvention would deliver adequate postvention support. Andriessen et al., (2019) defined suicide postvention service model as a "coordinated approach to providing support to people impacted by the death of a family member, friend or person in a network (such as a school, nursing home, workplace, etc.) through suicide." Questions surrounding who should deliver and how services should be delivered are discussed. Health services delivering postvention support may be suitable. Ligier et al., (2020) found that individuals bereaved by suicide who did not receive professional help from health care professionals felt that they may have benefitted from such support. On average, participants received a call from a health care professional within 66 days of the suicide. Pettersen et al., (2015) reported reasons for seeking help from health services in Sweden was to cope with grief, facilitate social relationships and search for meaning making. Reasons to not seek help from health services included the lack of trust in health professionals, incapability due to grief responses and no experienced need for help from health professionals. This study concludes that health services should offer immediate and repeated contact, empathy, personal meetings, information and grief-related support. Feigelman et al., (2020) found that nearly half of participants received positive support and responses from physicians. However, a small number of respondents reported doctor expressed a negative opinion about the deceased, doctors expressed a negative opinion about the way they died, doctors said things that they felt were hurtful or dismissive. Over half reported that their doctor offered medication to help deal with the loss. 48% reported the doctor suggested a referral to mental health resources and 34% stated doctors suggested resources in the community such as a support group. These studies suggest that support from health services could be of benefit. However, attempts should be made to improve the experience of those seeking support from health professionals to ensure that suicide bereavement support is sensitive to the needs of those bereaved.

Peer support models may also be beneficial. Bartone et al., (2018) found that effective peer support programs for the bereaved should be confidential and easily accessible interventions that provide a safe environment. Interventions should employ peer supporters with similar shared experiences to clients but should also select peer supporters carefully and ensure that peer supporters are trained. Professional mental health providers should also be involved in peer support. Peer support should also provide care and monitoring for peer supporters. Farragh (2018) assessed teachers' ability to support children experiencing the suicide of a classmate or friend within the school community. This study found that teachers feel unprepared to support students and felt that school counsellors were critical or essential in supporting teachers as school counsellors had expertise in this area. Teachers interviewed in this study reported that they were unaware of school policies in dealing with student suicide and were unsure who or how the school crisis plan was implemented. Teachers felt that they supported students as best as they could, suggesting they wanted to be of support but felt that school response plans were inconsistent. Therefore, it may be reasonable to suggest that teachers could be supported by other professionals when a suicide occurs in the school community.

Goodwin-Smith et al., (2013) aimed to understand how postvention could support Aboriginal individuals bereaved by suicide in Australia. Results suggested that Aboriginal people should be involved in service delivery to demonstrate “walking together”. This suggests the importance of models of postvention involving the very community that they support in order to maximise effectiveness and service delivery. Tiatia-Seath et al., (2019) assessed the needs of pacific communities and found that service providers were no more aware of postvention support available than community members. The majority of service providers were unaware of group discussions (known as fono by this community). 25.9% of service providers were dissatisfied with resources and 23% felt the materials had limited or no effectiveness. These findings suggest that communities would benefit from working with service providers who provide culturally appropriate support. Service providers felt that health professionals, churches and community leaders were best placed to lead postvention in this community. Furthermore, Trimble et al., (2012) found that individuals bereaved by suicide valued the helpfulness of social support and saw support groups as a vehicle to contextualise and normalise feelings. There was a desire for understanding and knowledge from professionals and an acknowledgement of the traumatic nature of bereavement by suicide. This suggests that models of postvention may be most beneficial when they include peer support, group intervention and intervention from professionals. Furthermore, Dyregrov (2002) found that 85%

of parents bereaved by suicide had received some kind of support from professionals. Community professionals believed that medical doctors, psychiatric nurses and public health nurses were common supportive professionals. However, individuals bereaved by suicide felt that undertakers were significant helpers, which was not reflected in community professionals' beliefs. Supportive counselling was most often received and provided for, as reported by 80% of the bereaved and 86% of the local authorities. However, only 26% of the parent survivors had participated in support groups, whereas 40% of the local authorities reported to have such group. The study concluded that local authorities lack the ability to fulfill expectations of those bereaved by suicide.

Web-based models have been evaluated, with Chapple and Ziebland (2011) finding that a minority of people had no access to a computer or preferred not to use the internet in this way. However, few adverse effects of internet support were found and there was evidence that the internet could be beneficial. Furthermore, Feigelman et al., (2008) found that internet support was utilised to similar levels by those in urban, cities and rural areas. Factors which users found to be beneficial were that internet support has no time constraints as it is constantly accessible, there are also opportunities to meet face-to-face. Out of 104 participants, only 6 experienced worsening depression due to internet support. However, internet support users felt greater stigmisation than those accessing face-to-face support.
Furthermore, Westerlund (2020) found that higher online support use was related to more satisfaction with psychosocial health. However memorial websites did seem to have the opposite effect as participants had increased rumination. This study suggests that online support groups may be an effective model, however memorial websites may cause further emotional distress. Pietilä (2002) found that half of participants had participated in support groups which enabled communication about the suicide and influenced meaning-making. Participants reported finding benefit from group participation as it helped to normalise their experiences. Anonymous groups were found to be easier and more accessible than family support, with the ability to be honest and talk openly most valued by users. Juhnke and Shoffner (1999) evaluated using a model known as Adapted Critical Incident Stress Debriefing. However, as this study uses general comments and anecdotal evidence, there is insufficient empirical data to suggest acceptability of this model of postvention and therefore, we cannot determine whether this model to be effective in supporting those bereaved by suicide.

In summary, models of postvention should involve the community they serve, and be timely and culturally appropriate. Successful models include community-based support which could utilise peer and professional support. Group postvention models may also be effective in creating a community around bereaved individuals, enabling them to talk about their grief without being judged and normalising their experiences. Internet support may also supplement this but may not be suitable for everyone. For young people, school-based models may be effective to address bereavement in the school community.

2.5 Discussion

To our knowledge, this review of postvention services is the first to include non-controlled and qualitative studies within the analysis. The aim of this systematic review was to assess research which evaluates postvention services supporting those bereaved by suicide. Secondly it aimed to assess the acceptability of methods of postvention in terms of community support, peer support, group support and internet support.

This review showed that evaluations on specific postvention services were mostly rated as medium or high. Successful evaluations on effectiveness and cost-effectiveness included the Standby service in Australia, SOBS groups, the LOSS service, art projects, online forums and the Help is at Hand online resource. Ongoing evaluation of postvention services would enable the services to continue offering a good standard of care for beneficiaries. This supports Andriessen et al.,'s (2017) findings that postvention research should be theory-driven and increase intercultural collaboration. Resources made available to individuals bereaved by suicide may be beneficial to alleviate some of the anxieties caused by the legal process which concurs with Jacoby's (2002) findings that individuals bereaved by suicide felt highly distressed by legal procedures, specifically the coroner's office and the inquest. Similar levels of distress were caused by the media reporting of their loved one's suicide and postvention services should address these experiences. Therefore, providing practical and informative support may be a valuable part of any postvention service.

Postvention research reviewed in this paper rarely included experts, professionals working in suicide and those bereaved by suicide using qualitative methods. It would be beneficial for further research to assess the effectiveness of suicide postvention support services to assess both the professional and peer support provided to those bereaved by suicide. Using qualitative evaluation methods will enable those bereaved by suicide to explore their experiences and needs. This review also reported that models of postvention services should include community-based interventions and group interventions, which could be supported by online interventions. Young people and school communities would also benefit from support within the school environment. Andriessen et al., (2019) recommended that a public health model of postvention can allow for a tailor-made approach to service delivery and meet the needs of bereaved individuals. They suggest that models can range from information and awareness-raising targeting all people bereaved by suicide to specialised psychotherapy for those bereaved people who experience high levels of grief and symptoms of poor mental health. This also supports Ali and_Lucock's (2020) recommendations that services should be tailor-made and flexible in the timing and duration. Furthermore, Campbell (1997) suggested that adequate and early postvention services may normalise the grief process after suicide, identify more at-risk survivors, and reduce the risk of further suicides. Campbell (1997) suggested that an active model of postvention rather than a passive one would improve outcomes for those bereaved by suicide. It concludes that increasing access to support through community postvention services, the impact of postvention services can facilitate the grief process while providing information about resources in the community. The long-term consequences of suicide may be averted if the problems of access to services and awareness of resources could be overcome. Dyregrov (2011) recommended that postvention support should adapt to meet each individual bereaved person's needs and therefore, any postvention model should include support that meets the needs of the community it supports.

This review highlighted the lack of evaluations on UK interventions, with only two services included in this review; one on the effectiveness of the SOBS groups and another on the Help is at Hand online resource. There has been little to no research completed on the effectiveness of postvention services, with Australia and the US leading the way on postvention services evaluations. Furthermore, limited research has been done on the acceptability of models of postvention. Some issues were highlighted by this systematic review. Firstly, it highlighted *n* = 4 postvention evaluation studies and *n* = 1 acceptability paper was poorly conducted and discussed. Studies were rated as poor due to not having clear research questions and it being unclear if the data collected could address the research aims. To address this, the author of this review also considered papers which did not have research questions but did have clear aims. Due to this, one paper was rated high rather than medium (Ali & Lucock, 2020). Furthermore, MMAT ratings indicated a distinct lack of rationale for using mixed-methods design, and where rationale was given, this was often unclear. Furthermore, many mixed methods studies did not adhere to the quality criteria for each tradition of the methods involved. Therefore, many mixed-methods papers were rated lower. One study rated poorly was a debriefing model of postvention (Juhnke & Shoffner, 1999). This study was a qualitative study which did not provide enough of a rationale and outline adequate evidence for the acceptability of such a model. Much research has been conducted on debriefing professionals when they experience a suicide in their professional capacity, however very little research has been done on the acceptability of debriefing suicide bereaved individuals. Therefore, this review cannot conclude that this model would or would not be of benefit and further research would need to be done.

Some services had many evaluations, in the case of Standby, four evaluations of their service were included in this review. This may be simply because they could have the resources or funding to have ongoing evaluation, thus proving their effectiveness. Other services may be just as effective, but we have been unable to evidence this. One reason for this may be due to inadequate reporting, for example, the WAVES evaluation, was rated as poor due to not adequately outlining research aims and methodology. Therefore, it may be that the WAVES service is a successful service, but the paper outlining the service has been rated as poor due to the quality of the research paper. Other services may have found it difficult to access funding or resources for evaluation. Other issues reported were incomplete data sets and groups being incomparable at baseline. Some studies had low retention rates and small sample sizes. Samples were overwhelming Caucasian women in most of the papers discussed in this review. There was also self-selection bias in many of the studies, as evaluations focused on individuals who were supported by the services and had volunteered to participate. Therefore, individuals who took part may be the most satisfied with their experiences with the service. Some studies had multiple intervention arms but no control groups. (Scocco et al., 2019; Constantino et al., 2001; Ryan et al., 2013). Furthermore, some studies with control groups were matched 4:1 and were significantly different in ages and other factors (Visser et al., 2014: Comans et al., 2013). However, it is important to note that this review aimed to evaluate qualitative and mixed methods postvention evaluations as the author aimed to determine whether a non- controlled approach would yield stronger quality of studies that also allowed us to gain insight into the experience of being bereaved by suicide, creating services which are providing a good standard of support. As such, concerns about quantitative studies were expected.

Studies were rated using MMAT scores, which has different questions for studies with the following methods: qualitative, quantitative randomised controlled trials, quantitative non-randomised, quantitative descriptive and mixed methods. For mixed methods studies, to answer the final question, the rater must complete the questions for both components of the mixed methods (for example, qualitative and quantitative non-randomised). The questions are different for each method. Therefore, some studies may have confounding variables or a sample which is non-representative, if the questions for that method do not feature those criteria, this study will have been rated higher. The researchers have endeavoured to discuss that in the reporting of the studies. Furthermore, the ratings were based on three answers; “yes”, “no” and “can’t tell”, for example, if the researchers could “not tell” if confounders were accounted for in the design and analysis of a qualitative non-randomised study, this was rated the same as if the study did not account for confounders. Therefore, studies where there was no clear discussion on the corresponding criteria were rated the same if they did not include this information. The extent to which a study was reported with clarity was crucial. However, it was felt that due to the wide range of methods, using one peer-validated tool to assess the studies would be beneficial.

Future Research

Future research should focus on longitudinal studies to evaluate the services’ longitudinal effectiveness. Studies with appropriately matched control groups would enhance research evaluating postvention services. Finally, more resources should be made available to services to enable them to evaluate effectiveness and ensure the longevity of services that prove to be effective in supporting people bereaved by suicide.

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Chapter 3: Methodology

As highlighted in the previous chapter, there was a lack of research assessing the perceived effectiveness of UK interventions. There has been little to no research conducted on the effectiveness of postvention services in the UK. To date, previous research has been conducted in Australia and the USA. In chapter three, I discuss the methodological approaches utilised in this thesis to assess the perceived effectiveness of UK-based postvention services. I aim to briefly outline the debate on the movement to embrace a scientific approach to knowledge acquisition through epistemological issues and I will provide justification for the methodological approach in this research. I will then describe the procedures used to collect and analyse data for this thesis.

3.1 Research paradigms

Scientific research and knowledge acquisition can be viewed through many different lenses. The oldest example of this can be seen through Galileo's telescope experience in which Padua university professors refused to look through the telescope to look at the moon, claiming that whatever they saw would have been invented by Galileo and was not actually in existence (Gingerich, 2011). The phrase “Paradigm shift” was coined by Thomas Kuhn (1970) who stated that paradigms are assumptions we have about the world that make everyday decisions possible, therefore a paradigm shift was a term used in contemporary discussions of organisational change and intellectual progress. Ultimately, what we know about the world or ontology, how they are known to us or epistemology and how knowledge acquisition can change those beliefs. Bryman (2008, p.13) defined epistemology as “the question of what is (or should be) regarded as acceptable knowledge in a discipline”. Furthermore, Manion and Morrison (2007) stated that epistemology is about the assumptions that one makes about “the very bases of knowledge – its nature and form, how it can be acquired and how it is communicated to other human beings”. There are many theoretical paradigms, but two important epistemological positions are positivism and constructivism.

Historically, positivism has been favoured by scientific research. Positivism is the paradigm which adopted the ontological position of realism, and it is the paradigm that has been held in most regard. Crotty (1998) stated that there is one single fundamental reality that is value-free and best described in numbers. The researcher should be neutral and should favour experimental investigation, hypothesis testing, deductive reasoning, and objective measurement. Epistemologically, the research and the research subjects are independent from one another, and the researcher should not influence or be influenced by the research conducted. Indeed, Guba and Lincoln (1994, pg. 110) stated that “inquiry takes place as through a one-way mirror”.

In opposition, the paradigm interpretivism emphasised the meaningful nature of people’s character and participation in social and cultural life (Elster, 2007; Walsham, 1995). As it adopted the position that people’s knowledge of reality is a social construct, created by humans, it therefore disavowed the methods of natural science (Eliaeson, 2002; McIntosh, 1997). Therefore, interpretivists strived to discover meaning and motives behind actions such as the behaviours and interactions between humans in society and culture and thus, we could understand people’s ideas, thinking and the meanings that are important to them (Boas, 1995; Whitley, 1984).

Interpretivism rejected positivism, as interpretivism was a methodological approach to scientific social study of how humans make meaning of their world and experiences. Researchers interpreted the various interpretations made and used by participants expressing what is meaningful to them. Through interpretivism, analysis explored meaning in the context of research, as researchers frame their research question around that meaning. In particular, the creation of research questions arises from sources such as existing theories, field work and personal experiences. This process was fluid, as research questions may change during the research, as exposure to the participant’s worlds increases. Interpretive research depended upon the researcher’s discipline, previous literature, research questions, exposure to methods of data collection and analysis, prior experience and skills (Schwartz-Shea & Yanow, 2020). Interpretive and positivist-informed qualitative research used observing participants, interviewing and talking to participants and/or used existing information on participants, such as documents, reports and photographs (Schwartz-Shea & Yanow, 2020).

The foundation of all research lays in ontology, from which one’s epistemological and methodological stances naturally ensued. Blaikie (2000, pg.8) suggested that ontological claims were “claims and assumptions that are made about the nature of social reality, claims about what exists, what it looks like, what units make it up and how these units interact with each other. In short, ontological assumptions are concerned with what we believe constitutes social reality". Therefore, it asked "what is reality?" Realism aligned with the epistemological position of positivism, while relativism was associated with interpretivism. Realism referred to the assumption that one universal reality or 'truth' existed independently of the individual, but it may never be fully understood due to unknown variables within nature and uncertainty in measurement (Archer et al., 2016; Wiltshire, 2018). Therefore, the question of "what is reality?" was answered, by realism, as there is one single reality or truth. In contrast, a relativist ontological position implied that the concept of 'reality' was dependent on those interpreting it (Guba & Lincoln, 1998; Lincoln, Lynham, & Guba, 2018). As such, the same question of "what is reality?" was answered by interpretivism as there is no single reality as reality was created by individuals and groups and therefore, it needed to be interpreted and discovered to learn the underlying meaning.

These positions therefore affected how knowledge was acquired. Positivism aligned with quantitative research and suggested that knowledge should be through scientific methods such as hypothesis testing, measurements, questionnaires and observations. Rigour, reliability, validity and objectivity were valued (Guba & Lincoln, 1989). Opposingly, interpretivism aligned with qualitative research. Qualitative research aimed to understand participants' experiences, views and perspectives and aimed to do this in participants' own environments (Bryman, 2004). This type of research did not include mathematical models, which was favoured by quantitative research. However, it used observations, interviews, interpretation to explore underlying meanings and patterns of relationships. Rather than hypothesis testing, it asked broader research questions and then looked for themes and patterns within a set of participants. Rather than demanding the researcher remain impartial, it recognised that researchers can be subject to bias, acknowledged the effects of this and valued the input of researchers (Bryman, 2004; Silverman, 2005). Rather distinctly, it also valued the views of the minority and ensured that these views were included in the analysis process.

The debate had therefore led to a divide between quantitative and qualitative methods, particularly when researching complex social life. The paradigms discussed and the divide in preferred methods had influenced researchers through which issues are considered to be important, the research questions, study design and implementation and what is considered as "evidence". To bridge this divide, mixed methods approaches have become more popular in recent years. This approach allowed for close interaction and in-depth insight into the lives and experiences of participants, without sacrificing reliability and validity. In essence, using one method to compliment the other and answer the research questions to gain a deeper understanding. Mixed methods research could be aligned with pragmatism, which had the view that the best method was the one that solves problems and change was the underlying aim (James, 1907). To answer the question “what is reality”, pragmatism suggested that reality was continually renegotiated, discussed, and interpreted to provide useful learning about novel situations.

Pragmatism placed itself somewhere in the centre of the paradigm debate, embraced the two extremes and offered a flexible and more reflexive approach to research design (Feilzer, 2010; Morgan, 2007; Pansiri, 2005). Pragmatist researchers selected the research design and the methodology that were most appropriate to address the research question. Pragmatism was typically associated with abductive reasoning that moved back and forth between deductive and inductive reasoning. In this way, the researcher was actively involved in creating data as well as theories (Goldkuhl 2012; Morgan 2007). Another important aspect of pragmatism is that a researcher’s worldview can influence the way researchers conducted their research. Kuhn’s (1962, 1970) concept of paradigms was explored as a set of shared beliefs among the research community to elaborate on what counts as most important research questions and the most appropriate research methodology (Morgan, 2007). This was important as not all research questions are equally important and not all methodologies are automatically appropriate for a given study. Ultimately, the researcher made the choices and decided which question was important and what methodology was appropriate, and those choices were certainly influenced by the aspects of social and political persuasion of the researcher, personal history, and belief system (Morgan 2007). Morgan (2013) suggested a model for conducting pragmatic research: 1) selecting a problem, 2) reflecting on the choice of the problem, 3) creating a potential research design, 4) reflecting on the choice of methods and finally, 5) conducting the research. This research aligned itself with pragmatism as it used personal and professional experience of suicide and suicide bereavement as a foundation for the motivation to explore the support received by the suicide bereaved. It was believed that the researcher should not separate themselves from their research and they should use their worldview to influence how they approach research design. Therefore, it was believed that a mixed methods approach, using a pragmatist foundation, would allow the researcher to answer the questions: What is the current suicide postvention service provision in England? Are the services perceived to be effective in reducing further suicides and improving the wellbeing of the people they support? What impact do these services have on other organisations and the wider community in the areas they are located?

3.1.1 Mixed methods for suicide research

The aim of using a mixed methods approach was not to favour one method over another, but to use the strengths of both methods and minimise their weaknesses to provide the best understanding of suicide and suicide bereavement. Historically, suicide research has favoured quantitative methods. However, mixed methods research in this area has grown in popularity (Creswell & Creswell, 2017; Kral et al., 2012). This enabled a better understanding of demographic and psychological variables, whilst also integrating the experience of those affected by suicide, to ensure we are answering the question of how best to support those bereaved by suicide and the difficulties that they face. This in turn allowed us to understand how to prevent suicide, in particular for those at increased risk of suicide. Kral et al., (2012) advocated the use of mixed methods, suggesting that this method would expand knowledge of suicide by “integrating theory-based variables and subjectivity as objects of inquiry” (pg.236). Furthermore, they stated that mixed methods would “allow for a broadening of research questions, more substantive understanding, and are necessary for a multidimensional and multidisciplinary suicidology” (pg.236). Moreover, Kolves et al., (2021) published a guide “Advancing Suicide Research” which advocated for adopting mixed-methods research approaches in this field.

Following these debates, this thesis adopted a pragmatic approach in using methods that best answered the research questions and addressed the gaps in understanding suicide bereavement and suicide postvention services. The qualitative research used semi-structured interviews to understand the experience of those bereaved by suicide, the support they have received and the impact the services had on individuals bereaved by suicide and the wider community. The quantitative research assessed demographic and psychological variables in people bereaved by suicide. When considered together, the qualitative and quantitative research aimed to evaluate postvention services in England and the impact the services have had. See Table 2 for information on the methods and the research questions, study objectives and aims used.

3.1.2 Rationale for a mixed methods approach

A mixed methods approach was assumed as the researcher believed that this enabled a greater understanding of suicide postvention and the services that support individuals bereaved by suicide. It was felt that this approach enabled the researchers to answer the research questions most effectively. Specifically, interviewing those bereaved by suicide and individuals who had experience of these services (qualitative) offered an in-depth insight into postvention. Furthermore, evaluating data collected routinely by these services (quantitative) gave the ability to describe characteristics and understand the demographics of individuals supported by these services. This also allowed the assessment of outcome measures to determine if the service had made a quantifiable difference to the individual's well-being.

Kral, Links and Bergmans (2012) stated that "mixed methods will allow for a broadening of research questions, more substantive understanding and are necessary for a multidimensional and multidisciplinary suicidology" (pg. 236). Creswell and Plano Clark (2007) identified five types of mixed methods designs. Firstly, sequential design consisted of an element of a study being quantitative, whilst another element is qualitative. The second, triangulation design, assessed data on a singular topic using different methods across different studies. The third is an embedded design which consisted of one method (qualitative or quantitative) being secondary to the other. The fourth method, explanatory design is a form of sequential design but added a qualitative component to answer questions raised by the quantitative data. The fifth method is an exploratory design which is similar to an explanatory design, however the development of a quantitative method was based on the qualitative data.

This research used secondary quantitative data from the services own audit and evaluation outcomes data in order to understand what is currently collected and how it is utilised. Watkins (2022) explored the use of secondary data in mixed methods research and highlighted three types of mixed methods designs, using secondary data. Firstly, convergent design collected and analysed qualitative and quantitative concurrently, with findings interpreted jointly. Secondly, exploratory sequential design collected and analysed the qualitative findings and then the quantitative data. For this design, the findings of the qualitative data were used in the design of the methods and interpretations of the findings of the quantitative data. Finally, explanatory sequential design prioritises the quantitative data and used this to make decisions about the methods and analysis of the qualitative data.

This research used a convergent design as data was collected simultaneously and analysed separately. This method allowed for the ability to combine or compare the results to draw a conclusion about suicide postvention in the UK. By utilising both quantitative and qualitative findings, we gained an in-depth understanding of the perceived effectiveness of postvention services on beneficiaries and key stakeholders. Indeed "the intent of integration in a convergent design is to develop results and interpretations that expand understanding, are comprehensive and are validated and confirmed" (Creswell & Plano Clark, 2018, p. 221). In essence, the quote suggested that integration within a convergent design is aimed at producing rich, comprehensive, and well-validated insights that advance understanding in the research field. Furthermore, Dawadi et al., (2021) suggested that in the analysis phase, convergent design may include looking for common concepts across the data, and this could be done by presenting each study and then integrating and interpreting the data collectively. Therefore, this approach provided a more comprehensive insight into suicide postvention as qualitative approaches facilitated the exploration of nuanced aspects, while quantitative methods offered statistical validation and broader perspectives (Creswell & Plano Clark, 2018). This iterative and holistic approach enabled the researcher to refine their understanding by continuously synthesising qualitative and quantitative data, leading to deeper insights. This design allowed for triangulation, a key tenet of mixed-methods research, facilitated through the convergent design. By triangulating data from diverse sources, researchers enhanced the validity and reliability of findings (Tashakkori & Teddlie, 2010). This methodological triangulation strengthened the credibility of the research outcomes by corroborating results across different methodological approaches (Creswell & Creswell, 2017). Finally, a convergent design was thought to be more accessible. Stakeholders with varied preferences, such as policymakers, practitioners, and academics benefited from the integration of qualitative narratives and quantitative data, ensuring relevance and accessibility of the research findings (Creswell & Plano Clark, 2018). Therefore, this design approach offered a methodologically rigorous approach to studying a complex phenomenon by integrating qualitative and quantitative methodologies. Supported by the principles of triangulation, complementarity of data, and an iterative process, this approach enhanced the credibility, validity, and comprehensiveness of the research outcomes.

3.1.3 Rationale for specific qualitative approach

At the inception of this study, there was careful consideration as to the qualitative approach which would be the most appropriate given the design discussed above and to answer the research questions. The approach needed to enhance the credibility of the qualitative aspect of this study. Tong et al., (2012) published the enhancing transparency in reporting the synthesis of qualitative research (ENTREQ) statement which consisted of 21 items grouped into five main categories: introduction, methods and methodology, literature search and selection, appraisal, and synthesis of findings. They suggested that researchers should use the ENTREQ statement to aid in the reporting of the stages most commonly associated with the synthesis of qualitative research such as searching and selecting qualitative research, quality appraisal, and methods for synthesising qualitative findings. Furthermore, Rosenthal (2016) made a total of eight recommendations and considerations for conducting qualitative interviews. Firstly, researchers must carefully consider which data collection approach answers their research question most effectively and efficiently. The interview schedule should be developed thoughtfully as improper and poorly designed questioning could result in poor data and findings. Sampling and recruitment methods should be thoroughly considered. Interview modalities should be decided upon, whether that be face-to-face or remote means. Interviewer skills and experience should enable participants to feel comfortable. Furthermore, professional transcribing methods are crucial. The development of themes should be reviewed using the original transcripts. The final recommendations highlighted the need for clear and detailed methods as others must be able to replicate the study process and the researcher should embed direct quotes into the research article to ensure that qualitative research is based upon the experiences of the participants and not conjecture. As qualitative research became increasingly valued and recognised, it was crucial to adopt rigorous methodologies to yield meaningful and impactful findings. Nowell et al., (2017) argued that thematic analysis was a qualitative research method that could be widely used across many epistemologies, to address a wide range of research questions. Thematic analysis is a method for identifying, analysing, organising, describing, and reporting themes found within a data set (Braun & Clarke, 2006). Thematic analysis has been described as a “translator” for qualitative and quantitative analysis, which enabled researchers who use opposing methods to communicate their findings to one another (Boyatzis, 1998). Braun and Clarke (2006) highlighted that their thematic analysis can produce trustworthy and informative findings. They also suggested that it was the theoretical freedom and flexibility that thematic analysis provides that enabled it to be modified to address research questions and be led by the data, rather than the data being constrained by the methods. Another advantage highlighted by King (2004) suggested that thematic analysis allowed for examining the unique perspective of different research participants, as one could compare similarities and differences across these experiences. They concluded that this method also allowed for the generation of unanticipated and unexpected insights into human experiences. King (2004) also suggested that thematic analysis was useful when handling large participant numbers and lengthy interviews as the researcher must be meticulous and use a structured approach to produce a clear understanding of participant's narratives. One disadvantage of thematic analysis could also be seen in its flexibility, as this could lead to inconsistency and a lack of a coherent process when developing themes derived from the interviews (Holloway & Todres, 2003). However, this could be addressed by being explicit in epistemological positions and indeed the processes in which the researcher has used thematic analysis to interpret the data. This research attempted to address this by using a clear process and by using a framework to systematically analyse the data, commonly known as Thematic Analysis (Braun & Clarke, 2006). More recently, Braun and Clarke (2019) introduced reflexive thematic analysis, which used the process of the six phases of thematic analysis, but "embedded in and surrounded by, a bigger set of values, assumptions and practices, which collectively make up the method" (Braun & Clarke, 2021, p. 6). Assumptions of reflexive TA (Braun and Clarke, 2021) included researcher subjectivity, the importance of collaborative coding and themes as patterns rather than summaries. Furthermore, themes did not passively emerge from the data, but were built from the codes through the researcher's systematic engagement with the dataset. Also, important to note was that reflexivity was key and researchers should strive to understand from these perspectives. Inductive TA suggested that the researcher allows themes to be developed from the data based on the participants' experiences, whereas deductive TA is where the analysis is shaped by existing theories (Braun and Clarke, 2021). Therefore, this study used a more inductive TA orientation.

3.1.4 Provisions of Trustworthiness

Historically, scientific rigour had influenced decision making when ensuring research quality. The terms 'reliability' and 'validity' had been synonymous with rigour within positivist research and underpin a study's claim to generalisability (Patton, 2002). Research validation has been described as "the ability of the researcher to draw meaningful and accurate conclusions from all of the data in the study" (Creswell and Plano Clark, 2007, p. 146). As the influence of postpositivist values on scientific research increased, the popularity of qualitative approach grew (Tashakkori & Teddlie, 2003). With this, there was a growing demand for a more comprehensive understanding of various health and social issues led to the use of a multitude of qualitative methodologies from different pragmatic positions within mixed methods. When combining qualitative and quantitative approaches, the concept of rigour and the assumption of generalisability needed to be expanded (Giddings & Grant, 2009). Furthermore, Giddings and Grant (2009) advocate for keeping the quantitative and qualitative rigour strategies as separate but allowing the strategies to work together to provide confidence in the overall integrity of a study.

3.1.4.1 Quantitative concerns

Abowitz and Toole (2009) suggested that reliability was based on the application of uniform measurement rules and the uniformity of measurement results over time. Having and applying operational definitions produced consistent and stable results and therefore, the same indicator should produce the same results when other relevant factors are stable. Problems of measurement reliability arose from inadvertent changes in the measuring instrument (Abowitz & Toole, 2009). Only three services collected data, with one service stating that their data was inconsistent and therefore two services were included. However, the remaining two services used different psychometric scales to assess well-being. Therefore, the use of different psychometric scores in the quantitative section of this study posed a problem. The scales used different cut-off points and categories that indicate poor and high well-being which made it difficult to compare well-being. Therefore, the researcher discussed this with the research team and opted to look at 'change', did the participants well-being remain the same or change over time? Furthermore, as some of the participants completed the well-being measures more than two times but this was not consistent across all participants and some participants were supported for longer than others, the research team decided to use the first initial well-being scores and the last well-being scores. The issue of the reliability of the data was supported by the commissioners of the services who requested and oversaw the use of this data. In terms of validity, sWEMWBs and Core-10 have been validated for its use in clinical and general populations to assess mental well-being and risk of suicide (Barkham et al., 2013; Ng Fat et al., 2017; Vaingankar et al., 2017).

The use of secondary data has been much debated amongst researchers. A disadvantage of secondary data is that the researcher did not participate in data collection and was not aware of how it was collected. The researcher does not know if there were any biases, barriers or difficulties that could affect the responses (Johnston, 2014). A major advantage associated with secondary data analysis was the potential for the cost-effectiveness and convenience, as someone has already collected this data, the researcher did not have to use financial resources as this data has already been collected (Dale et al., 1988; Glaser, 1962; Smith 2008).

Stewart and Kamins (1993) suggested key questions to ask when evaluating the appropriateness of the dataset. See the table below for these questions and how they were satisfied. The second column in this table describes how these key questions were applied to the data collected in this thesis.

Table 7: Evaluating the appropriateness of the dataset.

Stewart and Kamins (1993) Key questions	How they were satisfied in the present study
What was the purpose of the original study and what is the purpose of this study?	The data was collected by suicide postvention services, as required by commissioners, to evaluate their effectiveness. This data has not been used in another empirical study. It was then used in the present study to empirically attempt to assess the effectiveness of these services and assess how they measure this effectiveness. Demographic data of the beneficiaries was also collected, to understand the sample of people using the service and identify gaps or areas for further development.
Who was responsible for collecting the information?	The suicide liaision workers collected this data during their appointments with beneficiaries. This was then added to a

	database and given to commissioners.
What information was actually collected?	Scores for each question and an overall score of well-being. Beneficiary gender, age, location, finder of the body and other information was also collected.
When was this information collected?	Well-being scores were taken at the first appointment and latest appointment with the beneficiary. In some instances, this was done more frequently in between these appointments. Time between these measures varied, as some beneficiaries were supported for longer than others. Demographic data was collected at the first appointment with the beneficiaries.
What methodology was employed for obtaining the data?	The data was sent using Microsoft excel spreadsheets. Missing responses were omitted. Some participants only had one response and as such, they were omitted. Information was available from other sources, such as the PowerBi which held demographic data on the beneficiaries. However, it was not possible to link this data.
How consistent is the information obtained?	Out of the nine services, two services consistently used well-being psychometric scales. The information varied in consistency. Some participants only had one score, but this was often due to them being an active and current beneficiary, and therefore there was not another score obtained. One service only collected scores from 34

	beneficiaries from one year, whereas another had 270 from multiple years. These services used two different well-being scores. Demographic data was more consistent.

3.1.4.2 Qualitative concerns

For qualitative research to be valued and recognised, conducting it in a rigorous and methodical manner allowed researchers to yield meaningful and useful results (Attride-Stirling, 2001). Trustworthiness is one way researchers can persuade themselves and others that their research findings are worthy of attention (Lincoln & Guba, 1985). Indeed, it was important that researchers could provide evidence that their results could be trusted. Lincoln and Guba (1985) refined the concept of trustworthiness by introducing the criteria of credibility, transferability, dependability, and confirmability to parallel the conventional quantitative assessment criteria of validity and reliability.

Guba and Lincoln (1989) suggested that credibility can be supported by prolonged engagement with a topic, data collection triangulation and researcher triangulation. Peer debriefing could provide an external check and therefore increase credibility. Finally, checking preliminary findings and interpretation against the raw data could address credibility. The researcher utilised a Public Advisory Group (see section 3.3 on Public Advisory Group) which included experts in this field to discuss findings and interpretations. They also helped to develop qualitative semi-structured questions. Shenton (2004) advocated for “the development of an early familiarity with the culture of participating organisations before the first data collection dialogue take place” (p. 65). The researcher aimed to establish this with each organisation to gain an understanding of the organisation and to establish trust. Furthermore, a random sampling of the participants allowed for the researcher to have no prior knowledge of the participants and for the service to not be aware of who was included in the analysis, as services contacted participants and gave them the researchers details and as such, services weren’t aware of who was actually participating. This random sampling was also encouraged by Shenton (2004). The researcher was also a member of a Suicide and Self Harm Research Group which included academics and other researchers in this field and regularly discussed the research process and methodological considerations. The researcher offered the participants an opportunity to read the transcripts. Transferability refers to generalisability and to address this, the researcher provided rich and detailed descriptions to support those who wish to transfer the findings. The very objectives of this study were to support other services in learning from these findings and applying them to their service, if they wish. To address dependability, researchers should ensure the research process is logical, traceable and clearly documented (Tobin & Begley, 2004). All decisions were discussed with the research team and logged within a journal kept by the researcher. The researcher and primary research supervisor read through each of the transcripts independently and then discussed emerging themes with two other members of the team. The primary researcher then refined the themes and again, discussed these refined themes with the rest of the supervisory team. Themes and sub-themes were created and discussed as a team. The final issue of confirmability can be confirmed when credibility, transferability and dependability are all achieved. Confirmability can be established when the researcher's interpretations and findings are clearly derived from the data, requiring the researcher to demonstrate how conclusions have been reached (Tobin & Begley, 2004).

3.1.5 Theoretical Perspective

Understanding suicidal behaviour and the risk of suicide for those affected by it can be facilitated by various theories. The Interpersonal Theory of Suicide (Van Orden et al., 2010) suggested that suicidal behaviour is largely influenced by two interpersonal factors: thwarted belongingness and perceived burdensomeness. Thwarted belongingness reflected feelings of isolation, while perceived burdensomeness involved feeling like a burden to others. It's important to note that the capability for suicidal behaviour is distinct from the desire for suicide. However, when both the desire and capability are present, the risk of suicide increases, with factors like a family history of suicide contributing to this risk.

Additionally, the integrated motivational-volitional (IMV) model of suicidal behaviour (O'Conner & Kirtley, 2018), proposes that feelings of defeat and entrapment drive suicidal thoughts. Volitional moderators then play a role in transitioning these thoughts into actual suicidal behaviour. These moderators included factors such as access to means of suicide, exposure to suicide, fearlessness about death, increased tolerance for physical pain, suicide planning, impulsivity, and past suicidal behaviour. Thus, it is plausible to suggest that those bereaved by suicide may have been exposed to suicidal behaviour and, in their grief, develop a fearlessness about death as they long to be reunited with their deceased loved ones. This theory is important and has been used in this thesis as the IMV model is a tri-partite model that described the biopsychosocial context in which suicidal ideation and behaviour may emerge (pre-motivational phase), the factors that lead to the emergence of suicidal ideation (motivational phase) and the factors that govern the transition from suicidal ideation to suicide attempts/death by suicide (volitional phase). Therefore, it explains the difference between thoughts and acts of suicide. It also considered vulnerability factors combined with stressful life events that put individuals at an increased risk for suicide, furthering the argument that suicide bereavement is a distinct bereavement that requires specific support. This created a rationale for the suicide postvention and the importance of ensuring the services are effective. This theory has been empirically tested and has shown equivocal evidence (Dhingra et al., 2015; Mars et al., 2018; Tucker et al., 2016). One such study found that those who reported suicidal ideation did not differ in motivational-phase variables from individuals who had attempted suicide in multivariate analyses, but they did differ on volitional-phase variables, as per the IMV model (Dhingra et al., 2015). Another study found that exposure to self-harm of others was the factor most associated with a suicide attempt, as compared to those who had thought about suicide without a suicide attempt, giving further support for the concept of motivational variables (Mars et al., 2018). However, inconsistencies in the findings for the link between defeat, entrapment and suicidal ideation have been reported. Tucker et al., (2016) found defeat was directly associated with suicidal ideation, but not entrapment. There have also been critical limitations in suicide prevention and postvention research. Firstly, an inability to predict suicidal behaviour in individuals persists, meaning that professionals are unable to identify who may die by suicide and who may have suicidal thoughts but not attempt suicide (Chan et al., 2016; Chu et al., 2015; Fowler, 2012). Crucially, there has been a lack of multi-level theoretical development of suicide. Cramer and Kapusta (2017) have proposed a social-ecological framework which suggests a multi-level understanding of suicide. This model proposed both risk and protective factors for a multitude of levels, including societal, community, interpersonal/relationship, individual, psychiatric and psychological. In support of suicide postvention, this theory suggested that community risk factors were local suicides and barriers to support, whereas community protective factors were effective support, community involvement, trained gatekeepers and crisis support. Interpersonal and relationship protective factors included presence of social support, the perception of that social support, connectedness and help-seeking behaviours. The risk factors associated with interpersonal issues were a family history of suicide and mental health, exposure to suicide, death and bereavement and social isolation. Societal protective factors included the funding for support and a healthy economy whereas societal risk factors were stigma about mental health and suicide and poverty. Psychological risk factors included previous suicide attempts, present suicidal intent and a suicide plan, hopelessness, feelings of burdensomeness, rejection/thwarted belonging, and internalised stigma. Psychological protective factors include problem solving skills and coping skills, the desire to live, optimism, hope, positive future thinking and resiliency. This theory provided a more holistic theory of suicide, suggesting protective factors which can be used by those working in prevention and postvention to prevent suicide in at-risk populations. Traditionally, prevention efforts in public health and health science have often lacked robust theoretical foundations. However, literature in health professions emphasised the necessity for strong theoretical frameworks for effective prevention strategies (Im, 2015; Krieger, 2016; Prestwich et al., 2015). The incorporation of theory into public health practice offered several benefits, including the ability to conceptualise multi-level prevention and intervention programs, facilitate transdisciplinary communication, and account for practical societal and scientific factors such as funding and political considerations. This theory therefore gave an understanding on the importance of specific, tailored suicide prevention and postvention as a public health obligation. Services working in suicide should aim to incorporate and consider this multi-level theory into their support package. At present, it remains unclear whether suicide postvention considers the range of factors associated with suicide.

3.2 Ethical Considerations

This study was approved by the Liverpool John Moores University Research Ethics Committee (Reference number: 19/NSP/064, Appendix A). The services included gave their informed consent, all participants gave informed written consent and took part voluntarily. This included consent to audio record the interviews. Services received a gatekeeper information sheet, and all participants received a tailored participant information sheet that was relevant to them. These information sheets included a thorough explanation of the study, what participation would entail, confidentiality and the limits to confidentiality. Participants had multiple opportunities to ask the researcher questions before taking part.

The researcher also attempted to minimise potential harm to both the researcher and participants. Participants could participate if they had been bereaved for over one year to avoid disrupting any support they were getting from the service, to ensure the inquest had taken place and, in an attempt to prevent re-traumatisation. Participants were reassured that they could take a break or stop the interview at any time. Participants were also reassured that they could withdraw their participation or request statements to be redacted. Questions were worded sensitively and did not focus on how or why their loved one died, but simply focused on their experience of being bereaved and support by the service. At times, participants did discuss the death of their loved one and this was handled sensitively by the researcher. Participants taking part remotely at home or in the workplace were advised to find a private room or location. The researcher attempted to be aware of any signs of distress. All participants had the opportunity to debrief, and the researcher enquired about their well-being at the end of the interview. During this debrief, participants were given contact details of Samaritans and advised to contact their GP for further support, if necessary. Researcher distress was also managed as no more than two interviews were conducted in any single day and no more than five interviews in any single week. The Standard Operating Procedures includes a lone-worker policy and provided guidelines to ensure researcher safety for data collection (See following link https://www.ljmu.ac.uk/~/media/sample-sharepoint-libraries/policy-documents/scp18.pdf?la=en). The interviewer also had to have a mobile phone with them. Regular contact was maintained between the research supervisor and researcher and there was a debriefing opportunity at the end of each interview. At the start of the project, the student researcher had two years previous experience with this work and previous training in data collection and how to manage discussion of sensitive topics, specifically in relation to suicide research. See Appendix B for PhD protocol and Appendix C for the risk assessment form completed by the researcher.

Participants' privacy and confidentiality of personal data was a paramount concern. Contact details for services and potential participants, including phone numbers and email addresses were kept securely, on a password protected LJMU portal known as OneDrive which is a cloud-based system. Participants were immediately assigned a pseudonym. Audio recordings were stored securely and deleted as soon as transcriptions were complete. Services were not made aware of who was interviewed. Identifiable information was removed or anonymised. Data was stored on a password protected LJMU OneDrive. Completed consent forms were stored in a locked cabinet at LJMU, with the student researcher possessing the only key.

There was a risk of indirect identification in this study given the different service locations and the service’s support in participant recruitment. Quotes minimise the risk of identification of participants and all interviews have been sufficiently anonymised.

3.3 Public Advisory Group

3.3.1 Public Advisory Group (PAG) Formation

The PAG comprised of a group of individuals from different backgrounds, interested in postvention, who were bereaved by suicide, researchers in this field, clinicians or commissioners. These individuals were interested in developing a standardised tool kit for postvention services. Postvention services were also involved, as they wanted to evidence the impact of these services. This group worked collaboratively and co-created the PhD protocol. The aim was to review literature on postvention services and review how services were collecting outcome data within the current UK postvention delivery. It was envisioned that the PhD would inform the National Suicide Prevention Alliance guidance documents for the implantation of postvention services. The PhD was match-funded from LJMU and two charities working in suicide prevention. Once the PhD researcher was in place, they developed a formal public advisory group.

3.3.2 The aim of the PAG

A Public Advisory Group of experts was created to support the researcher in conducting this programme of work. This group included service Chief Executive Officers (CEOs), commissioners, researchers and academics, creators and founders of third sector organisations working in suicide, experts by experience, ambassadors and advocates. The aim of the group was to provide expertise, guidance and leadership to the project and the researcher. The objectives of the group were to advise on the set-up and management of the study, ensure that protocol was followed, identify services and individuals who could be approached to be involved in the study. Further objectives were to identify effective ways of engaging with suicide postvention services and explore perceived barriers to the research.

3.3.3 The governance

The Terms of reference was created and agreed upon by all members (see appendix D). It was agreed that meetings would be held on a tri-annual basis. Minutes would be circulated within two weeks of the meeting and papers would be sent via email at least three days before the meeting. Meetings were held face-to- face or via Zoom due to the Covid-19 pandemic.

3.3.4 The involvement of the PAG

The group was formed when the project began and as such, advised on the creation and implementation of the research methods. Interview schedules were developed and co-created in consultation with the group. The decision on who should be interviewed for this research was finalised in consultation with the PAG and it was decided that the researcher would also interview commissioners and commissioned service leads/CEOs. The final participant groups included: commissioners, CEOs, referrers, suicide liaison workers/employees, and service users, known as beneficiaries in this field. The PAG also supported the researcher in recruitment and communicating with services and potential participants, which became particularly important when the researcher lost contact with some services due to the temporary closure or reduced service offered by the organisations during Covid-19 (see section on Covid-19 below). The PAG facilitated contact details for services and aided with communicating with appropriate individuals in each service. The group informed on current and upcoming policies, guidelines and research in suicide and suicide postvention. The group also included the researcher in appropriate committees, such as the Measurement and Evaluation group meetings, led by SASP. The involvement of SASP was particularly valuable due to their links with the NSPA and their knowledge of suicide postvention services across England. The findings of this research will be used by SASP and the NSPA to inform national guidelines for postvention services for the use of standardised tools to ensure that services are able to evidence the impact that these are having.

Throughout the three and a half years that this research was conducted, this group was invaluable for a multitude of reasons. The group enabled the researcher to ensure that the research was applied and could support postvention efforts in the future. They were able to ensure that the researcher was informed about national guidelines. SASP informed on their work on core standards for suicide postvention services. Researchers and academics were particularly helpful in consulting on the systematic review, methods and thesis writing. Experts by experience, advocates and ambassadors were helpful in creating interview schedules that were appropriate for service beneficiaries and understanding what this research could do to support the suicide postvention community. The researcher was agreeable to sharing up-to-date suicide research to support advocates. Service CEOs and commissioners helped to create interview schedules, inform on the creation and implementation of services and support recruitment efforts. Barriers such as losing contact with services and potential participants were discussed with the group and members supported the research with contact details and re-establishing contact. For example, two key services where engagement ceased due to Covid-19. This was discussed within the group and a member of the group immediately contacted key people involved in these services and passed on the researcher's contact details. Within an hour of this meeting, the researcher had re-established contact with the services. There were some difficulties in consulting with a PAG. One such difficulty was the changing roles and crucial members leaving the group. Naturally, this affected the dynamics of the group, and the valuable input of these members was missed. However, new members were then included in the group which enabled the group to refresh and bring new information and support. Another difficulty was the fact that members of the group were individuals with a variety of commitments, and it was rare that all members could attend each meeting. This was overcome by sending members a Doodle poll where they could vote for a few different dates for the next meeting. This was sent well in advance of the meeting date. The researcher and Chair of the meeting would then attempt to keep track of which members could and could not attend the previous meeting and arranging a date for the next meeting that most of the members could attend. Members who could not attend meetings did contribute by commenting and supporting the development on materials and information shared by the researcher. Email updates and minutes of meetings were shared with all members to ensure those who could not attend were kept informed of the study progress.

Despite the minimal difficulties, the experience of consulting with a PAG was overwhelmingly positive and crucial to the success of the research. It is felt by the researcher that this study would not have been as impactful without the group as they were able to support the researcher by ensuring that this study met the needs of the suicide postvention service community and furthers their efforts in support for people bereaved by suicide. Their consultation ensured that this research was applied and added to the limited knowledge available on this subject. It is felt by the researcher that research such as this should not be and could not be conducted without the consultation and support of a PAG.

3.4 Qualitative methods

3.4.1 Study design

The study design for the qualitative aspect of the study was semi-structured interviews. Interview questions were formed through consultation with the public advisory group in the early stages of the project (See appendix E for interview schedules). A meeting with the PAG was arranged and members were sent the questions used in a previous piece of research conducted by the researcher, with the Amparo postvention service in Cheshire and Merseyside (Abbate, 2018). Each interview schedule was discussed in the meeting, with careful attention given to the language used. Members of the public advisory group then highlighted that they would find it beneficial to also interview commissioners and commissioned service leads/service CEO's. Two lists of questions were then created and agreed upon with public advisory group. Therefore, five separate interview schedules were co-created:

1. Beneficiaries
2. Suicide liaison employees
3. Referrers (GP's, police, coroners etc.)
4. Service leads
5. Commissioners

The qualitative methods included semi-structured interviews with beneficiaries, referral sources, commissioners, service leads and support workers. Interviews with beneficiaries focused on their experience of being supported by the services. Service lead and commissioner's interviews endeavoured to discover how the services were set up and the realities of delivering a suicide postvention service. Interviews with referrers included GPs, coroners, police and social prescribers. They focused on the impact the service has on these organisations and their experience of the referral process. Finally, interviews with support workers aimed to find out about the support they give and their experience of working in this way.

3.4.2 Setting

The inclusion criteria for services to be included in the research stated that services must have been in operation for at least one year, to allow for at least one year's worth of data and consistency in service delivery. Thirteen services that met this criterion were originally suggested for participation and contacted. Six services were contacted and did not take part. The creator of one of these services was interviewed as this person created the first postvention service in the UK. However, they no longer work for the service and the service opted to not be involved in this research. Reasons for non-participation included issues with availability, not responding to attempts to contact them, not offering postvention support and changes in the service leadership. Eight services were included. One of the services met the criteria for involvement later in the project and therefore participated when they had been in operation for one year. Another service started operating in additional areas and therefore, these newer areas were also included (see table 8).

Table 8: Postvention services that participated in the study.

Participating Services
IFUCARESHARE (Northumbria & Durham)
Every Life Matters (Cumbria)
SBSUK (Cumbria & South Scotland)
Amparo (Merseyside & Cheshire)
Amparo (Suffolk & Lancashire)
The Tomorrow Project (Derbyshire, Nottinghamshire & Leicestershire)
Pete's Dragons (Devon)
Outlook Southwest (Cornwall & Isles of Scilly)
WHSCT Service, 1 participant (Northern Ireland)

Across the nine services, eighteen beneficiaries, three commissioners, seven service CEOs/creators and seventeen suicide liaison employees were interviewed. Thirteen referrers were also interviewed. The participant group of referrers included five coroners, one GP, one public health official, one social prescriber, and five police officers. All participants had experience with referring into the service and/or supporting someone who had been referred into the service.

3.4.3 Participants

The sample for this study included 58 interviews conducted with 54 individuals who had experience of eight services providing suicide postvention support in England. One interview was conducted with a participant from an additional service in Northern Ireland as they originally created the first service in the UK. However, this service declined to participate. Therefore, it is only services in England that participated. Two interviews were dyadic interviews. Two interviews have been counted twice as two individuals were past beneficiaries who now worked for the service and as such, they were interviewed twice to discuss both experiences. See table 9 in for participant information and a summary for each interview discussion.

The following inclusion criteria was used for individual participants:

- Those bereaved by suicide must have been bereaved for at least one year, as the inquest was likely to have taken place and participation in this research would not disrupt support given by the postvention services.
- Anyone interviewed must have had direct experience of the postvention service (being employed by a service, referring into a service, commissioning a service, setting up a service or receiving the service).

Table 9: Participant demographics and summary of interview discussion (N=58).

Participant code	Gender	Job title/ Relationship to deceased	Summary
Beneficiaries			
B1	Male	Parent	Dyadic interview Coroner offered referral - Previously said no to support Conflicts
B2	Female	Parent	Dyadic interview Consented to support for family Conflicts
B3	Female	Wife	Police referral Support for children, benefits, finance Signposting
B4	Female	Wife	Police referral Husband had terminal illness Covid affected support – support was good
B5	Female	Partner	Police referral Conflicts Flexibility of support
B6	Female	Wife	Police referral Support affected by covid but bene felt the support was good
B7	Male	Brother	GP referral Covid affected support – support was good Service also provided counselling and signposting
B8	Female	Parent	GP referral Writes poems Impact extremely evident
B9	Female	Parent	Word of mouth, self-referral Impact – lots of support Problems with police Covid impacted grief
B10	Female	Daughter (adult) Previously also grandad	Employee/Beneficiary Mum found service – self-referrals Support for family – impact Aromatherapy support
B11	Male	Son (Adult)	Self-referral, told about service through work Covid Modelled how to talk about suicide, encouraged family to talk
B12	Female	Partner	No memory of referral Service holiday home, reiki

			Support with difficult relationship with in-laws Support for children
B13	Female	Wife	Self-referral Historic death – unsuccessful support elsewhere first Other deaths in family discussed with service Walking group
B14	Female	Daughter in law	Police referral FIL ill-health, caregiver for him Covid Angry
B15	Female	Partner	GP/self-referral Bespoke, support in many ways
B16	Female	Wife	GP referral Support began later Groups & counselling later
B17	Female	Ex-partner	Found info about service Initially hesitant to talk in group Group modelled grief reactions
B18	Male	Father	GP provided info about service Travelled out of area to attend
Commissioners			
Comms1	Female	Commissioner	Moral & professional motivation Services need to be more creative Cost-effective - funding
Comms2	Female	Commissioner	Dyadic quantitative and qualitative reports Funding
Comms3	Female	Commissioner	Dyadic Moral & professional motivation Funding
Referrers			
R1	Female	Coroner	Motivation Reasons for not consenting to service, asking too soon Brief form, satisfied with this
R2	Female	Coroner	Good relationship, motivation Funding
R3	Male	Coroner	Relief that service exists
R4	Male	GP	Impact, relief
R5	Female	Police	Multi-agency working Relief More awareness needed within police

R7	Male	Police	Relief Reasons why people don’t consent to support
R8	Female	Coroner	Motivation, relief – aware of own role Ease of referral pathway
R9	Female	Public Health	Relief Better links between organisations in this field needed Ease of referral pathway
R10	Female	Public Health	Motivation, impact Awareness raising needed Multi agency working
R11	Female	Police	Real time surveillance Impact and motivation Brief, appropriate referral pathway
R12	Female	Police	Motivation – aware of own role Out of area referrals
R13	Male	Police	Straightforward referral pathway Concerns about increases in rates and overwhelming service
Suicide Liaison Officers (SLOs)			
SLO1	Female	Suicide Liaison	Personal motivation – bereaved Was a volunteer for service - trained
SLO2/Bene	Female	Suicide Liaison	Previously a beneficiary – motivation Steering group member also Importance of support as bene before becoming staff
SLO3	Female	Suicide Liaison	Motivation – professional Out of area referrals, advertising service
SLO4	Female	Suicide Liaison	Motivation – professional, was a GP receptionist and nurse Peer support as an improvement
SLO5	Female	Suicide Liaison	Counselling background Specialised support needed
SLO6	Female	Suicide Liaison	Probation background Complexity of needs, wants to deliver more support
SLO7	Female	Suicide Liaison	Previously worked for Samaritans Counselling background Having a designated police officer
SLO8	Female	Suicide Liaison	Previously a beneficiary – bereaved Covid affecting service delivery at time of interview
SLO9	Female	Suicide Liaison	Counselling background Trauma focused, links with IAPT

SLO10	Male	Suicide Liaison	Community mental health background Real time surveillance Outcome measures
SLO11	Female	Suicide Liaison	Personal motivation – bereaved Funding concerns Keen to help the service grow
SLO12	Male	Suicide Liaison	Personal motivation - bereaved Concerns about outcome measures Use of lived experience focus group
SLO13	Female	Suicide Liaison	Personal motivation – bereaved Changing outcome measures, stopped using some measures and just started using a new one
SLO14	Female	Suicide Liaison	Personal motivation – bereaved Covid effects on service delivery Preparation for role is key
SLO15	Female	Suicide Liaison	Volunteered for another service (women's centre) Professional motivation Concerns with GDPR
SLO16	Female	Suicide Liaison	Teacher experiencing suicide in role, then trained as a counselling Safety plans, risk assessment Multi-agency working
SLO17	Female	Suicide Liaison	Volunteered for service previously Opt in vs. opt out
Service Lead (CEOs)			
CEO1	Male	Service lead/CEO	Funding and commissioning Professional motivation
CEO2	Male	Service lead/CEO	Personal motivation – bereaved Funding and commissioning Pilot for emergency service not funded
CEO3	Male	Service lead/CEO	Professional motivation Cost-effectiveness
CEO4	Female	Service lead/CEO	Professional motivation Concerns with using outcome measures IAPT links, trauma-focused
CEO5	Male	Service lead/CEO	Personal motivation Challenges, effects of covid Evolution of service

CEO6	Male	Service lead/CEO	Professional motivation Concerns with using outcome measures but is aware this is needed Difficulties recruiting
CEO7	Female	Service lead/CEO	Personal motivation – bereaved Funding concerns Further support after postvention support

3.4.4 Recruitment

In terms of recruitment for services, a scoping exercise was undertaken. Search engines were used to find postvention services and their contact information. The Public Advisory Group comprised of prominent figures in the field of suicide postvention who facilitated with contact information and suggestions for potential services. The Support after Suicide Partnership also supported with this. The primary author contacted the services via email or telephone. Potential services were then sent information regarding the project and were asked to sign a gatekeeper consent form.

In terms of recruitment for individual participants, once the gatekeeper consent form had been signed, the service themselves would find suitable potential participants, contact them and either a) give them the primary researcher's contact details and ask them to contact the primary researcher or b) ask permission to give the primary researcher their contact information and the primary researcher would contact them. The primary researcher would then be sent a list of contact details and would contact individuals to discuss the research and answer any questions. Subsequently, participants would be emailed a consent form and information sheet. Participants were given a minimum of 24 hours before being followed up by the researcher via telephone or email. Any questions raised by potential participants were answered during a follow up telephone call or email. Once written consent was given by the participants, interviews were scheduled at a time suitable to them. The primary researcher ensured that participants understood that the location and time of the interview should be arranged to observe their confidentiality and privacy, for example ensuring that they were not in a busy public place or likely to be disturbed or distracted.

3.4.5 Procedure

Potential services for inclusion were identified by the researcher, supervisory team and the PAG. The researcher invited services to take part in the study via telephone or email. The email text used was approved by Liverpool John Moores University Research Ethics Committee and was created in consultation with the PAG and the supervisory team. This explained the aim of the project and set out what participation would entail. A follow-up telephone call would be arranged to discuss this and answer any questions the service had. Once the service agreed to participate, a gatekeeper consent form and gatekeeper information sheet would be sent to them via email (see appendix F). Once this was signed, services would identify potential participants. To recruit potential participants, the service would contact them and either; ask them to make contact with the researcher or ask for permission for the researcher to be given their contact details and would contact them. Services were informed that beneficiaries had to be bereaved for over one year. Services were also made aware of who had participated but would be contacted if further participants were needed.

Potential participants were sent an invitation letter via email (appendix G). Potential participants then communicated with the researcher via telephone or email.
Following the initial contact, a consent form and participant information sheet was sent to them. Once signed and agreed to, a date and time was arranged for the interview. Interviews were conducted via telephone, Zoom or Microsoft Teams due to Covid-19. Interviews were recorded using two separate devices to prevent technical issues.

3.4.6 The interview process

Semi-structured interviews were conducted to collect data from 58 participants. One researcher completed the interviews. Interview schedules differed slightly depending on the participant type. Beneficiary interviews tended to last longer at around 1-2 hours. Interviews with referrers such as police officers, coroners, social prescribers and GPs lasted between 20 to 30 minutes. All interview schedules, regardless of participant type, shared a common theme in understanding the participant's experience of the postvention service. Verbal assent was also given at the beginning of each interview.

Immediately prior to the interviews, the researcher explained the purpose of the study and checked that they had understood the participant information sheet (appendix H) and signed the consent form (appendix I). Participants were given an opportunity to ask questions or opt out of the interview. Once they were ready to proceed, the researcher started to audio record the interview. A short disclaimer was read out to all participants, which outlined the aim of the study, how long the interview would take, that the interview would be recorded and how their data would be stored and used. Confidentiality and anonymity were assured, except in cases where they were to discuss imminent risk to themselves. If this was to occur, the procedure to follow was to discuss this with the participant, terminate the interview, report this to line manager and signpost the participant to their GP. Participants were reminded that they could ask for a break or stop the interview at any time. The researcher asked all participants for basic demographic information such as age, gender, occupation and geographical location at the start of each interview.

During the interview, an interview schedule was used to guide the conversation. The researcher attempted to be an active listener who listened carefully but at times, providing examples and repeating or rephrasing the question. At times, the interviews did deviate from the schedule, if necessary. This depended upon the topic of discussion and if the participant was discussing something that the interviewer wanted to discuss further. Two interviews were dyadic interviews, one of these were two beneficiaries, the other was two commissioners. Some interviews were with support workers who were previous beneficiaries of the service, in these cases the researcher would ask if they were agreeable to answering questions about their experiences of delivering and receiving the services. If they consented, both interview schedules were used to gain this information.

3.4.7 Data analysis process

In this study, semi-structured interviews were used to collect data from 58 participants from 9 services, including beneficiaries (n=18), referrers such as coroners, police officers, GPs, and public health (n=13), suicide liaison workers (n=17), service lead/CEO’s (n=7) and commissioners (n=3). Due to the length and quantity of interviews, interviews were transcribed using an online service, UK Transcription, or by the researcher using a software transcribing app, Otter.ai. These transcribing methods were approved by LJMU ethical committee. All interview transcripts were read and formatted by the researcher. This was to ensure uniformity and the removal of any identifiable information. The researcher also removed any information that the participant asked to be removed. For example, if a participant disclosed personal information relating to family or confidential employment information and they asked for this information to be removed from the final transcript. Where this occurred, in the transcript the researcher would write “information omitted”.

Interviews were transcribed and uploaded to NVivo12 (see Figure 7). Interviews were analysed once by service groupings and a second time by participant group, using Reflexive Thematic Analysis (Braun & Clarke, 2006, 2019, 2021). The data analysed using a primarily inductive approach, focusing on what was personally meaningful to participants. For example, the interviewer asked questions surrounding the support they have received and how this support impacted their grief experiences. Each interview was read through to gain an understanding of each participant’s experience. Each interview’s analysis focused on the impact the service had had on that individual. Analysis for interviews by service were completed first. Phase one of analysis began by looking at individual interviews, using NVivo to highlight potential codes (See appendix J and K). Phase two consisted of generating an initial list of emerging codes (flexibility, inquest support, practical support, emotional support, funding, see appendix J & K) and then looking across participants in the same group to develop the list further. Phase three included refocusing the broader codes into wider themes and considering how these codes may combine or interact. Phase four consisted of reviewing themes, creating clear distinction between themes and considering the possibility of their interaction or a sub-theme appearing in two separate themes. For example, the theme of finance and funding was emerging. Within that theme, the cost-effectiveness of the services was highlighted and in consultation with the research theme, it was decided that the theme of cost-effectiveness would be separated from funding. Furthermore, the different aspects of the support were grouped together to form a theme. This was an iterative process, returning to the data and relabelling codes to develop the themes. Phase five included defining, naming themes and creating a map of their interaction to create a narrative of the data). This process was then repeated in its entirety to analyse interviews by participant type. Although the inductive analysis approach allowed for the themes to develop based on the participants experiences, complete removal of the researcher’s background, knowledge, experience, and theoretical leanings are not possible (Watling & Lingard, 2012). Therefore, it became important that the research team held regular meetings to review transcripts and then discuss emerging themes.

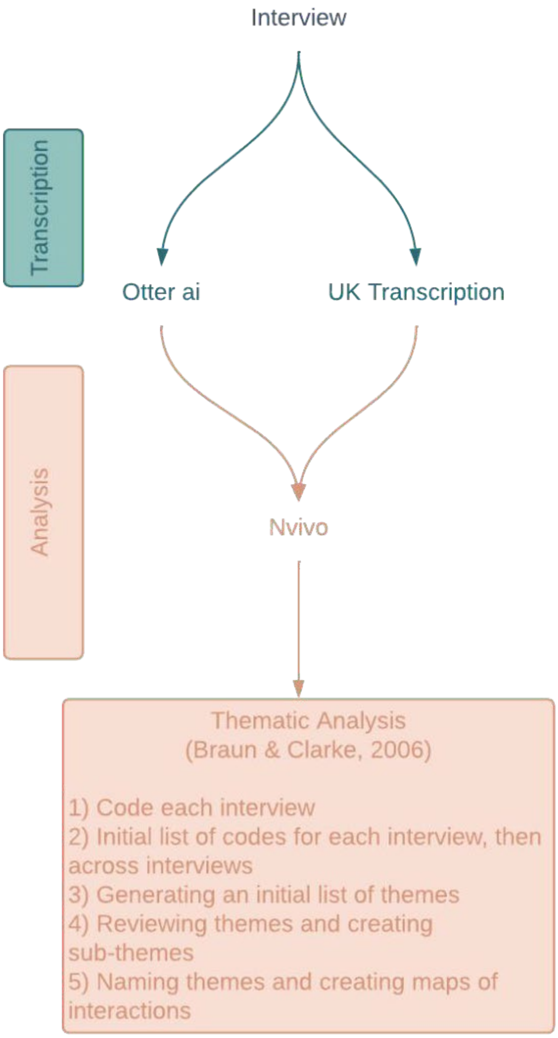


Figure 7: The process of analysis.

3.5 Quantitative methods

3.5.1 Study design

In this study, the quantitative methods included the following data:

1. Audit data
2. Outcome evaluation data using psychometric scales that assess mental well- being and psychological distress, Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS) and Clinical Outcomes in Routine Evaluation (CORE-10)

The data that this research focused on is as follows (see Table 11 & 12):

Table 10: Amparo data collected and type of data.

Amparo	
Data	Type of Data
Participant demographics	Age, gender, relationship to deceased, finder of the body
Referral Information	Number of referrals, why referrals weren't accepted, number of beneficiaries, referral source
Outcome measures	SWEMWBS

Table 11: Pete's Dragons data collected and type of data.

Pete's Dragons	
Data	Type of Data
Participant demographics	Age, gender, relationship to deceased, finder of the body
Referral Information	Number of referrals, why referrals weren't accepted, number of beneficiaries, reason for case closure and length of time in service
Outcome measures	CORE-10

3.5.2 Setting

The quantitative setting included audit data from two services, Amparo and Pete's Dragons (see Table 12). Amparo data was provided by three locations, for three years of operation: Cheshire and Merseyside, Lancashire and South Yorkshire 2019-2020, 2020-2021, and 2021-2022. Additional data from two newer Amparo services was collected from Kent and Medway 2021-2022, and Coventry and Warwickshire 2021-2022. Therefore, three years of data has been collected from three Amparo services. One year of data was collected from two Amparo services. Pete's Dragons data was collected from one area of Devon and Plymouth from one year, 2021-2022.

Table 12: Audit data sources (Amparo & Pete's Dragons).

Amparo	Pete's Dragons
Merseyside & Cheshire	*Devon & Plymouth*
2019-2020	2021-2022
2020-2021	
2021-2022	
Lancashire	
2019-2020	
2020-2021	
2021-2022	
South Yorkshire	
2019-2020	
2020-2021	
2021-2022	
Kent and Medway	
2021-2022	
Coventry and Warwickshire	
2021-2022	

3.5.3 Participants

The data collected included demographic beneficiary information such as age, gender and ethnicity. Referral information such as how beneficiaries were referred into the service, how many referrals were rejected and why and how many referrals were supported. Additional information such as relationship to the deceased and whether the referral found the body was also collected. All participants were service users, known as "beneficiaries", of either Amparo or Pete's Dragons.

3.5.4 Study Materials

3.5.4.1 Audit data collected from Amparo

Amparo collects data from all participants including demographic information, referral information and information about the deceased. Amparo uses Microsoft PowerBi to manage all their audit data on their beneficiaries. The researcher was given access to PowerBi and used this system to report on the data. The data collected by Amparo was comprehensive, this was discussed by the researcher and supervisory team, and it was decided which data would be most pertinent and appropriate to use. It was decided that participant demographics such as age, gender, relationship to deceased and finder of the body. Referral information was also included, such as number of referrals, reasons for referrals weren't accepted, number of beneficiaries and referral source.

3.5.4.2 Audit data collected from Pete's Dragons

Pete's Dragons audit data was also collected. They collect data from all participants including demographic information, referral information, information about the deceased, beneficiaries' length of time accessing the service and reason for case closure. Pete's Dragons provided the researcher with this information in a Microsoft Excel spreadsheet, via the researcher's university email address.

3.5.4.3 Amparo Outcome Measures

The researcher accessed evaluation outcome measures which was SWEMWBS, from one Amparo service (Merseyside and Cheshire) between 2016- 2022. This data was sent by Amparo via email, in a Microsoft excel spreadsheet. It does not include every referral or beneficiary that they supported in this period and did include missing data. Reasons for this missing data included losing contact with the beneficiary, unable to contact beneficiary, outside of remit and signposted, and only completing scores at one timepoint. SWEMWBS is a 7-item scale measuring well-being within the last two weeks. Five responses ranged from 'none of the time' to 'all of the time'. This is completed by the suicide liaison support worker with beneficiaries, usually at their first and last meeting, to assess well-being at those timepoints and to ascertain changes in well-being. Another aim of using this scale was to assess risk of suicide and self-harm. SWEMWBS has been validated for the general population (Ng Fat et al., 2017) and for clinical populations, including individuals diagnosed with schizophrenia, depression and anxiety (Vaingankar et al., 2017).

3.5.4.4 Pete's Dragons Outcome Measures

Pete's Dragons also collect outcome measures using The Clinical Outcomes in Routine Evaluation 10 (CORE-10), this is a 10-item scale measuring well-being within the last one week. CORE-10 assesses anxiety, depression, trauma, physical problems, functioning and risk of harm. This includes six high intensity/severity and four low intensity/severity items. It asks users to rate their well-being over the last week, on a scale of 0 (not at all) to 4 (most of the time or all of the time). Five responses ranged from 'not at all' to 'most or all of the time'. This is completed by the suicide liaison support worker with beneficiaries, usually at their first and last meeting, to assess psychological distress at those timepoints and to ascertain changes in distress over the course of some kind of treatment to monitor progress.
Another aim of using this scale was to assess risk of suicide. Barkham et al. (2013) also validated the CORE-10 in primary care patients as well as the general population, with an internal reliability (alpha) of .9. A total score of 11 or above is within the clinically significant psychological distress. Scores above 13 indicated depression, with a sensitivity and specificity of .92 and .72, respectively. The researcher was able to access this data directly through Microsoft excel spreadsheet sent by the service. This data consisted of 34 individual's CORE-10 average initial score, average final score and average change.

3.6 Data analysis

3.6.1 Amparo audit data

Amparo audit data from five Amparo services between 2018-2022 was accessed using Microsoft PowerBi, where Amparo collates this data. Amparo did not show individual cases but did show overall numbers for descriptive statistics. For example, N number of age ranges and N number of genders. The following overall descriptive data was collated and reported upon:

- Participant demographics: age, gender, relationship to deceased, finder of the body.
- Referral information: number of referrals, why referrals weren't accepted, number of beneficiaries and referral source.

3.6.2 Pete's Dragons audit data

Pete's Dragons audit data from Devon in 2021-2022. This data was sent by the service via Microsoft Excel. Pete's Dragons did not show individual cases but did show overall numbers for descriptive statistics. For example, N number of age ranges, N number of genders and so forth. The following overall descriptive data was collated and reported upon:

- Participant demographics: age, gender, relationship to deceased, finder of the body.
- Referral information: number of referrals, signposting and support enquiries only. Referral source, reasons for declining the service, reasons for case closure and length of support.

3.6.3 Amparo evaluation outcome data

Amparo evaluation outcome data was input into SPSS-28 to explore the impact of the service. After removing missing data, the data consisted of 270 individual cases of SWEMWBS scores taken from two time points, the earliest Amparo appointment known as the “first visit” and the most recent “last visit” appointment. SWEMWBS included seven questions on well-being. SPSS was used to analyse total scores from all seven questions at the earliest and recent timepoints. SWEMWBS cut off points were used to analyse low, medium and high levels of well-being. This was ascertained using Ng Fat et al., (2017) cut off points adopted by Warwick medical school “15% of the population can be expected to have a score >27.4 so we have set the cut point at 27.5 for high wellbeing. Equally 15% of the population can be expected to have a score <19.6, so we have set the cut point at 19.5.” Therefore, the researcher assigned low wellbeing to those who scored between 0-19.5, medium wellbeing to those who scored 19.6-27.4 and high wellbeing to those who scored 27.5 and above. A paired samples t-test was used to ascertain whether SWEMWBS scores improved over time as Amparo supported individuals bereaved by suicide. An ANOVA was conducted to see whether the year the individuals were supported and their location within Cheshire and Merseyside affected their SWEMWBS scores.

3.6.4 Pete’s Dragons evaluation outcome data

This dataset comprised of 34 individuals who completed the CORE-10 scale between 2021-2022. Scores are presented as a total score (0-40), as well as a mean score (between 0-4). Higher scores indicate higher levels of general psychological distress. Cut-off points were used to analyse levels of well-being. Connell and Barkham (2007) validated the following cut-off points: Healthy (0–5), low (6–10), mild (11–14), moderate (15–19), moderate-to-severe (20–24), and severe (25 and above). A paired samples t-test was used to ascertain whether CORE-10 scores improved over time as Pete’s Dragons supported individuals bereaved by suicide.

3.6.5 Data Quality

It was previously envisioned that data from all services would be incorporated in the quantitative analysis. However, only three services collected this data. One of the three services felt their data was not consistent and therefore, could not be included. Therefore, two services' data was used. As the data was not sufficiently linked, we could not make any inferences about any individuals. For example, we could not link the demographic data to the evaluation outcome data. Therefore, we could not assess whether demographics had any impact on evaluation outcome measures. Furthermore, Pete's Dragons provided 34 individuals who completed the CORE-10 scale within that year, despite the fact they supported many more individuals in that period. The Amparo service provided data from 439 SWEMWBS scores from 2016-2022. Once removing missing data and individuals with only one score, 270 individuals scores were analysed. The inconsistency in the data suggests issues with collection and recording of data. It was also difficult to match the data effectively, as one service had outcome measures from 34 individuals, whereas another service had 270 scores. Therefore, analysis could not be compared across these services. Paired samples t-tests were used to compare the means for a single group at two points in time, such as the initial and recent well-being scores. Further analysis was not possible due to the quality and quantity of the data.

As the data had some inconsistencies, we cannot determine effectiveness or impact. However, this does not negate the importance of collecting and using the data to attempt to assess whether these services are perceived to be beneficial and to support their efforts in adapting and improving the quality of their support, to meet the demands of commissioners. Previous research suggests that Randomised Controlled Trials (RCTs) should be conducted to assess effectiveness. Hariton and Locascio (2018) highlighted that RCTs are the "gold standard for effectiveness research". This would include randomly assigning participants to receiving one treatment and assigning another group to either receiving another treatment and/or a control group which does not receive the treatment, or they receive 'treatment as usual'. These groups are then compared, and a follow up can take place to ascertain whether this effectiveness is sustained. As stated by Hariton and Locascio (2018) RCT's have their difficulties, which include high monetary and time costs, and difficulties with retention. Furthermore, participants often volunteer to participate, which might not be representative. To date, there has not been any RCTs on suicide postvention. However, there are some RCT's on suicide prevention. One such study by Perez et al., (2023) compared telephone-based management, treatment as usual and a cognitive behavioural internet-based self-management tool for people who are actively suicidal. Thus, highlighting a gap in postvention research.

Although a service evaluation could not be conducted due to the lack of data collected by the services, the findings can be used to assess beneficiary and stakeholder experience of the services and its perceived impact on beneficiaries and communities. Descriptive statistics and outcome data can be analysed to review trends and gaps in service provision. Furthermore, lessons can be learned, and recommendations and improvements can be made to ensure the services continue to meet the needs of the community and the commissioners.

3.7 Triangulation of qualitative and quantitative data

Triangulation in research is the combination of two or more approaches to address a research question and to increase confidence in the findings through the justification of combining multiple theoretical approaches. Tashakkori & Teddlie (2003) suggested that the combination of findings from two or more approaches provides a more comprehensive picture of the results than one approach in isolation. Furthermore, Williamson (2005) argued that "this can allow the limitations from each method to be transcended by comparing findings from different perspectives". Therefore, triangulation is the methodological approach to combining approaches and in this case, quantitative and qualitative methods, to investigate the current suicide postvention service provision in England, the perceived effectiveness and impact of these organisations.

Heale & Forbes (2013) suggested that triangulation can result in three things: 1) the findings may converge and lead to the same conclusions; 2) the findings may relate to different phenomena but may complement each other; and, 3) the results may diverge or contradict one another. Results that converge verify one another and therefore, increase the validity of the study. Results that complement both aspects highlight the different aspects of a study. Results that diverge and contradict can lead to a better understanding and build a foundation for further research. Heale & Forbes (2013) highlighted some issues with triangulation as this process assumes that the differing methodological approaches are equal and comparable.

One example of methodological triangulation is Bekhet & Zauszniewski (2012), as they used a blended qualitative and quantitative approach. They found that the "qualitative data complemented and clarified the quantitative findings". The qualitative data supported findings by identifying common themes. Turner et al., (2019) examined integral breath therapy and its effectiveness for suicide bereavement. The results of this mixed methods study were used to triangulate data. Results of the qualitative and quantitative data suggested that it is a viable treatment to alleviate symptoms of complicated grief and improve well-being.

Triangulation in evaluation of programmes has been discussed by Greene and McClintock (1985). They discussed mixed-methods evaluation design using the independent, concurrent implementation of quantitative and qualitative methods, both investigating the same phenomena. The benefits of this strategy included reaping the benefits of both methods as a between-methods triangulation can support recommendations for change when evaluating programmes. The purpose of this design is "to obtain different but complementary data on the same topic" (Morse, 1991, p. 122). Therefore, this supported the purpose of converging different methods. The present study aimed to triangulate both qualitative and quantitative data to assess the perceived effectiveness of suicide postvention services in the UK. Figure 8 below shows the triangulation design of this thesis, using convergence. The researcher collected and analysed quantitative and qualitative data separately on the same phenomenon and then the different results were converged (by comparing and contrasting the results) during the interpretation stage. This model was used to compare results and corroborated the quantitative and qualitative results to gain findings about the single phenomenon of suicide postvention.

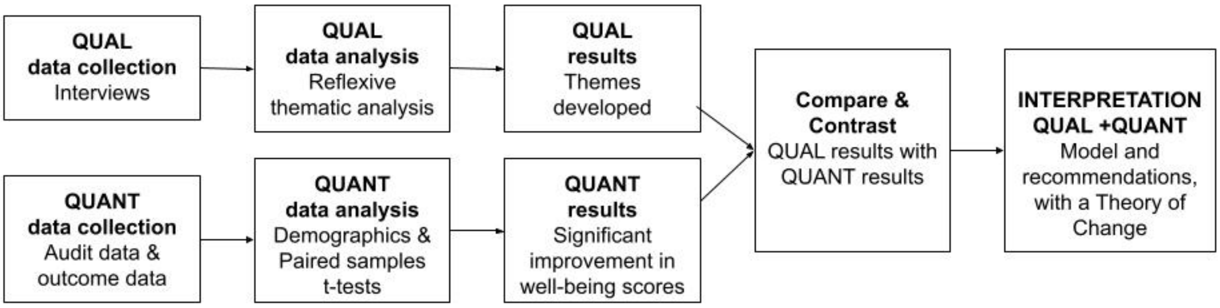


Figure 8: Triangulation design: Convergence model (adopted from Creswell & Plano-Clark, 2007).

3.8 Evaluation research

Researchers and evaluators have debated what evaluation is as there has been challenges in agreeing upon a single definition of evaluation (Castro et al., 2016; Levin-Rozalias, 2003). The overlap between related fields such as auditing, management, social science and public health exacerbates the issue as definitions may differ on the theoretical and contextual backgrounds. Indeed, some researchers are of the opinion that there is no difference between applied social science research and program evaluation, claiming "evaluation is applied research" (e.g. Barker et al., 2016; Hackbarth & Gall, 2005; Rallis, 2014). Opposingly, Montrosse-Moorhead et al., (2017) stated that evaluation is distinct from social science research, although evaluation does use social science methodology. This then created a vacuum of uncertainty surrounding what the differences are and to what extent evaluation differs from research. This uncertainty was summarised by Glass and Ellett (1980) who stated that "evaluation – more than – any science – is what people say it is, and people are saying it is many different things" (p. 211).

In a review of the topic by Wanzer (2020) they noted 13 different definitions of evaluations, used between 1968 and 2016. These definitions varied, with some discussing social research methods and social intervention programs, whereas others focused on decision making and comparing between alternatives. One such definition by Scriven (1991) focused on the evaluation as a "process to determine merit, worth, value or significance" (Scriven, 1991). This definition was used by many researchers and evaluators, however as evaluation methods differed, this added to the difficulty reaching a consensus. Schuchman (1968, p. 2-3) stated that evaluation applies "the methods of science to action programs in order to obtain objective and valid measures of what such programs are accomplishing… Evaluation research asks about the kinds of change desired, the means by which this change is to be brought about and the signs by which such changes can be recognised". However, some researchers discussed the differences between evaluation and "formal evaluation" as evaluation involved analysing and assessing a phenomenon, whether it's a person, object, or concept, against a defined measure. Formal evaluation entailed the structured assessment of a programme or policy's operation and/or results, in comparison to established criteria, with the aim of enhancing the programme or policy's effectiveness (Weiss, 1997). Perhaps the most useful definition for this thesis, the definition by Donaldson and Christie (2006, p. 250) who stated "evaluation generates information for decision making, often answering the bottom-line question "does it work?"…Follow-up questions to this basic question, frequently asked by those evaluating, are, "Why does it work?" "For whom does it work best?" "Under what conditions does it work?"

"How do we make it better?" Evaluators provide programme stakeholders with defensible answers to these important questions". This definition could be viewed as the one which aligned best with the intention of this thesis, as the aim of this thesis had been to ask the above questions, to ensure the services were delivery a good standard of support, and support stakeholders.

Table 13: Areas of difference between Research and Evaluation (adapted from Wanzer, 2020).

Area of Difference	Research	Evaluation	Where this research sits
Competence	Social science research design, methods, theory and so on	Same as research, but included interpersonal effectiveness, planning/management, political manoeuvring and so on	Research
Purpose	Generated knowledge to inform the research base	Generate knowledge for a particular programme/client and provided information for decision making/learning	Both research and evaluation
Primary audience	Other researchers	Clients	Both research and evaluation
Primary decision maker	Researchers decided the topic, methods, design	Clients and funders have a large role in determining what is studied	Both research and evaluation, due to the role of the PAG
Timeline	Decided by researcher	Bound by the organisations or funders timeline	Research
Funding	Research granted or university funding	Client organisation or funder, foundations	Both research and evaluation
What questions are asked	Researcher formulated their own hypothesis, research questions	Answered questions that primary stakeholders are concerned with; evaluative	Both research and evaluation, due to the role of the PAG

		questions	
Role of theory	Social science theory was embedded	Used social science theory, program theory and evaluation theory	Both research and evaluation
Value judgements	Value neutral	Provided a value judgement and often provides recommendations	Evaluation
Utility	Often did not think critically about use	Often concerned with use from the beginning	Evaluation
Publication	Published in journals	Rarely published and typically only clients view the reports	Both research and evaluation

The above table 13 highlighted the main differences between research and evaluation as adapted from Wanzer (2020). This table also showed where this research sits regarding the similarities and differences. Generally, this research could be viewed as both research and evaluation, particularly due to recommendations, models and the theory of change discussed in chapter 7. The involvement of stakeholders within the PAG also suggested that this research was evaluative. This research therefore supported the notion that in this particular case, there is no or few distinctions between research and evaluation (Barker et al., 2016; Hackbarth & Gall, 2005; Rallis, 2014). The overlap between the two could be favoured in cases such as this research, where researchers are attempting assess the quality, value or importance of a set programme or intervention.

The final point of debate on this topic asks the following question: but what if the data collection did not allow for the intended evaluation? As discussed in other chapters in this thesis, there were considerable barriers and complications when conducting this research. In particular, the lack of data collected by suicide postvention services and inconsistency within the data collected. This made it difficult to assess actual effectiveness or efficacy. Furthermore, the researcher could not embed themselves in the organisations due to the Covid-19 pandemic (as discussed in the reflexivity section). However, the data quantitative available and qualitative collected by the researcher could assess the perceived effectiveness by beneficiaries and stakeholders and share lessons learnt about what these services are attempting to do, with whom, and who benefits in terms of the wider community and stakeholders. Perceived effectiveness studies have been used to assess public health measures such as pandemic control measures during the COVID-19 pandemic (Chu et al., 2021). This study was similar to the present study as both studies had the outcome measures of the perceived effectiveness and positive attitudes of a public health concern, however the present study assessed suicide bereavement programmes known as postvention. Furthermore, this enabled the creation of a theory of change, recommendations and model which allowed for further research and stakeholders to understand the need, inputs and investments, activities, and short-term and long-term outcomes of suicide postvention.

3.9 Reflexivity

Further to the paradigm debate discussed in this chapter, there is often debate surrounding whether researchers can remain impartial and unaffected by preconceptions, particularly in qualitative research. Galdas (2017) revisited this and concluded that researchers conducting qualitative research "are an integral part of the process and final product, and separation from this is neither possible nor desirable" (p. 2). Furthermore, Galdas encourages researchers to be as transparent and reflexive as possible. The primary researcher of this study believes in post- positivist interpretivism, as this has led this research to focus on gaining knowledge from individuals and their experiences. In essence, one cannot learn about suicide, suicide bereavement and their support needs without immersing oneself in this topic. Interview schedules were created in consultation with people bereaved by suicide and individuals working in this area. I learnt from these people and adapted my way of working to optimise materials and my skills, to ensure the findings were applicable and added to knowledge that was much needed. Questions changed slightly over time in response to the needs of the community. Semi-structured questioning allowed for further exploration. Prompts were created and used where necessary to ensure specific questions were asked and allow for uniformity and replicability.

Although triangulation was a new concept to me, this further developed my knowledge of how the qualitative and quantitative aspects of a mixed-methods study can converge or diverge. I was then able to acknowledge the importance of this, as diverging results may be initially disappointing, we can learn a great deal from this. This therefore furthered my development in being objective and allowing the research to take me where it needed to go, rather than attempting to mould the findings into what I hoped to find. This was the final puzzle piece in understanding and developing this research.

It was disappointing that this research was conducted during a pandemic and as such, I was unable to embed myself in the services, as originally proposed.
However, due to the remote nature of working during the pandemic, I was able to interview a high number of people in a relatively short period of time. I found that participants were open to the experience of telephone and video conferencing interviews. I did not feel that their willingness to share and their honesty was impacted. We developed a rapport through our shared experience of conducting and being a participant of research during a global pandemic. It then therefore became increasingly crucial that debriefing was offered for both myself and my participants. It was also envisaged that I would be collecting quantitative data from all postvention services. However, it became apparent in the initial communication with services that very few services collected this kind of data. This topic then became an important feature in qualitative interviews as I strived to understand the reasons for not using psychometric scales to assess well-being and service effectiveness. This is now an important feature of the research. I am of the opinion that I cannot and should not separate myself from my experiences. It is those experiences that serve as inspiration and motivation to research in this field. Like many others in this field, it is almost a vocation. However, I agree that there must be a level of transparency and congruence to understand how these experiences have shaped research. I acknowledge that my prior experience of interviewing people bereaved by suicide, my training as a counsellor and working as a grief counsellor has helped me in the current study. Furthermore, for my Masters project, I worked with the Amparo service which gave me invaluable experience when extending the research to evaluating other postvention services. However, it is my experiences which also helped me to understand that although I am experienced in this field, I am not an expert, and I cannot claim to be an expert in what it is like to be bereaved by suicide and supported by a postvention service. I can of course, rely on my personal and professional experience, but the person that I am interviewing is an expert in their own lives and experiences. This is sufficiently humbling and allows me to rely on my empathic understanding. I believe it is my passion and commitment to this subject which has allowed me to fully immerse myself in the research and suicide postvention service community. This transparency has been extended throughout this thesis as I have endeavoured to be honest and open when outlining the creation of this study and the implementation of materials.

When this research project began in May 2019, it was envisioned that the primary researcher would be travelling to and immersing themselves in each of the services. However, in March 2020 Covid-19 was designated to be a pandemic and lockdown measures legally came into force. Educational settings, retail and all other non-essential buildings were closed, and social distancing was enforced. In July 2020 local restrictions came into force, banning people from travelling to other areas. Educational settings were re-opened in September 2020. A second lockdown began in November and in January 2021, educational settings were closed again. By March 2021, educational settings were re-opened, however non-essential travel was still discouraged until September 2021. As such, face-to-face contact with services and participants was not allowed. As the whole of the UK were under lockdowns, services were either closed or restricted to offering telephone and text support only. Furthermore, for the bereaved, all inquests were initially postponed. Eventually, inquests were conducted using Zoom, a remote video conferencing platform.
However, there was a backlog of inquests which is not expected to be fully cleared until the end of 2022. Postvention services also utilised Zoom to offer remote support to bereaved individuals.

The impact of Covid-19 on this research and research in general is difficult to quantify. As the lead researcher for this programme of research had young children who were at home full time and were being home schooled by parents, it became difficult to conduct confidential and ethical interviews, particularly as people were unable to leave their homes for non-essential travel. Therefore, all members of the researcher's families and indeed potential participants families, were in their homes. Services found it difficult to take part, as they struggled to provide appropriate support to the bereaved and simply did not have the capacity to take part. Therefore, some services declined to participate. The researcher endeavoured to keep in contact with services and complete interviews when they could. As restrictions eased, it became easier to access childcare, whether in schools or utilising “social bubbles” where one nominated person could be in close contact with the household. As country-wide restrictions were eased, local restrictions often replaced them. This research was conducted at LJMU, which was in a different local authority to the researcher, meaning the researcher was unable to access the university for extended periods of time. The university recognised the difficulty of continuing with research during this period, particularly for parents and caregivers. The university made the decision to offer a three-month extension of all PhDs, with an additional three months offered to those in difficult situations. Therefore, an additional six months was given to this research to compensate for the difficulties faced in conducting research during the pandemic.

Chapter 4: Qualitative Findings: Services

In this section, firstly I will describe the characteristics of each of the services that took part in this research, the participants from each service and the support that the services provided. As each organisation varied in their service delivery, structure, geographical location and organisational obligations, it became apparent that these differences needed to be explored before themes could be developed in relation to the shared experiences across services. The themes developed from analysing the data in this way allowed for an understanding of the needs of this sector as a whole, whereas the themes developed in the next section (chapter 5, qualitative analysis by participant type) gave an understanding of the experiences of beneficiaries and those who have experience of delivering or utilising the services such as referrers and key organisations involved in postvention support. Furthermore, analysing the experiences of those setting up and commissioning each service added to the knowledge gap that previous research has not provided, such as the motivation and vital considerations for how and why these services were created and to ensure they meet the key objectives recommended by SASP and the Zero Suicide Alliance. Finally, interviews with those delivering the service aimed to gain an understanding of the role, responsibilities and needs of those delivering a sensitive yet unregulated area of mental health support. It was thought that by conducting separate analyses on the services and then the different experiences of all of those receiving and working in postvention, would give a richer and deeper understanding of postvention support as a whole within the UK. The six themes that have emerged from the interviews with all nine services will be discussed below.

Figure 9: Diagram depicting postvention services and their main characteristics.

Figure 9 showed a diagram of the services and relevant characteristics of each service. Some services were commissioned by the NHS, some were commissioned by Local Authorities and others were not commissioned at all. The diagram also showed which services are police-led referral pathways, coroner-led referral pathways and self-referral. Some services operate with an early alert system. Also highlighted was which services used outcome measures in the form of psychometric scales such as SWEMWBS and CORE-10. There was only one service which offered support within an office, the other services operated within the community, often in beneficiaries' own homes. It was important to note that this diagram did not show any preference to any particular characteristic, it was a reflection on how the services may differ and the different options available to commissioners or organisations who are seeking to create another postvention service.

4.1 The Western Health and Social Care Trust (WHSCT)

WHSCT was set up due to a lack of services for people who had been bereaved by suicide in Northern Ireland and indeed across the UK. It was an NHS commissioned service which was police-led. The Sudden Death One (SD1) form was created by this service and would be completed by officers at the scene of a suspected suicide.

Whomever received that referral would then deal with the case henceforth. It was not just the police that referred into the service, there was a self-referral option and other services such as GPs could also refer patients into the service. The service was also asked to be involved in Serious Adverse Incidents (SAI’s) which was a review completed on individuals who had died by suicide whilst in the care of the trust.However, the participant felt it would be inappropriate for the service to be involved with these.

The scope of the service was to support “*anybody who had been impacted by a suspected suicide... It wasn’t just for families*” (CEO3). It was important to provide timely and early support, aiming to make contact with the potential beneficiaries within 24-48 hours of receiving the SD1 form from the police. They then aimed to have an assessment, or “chat” as the participant called it, with the potential beneficiaries within a week of the death. At this chat, it was encouraged for as many people to attend as possible, to ensure further family members or friends were given the option of support. The service also supported people in past suicide bereavements, the death did not have to be recent to be able to access this support.

4.2 Amparo – Merseyside and Cheshire

In 2015, the Cheshire and Merseyside Public Health Collaborative (CHaMPS) commissioned Amparo after researching potential postvention models. Listening Ear, a Merseyside based charity tendered the contract to implement the service. Amparo is Spanish for ‘shelter’ and was designed with support from CHaMPS and the Directors of Public Health England. Initially, it was commissioned for eight of the nine local authority areas of Cheshire and Merseyside as Sefton opted out. Throughout the years of operation, Amparo was then commissioned to also deliver the service in Sefton. Amparo was then commissioned to support people bereaved by suicide in the following areas: Cheshire & Merseyside, Coventry & Warwickshire, Kent & Medway, Lancashire, South Yorkshire, and Hampshire. However, for the purpose of this section, the service in Merseyside and Cheshire will be discussed.

Trained Amparo suicide liaison workers provided one-to-one support for those bereaved or exposed to a suspected suicide at an individual and community level. The aim of the service was to minimise emotional impact, promote recovery and reduce further suicides. The service offered practical support such as information surrounding the inquest, media and financial advice. It also provided emotional support and signposted to other services. Amparo supported families, next of kin to the deceased person and finder of a body; whether they were related to the deceased or not. Amparo also supported blue light services who are exposed to suspected suicides through their work, and communities such as schools, if there was a death within that community. In Cheshire and Merseyside, the service was offered by coroners when they make contact with bereaved individuals to make them aware of the process that must take place in terms of an inquest. They aimed to first make contact within 24 hours of receiving the referral. They also aimed to have a first appointment within 7 days.

4.3 Amparo - Newer Services

Since 2015, Amparo had grown and expanded its areas of operation. At the time of interviewing, it also operated in Lancashire, Suffolk and South Yorkshire. They no longer operate in Suffolk. At the time of writing this in 2022, Amparo operated in Cheshire and Merseyside, Coventry and Warwickshire, Kent and Medway, Lancashire, South Yorkshire and Hampshire. They all provided the same level of support; however, they differed in how they are commissioned, funded and therefore, the referral pathway.

4.4 Outlook Southwest

In 2010, Public Health in Cornwall asked Outlook Southwest to consider setting up a postvention service. There was no other NHS commissioned service in the country and service was created in consultation with the individual who set up an NHS Commissioned service in Northern Ireland. The service continued to have close links with the Clinical Commissioning Group in Cornwall as they had links with the IAPT service, it continued to be trauma-focused and was ran by IAPT trained therapists. The service was commissioned for one full-time post for the whole of the county of Cornwall and the Scilly Isles, covering a large geographical area. They reportedly averaged 110 referrals a year, providing practical and emotional support. They were able to offer a monthly visit to a family for about 90 minutes, supplementing this with text, email and telephone support. This support was until just after the inquest. Outlook Southwest also offered an eight-week grief education program, based on Acceptance and Commitment Therapy, which ran twice a year. They also offered referrals to the IAPT service and secondary mental health services. They also ran creative workshops, Cathedral memorial services once a year and monthly singing groups to improve well-being and help facilitate meeting others bereaved by suicide.

4.5 IFUCARESHARE

IFUCARESHARE was established in 2005 by a local family who were bereaved by suicide. It was started by creating wristbands to raise a small amount of money for charity. However, they raised much more, and their campaign grew. With the guidance of Professor Louis Appleby, the family began to think about the gaps in support and how they could address those gaps.

The service supported people in Durham, Newcastle, Gateshead, North Tyneside, Northumberland, South Tyneside and Sunderland. They offered practical and emotional support, whilst also supporting the wider community. They were commissioned by NHS North Tyneside Clinical Commissioning Group. It was a coroner-led service as the coroner referred to the prevention coordinator within Durham public health, IFUCARESHARE then received the referral from Durham public health suicide prevention coordinator.

4.6 Pete’s Dragons

Pete’s Dragons was created due to the death of the Service Lead’s brother whom the service is named after. It was commissioned to support anyone bereaved by suicide in the Devon area. They then began to operate a real-time suicide surveillance system in Devon, they received real-time information about suspected suicide deaths. They then contacted the police officer who responds and asked the officer to offer support to the family. They were commissioned by the NHS; however, they had multiple funding sources.

They offered traditional emotional and practical support, whilst also offering therapy for beneficiaries who needed further support after they have received the postvention support. Pete’s Dragons offered prolonged grief disorder therapy, emotional freedom techniques, grief recovery courses, hypnotherapy and Eye Movement Desensitisation and Reprocessing therapy (EDMR). They supported children through mindfulness through play. They arranged events such as family fun days, teenage forums and children's days out.

4.7 The Tomorrow Project

The Tomorrow Project was set up at the end of 2012 in response to a number of suicides in the community of East Leake on the Leicestershire/Nottinghamshire border. They were commissioned by Nottingham City Clinical Commissioning Group to support anyone bereaved by suicide in Nottinghamshire, Leicestershire and Derbyshire. They delivered this support in their offices, not the beneficiary's homes. They were a police-led service, using an automated referral system.

They offered immediate emotional and practical support to any individual that had been bereaved, affected, or exposed to a suspected death by suicide. This support extended to first responders and passers-by or witnesses. They offered 50–60-minute sessions every few weeks.

4.8 Every Life Matters – Cumbria

Every Life Matters was established in 2018 to address Cumbria’s high suicide rates. The Cumbria Observatory, using data from the Office for National Statistics reported that the suicide rate in Cumbria from 2018-2020 was higher (14.3 per 100,000) than in the Northwest of England (10.7 per 100,000) and the whole of England (10.4 per 100,000). The service was a charity, funded by the Lottery Fund.

Every Life Matters “is a ground-up approach to shifting public attitudes about suicide and skilling-up our communities to recognise and support those at risk of suicide" (National Suicide Prevention Alliance). They offered practical and emotional support to those bereaved by suicide in Cumbria, as well as aiming to raise public awareness, anti-stigma campaigning, training programs, supporting communities through community action plans and consultancy work. Every Life Matters was a police-led service, which involved the police referring people bereaved by a suspected suicide. This was done using a police alert system. There were other referral opportunities from health care professionals such as GP's and Social Prescribers, as well as the ability to self-refer.

4.9 Suicide Bereavement UK (SBSUK)

SBSUK was a service set up in Cumbria. This service used to be a SOBS group, otherwise known as Survivors of Bereavement by Suicide. Although SOBS is a nationwide service, the group support they offered was localised and ran by local volunteers. However, this relied on volunteers running the local group, therefore it could be that there was no functioning group within any town and attendees might need to travel to find their nearest group.

SBSUK was formed when a change in SOBS fundraising rules caused some concern. This change resulted in any fundraising taking part in the local area for that specific group would be given to the charity as a whole and therefore that fundraising may go to another area entirely. The founder of SBSUK did not agree with this change and SBSUK was formed.

SBSUK had no formal commissioning, it operated purely on donations from others and fundraising events. Their costs were for the rent of a room to hold group meetings once or twice a month and for tea and coffee. Trained facilitators oversaw the group sessions, and anyone could attend. They also had a Facebook group where the bereaved could talk. SBSUK also offered the opportunity to text or call the facilitators if a group member was in distress. Due to Covid-19, SBSUK started holding Zoom calls, which saw an increase in their numbers and people from other areas attending.

4.10 Qualitative data findings

Five themes were generated from the semi-structured interviews which included 58 participants from nine postvention services (Figure 10). Firstly, the support provision for people affected by suicide loss. Secondly, the accessibility of postvention services. Thirdly, the ongoing debate on useful and meaningful data collection. Fourthly, the sustainability and longevity of the services. Finally, the lessons learnt from delivering suicide support.

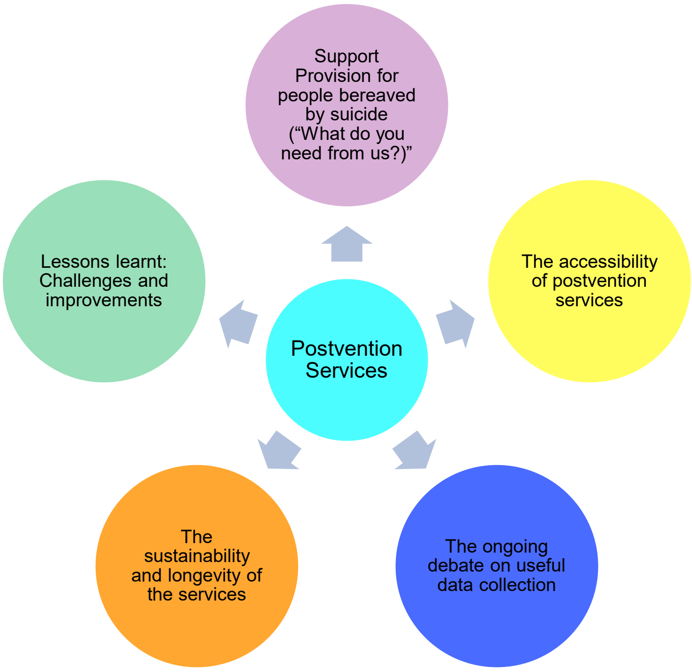


Figure 10: Five themes that emerged from the analysis of interviews by services.

The five themes were supported by sub-themes (see table 14). The first theme of support provision "what do you need from us" included sub-themes regarding the importance of both practical and emotional support, "survival" through the initial stages of grief, and the tailored, flexibility of the support. The second theme of the accessibility of postvention included two sub-themes which highlighted the perceived impact of coroner-led and police-led referrals, and the second sub-theme if you don't know, you don't know. The third theme discusses the ongoing debate surrounding data collection evaluation outcome measures and the sub-themes of the three questions of evaluation, and the need for data on cost-effectiveness. The fourth theme of sustainability and longevity includes sub-themes of funding avenues available to services and funding concerns for the continuation of services. The final theme of lessons learnt consists of two sub-themes of limitations and constraints, and coproduction and multiagency working.

Table 14: Themes and subthemes by service.

Themes	**Support Provision for people bereaved by suicide ("What do you need from us?)"**	**The accessibility of postvention services**	**The ongoing debate on useful data collection**	**The sustainability and longevity of the services**	**Lessons learnt: Challenges and improvements**
Subthemes	The importance of both practical and emotional support	Coroner-led vs police-led referral pathways	The why, the what, the how?	Funding avenues available to postvention services	The limitations & constraints in service delivery
	To survive through the initial stages of grief	If you don't know, you don't know	The need for data on cost-effectiveness	Funding concerns for the continuation of services	Coproduction and multi-agency working
	Tailored support that is flexible to individual needs				

4.10.1 Support Provision for people bereaved by suicide (“What do you need from us?”)

4.10.1.1 The importance of both practical and emotional support

The support offered by these services was the most frequent theme discussed, across the services. Services provided practical support which included support surrounding benefits, finances, funeral arrangements, inquest support, media support and any other relevant practical matters. Alongside this was non-judgmental, “listening ear” emotional support. The services also supported services and organisations affected by suicide, provided drop-in centres and community support when a death affects the wider community. They hosted events such as memorial events, remembrance events and events on key dates such as World Suicide Prevention Day. They send “anniversary” cards to people they support on the anniversary of their loved one's death. The quote below highlighted the many forms of support given to beneficiaries which included risk assessing beneficiaries for risk of suicide and worsening mental health issues.

> *“Practical support, when we go out and do a first visit… supporting them with what happens next. We go out and we explain the processes... We’re a listening ear... because they feel they can’t tell people because of the stigma that’s attached to suicide. We’re there for them to tell their story” (*SuicideLiaisonOfficer1, pg. 1, line 25 – 31).

The below quote highlighted some of the practical support they received and the perceived impact this had on the beneficiary:

> *“[Every life matters] phoned me, but with Covid and everything, well, at first they said we weren't allowed to go, but then they allowed me and my son to go. Obviously our local paper could phone in. Yes, he did, he supported me. I got a card off [them] when it was 12 months, just a 'Thinking of You' card off Every Life Matters and that. I thought, "Oh wow, how lovely is that?" I know it might just be a card, but it meant a lot to me”* (Beneficiary6, pg. 4, line 26-30).

Both emotional and practical support were essential facets of fostering well-being in those bereaved by suicide. Emotional support provided the empathetic foundation necessary for individuals to feel understood, valued, and validated in their experiences and emotions. It offered a comforting embrace during times of distress and a promoted resilient coping. Conversely, practical support addressed tangible needs, offering assistance with tasks, responsibilities, and challenges. This tangible aid not only alleviated immediate stressors but also demonstrated care and commitment in concrete actions. Additionally, expressing thoughtfulness through gestures served as a tangible reminder consideration and remembrance for not only the beneficiaries but also their loved ones who have died, adding to the trust and rapport between the beneficiary and their liaison worker, which then led to a positive opinion of the perceived effectiveness of the service.

4.10.1.2 To survive through the initial stages of grief

Participants identified that the services helped them to survive, giving them the tools and information to understand the process and the different agencies involved.

> *"I couldn't even see how I was going to survive the next minute… and I probably wouldn't have been able to do that if it wasn't for the support I was able to get. And I really do think the practical elements sometimes are just as important as the emotional elements in terms of having bought is just so important" (SuicideLiaisonOfficer4, pg. 8, line 25-30).*

Beneficiaries also valued that early, responsive support that often modelled appropriate grieving and confidence in their ability to be helped.

> *"because he'd been involved right from the beginning, he kind of got to know the characters in my life… I felt like he really cared, really got the feeling that he cared about how we me and the kids were. And he wanted to help. And I felt like he was sort of fairly confident. And that made me confident too that he that he could help us"* (Beneficiary5, pg. 4, line 27-30).

Retrospective testimonials provided by beneficiaries suggested that postvention services helped them to "survive" through the initial stages of their grief. The practical elements were equally as important as the emotional support provided and seeing a professional instilled hope and confidence that they could survive through this devastating experience.

4.10.1.3 Tailored support that is flexible to individual needs

The importance of the service offering bespoke support which had the ability to adapt to each beneficiary was also key.

> "*we're so bespoke, that's why it works because we tailor it to that person. We don't just say, this is Amparo, we've got these boxes to tick, and you must fit into these categories. We say, this is Amparo, what do you need from us?*" (SuicideLiaisonOfficer 16, pg. 8, line 15-17)
>
> *"So, I know that they pick up and that they will tailor make their approach to that individual. As I say, it's confidential on their part and it's best that way. I don't know need to know. All I need to know is that they've got that opportunity. I trust them enough to know that it will be done" (Referrer8, pg. 3, line 1-4).*

These quotes illustrated that services should be tailored to meet the needs of each beneficiary and the trust that is placed upon postvention services to support beneficiaries in ways in which referrers are not managing to. This highlighted the need to respect confidentiality and allowed the service provider the freedom to adapt their methods based on the specific circumstances of each person they assisted. The referrer acknowledged that they did not need to know the details of how the support was provided, as long as the individual received the help they needed. Overall, these quotes underscored the importance of personalised care and trust in services, emphasising a flexible and individualised approach rather than a one-size-fits-all approach.

4.10.2 The accessibility of postvention services

4.10.2.1 The perceived impact of coroner-led and police-led referrals

Another frequently discussed theme was referrals. However, the referral pathways for each service differed. Some services were police-led, which consisted of police officers referring the bereaved into the services. This tended to happen at the scene of the death or when the police notified next of kin of the death. Some areas had a designated police officer whose job it was to refer into the service and work on suicide deaths and this was represented in the participant sample with officers whose roles it was to solely attend suicide and other violent deaths. However, this was not common in all areas. Other services were coroner-led, coroners spoke to the next of kin to inform them of the coronial process and then also offered a referral into the service. Automated referral systems and real time surveillance were in operation in some services. This quotes highlighted how this system works:

> "*We work really closely with the police, we have automated referral systems in place with every single of the police forces of the four areas that we are in… we accept referrals from every other professional, we accept self-referrals. We accept referrals for people that are just concerned about a friend. We accept referrals on social media. So, we are very mindful of what can we do to remove barriers in accessing our service.*" (SuicideLiaisonOfficer 15, pg. 6, line 12-27).

The ongoing debate surrounding who is placed best to make the referrals continues amongst key stakeholders. This perspective offers an important insight into the decisions that each service must make when creating their referral pathways:

> *"Police officers, if they ask, they will fill it in this form [sudden death] but I'm thinking that's too soon… Sometimes we may need to wait for toxicology so we suspect the person may have taken an overdose but they may have lots of other health problems as well, so it's one of those, we need to wait for the cause of death first so it might be that, actually I'll hold off, I'll wait. So I've put here "to be confirmed, we're waiting for toxicology" so if it comes back 'Natural' then it's definitely not a suicide case but if it comes back as a massive overdose…On cases like that, the coroner's officer will get the cause of death and say look, it's confirmed, it looks like they have taken very large amounts of medication… more than can be accidental and that will be point where they can mention Amparo. But we have to be careful for those borderline cases"* (Referrer1, pg. 8, line 3-15).

The importance of flexibility, inclusivity and careful consideration on who was best placed to handle referrals was highlighted. This was most poignant for sensitive and complex situations such as suicide bereavement.

4.10.2.2 If you don't know, you don't know

Referrers and beneficiaries who were not involved in the service discussed how other people may be unaware of the service. Furthermore, it was the referrers whom often explain the service to the bereaved, services relied on referrers to adequately detail what the service was and how the service could support them. Some services received referrals from general practitioners and social prescribers. Services also had a self-referral option, however this relied upon bereaved individuals knowing about the service. Most participants discussed the benefits and issues with their particular referral pathway. It became apparent that to prevent missed opportunities, services should attempt to have an opportunity for multiple referral points and should network amongst other relevant organisations such as funeral directors, who could raise awareness of the services. Some services also worked with a real time data surveillance which was an early alert system with the police or coroners, which aimed to reduce the delay in reporting suicides, identify trends or clusters and support a community response.

> *"Initially it was through the coroner, discussions with the coroner because I was in contact with the coroner to talk about the death of [daughter], what was happening next and the coroner mentioned it during the conversation, whether we would be interested in being put in touch with Amparo. He didn't really explain too much about Amparo was, it was just more that it was there to help people after a death and at the time, I probably wasn't thinking very straight"*
>
> (Beneficiary1, pg. 1, line 9-14).

This interview was a dyadic interview with a husband and wife. This beneficiary then discussed declining the offer of the service, due to the explanation of what the service did, provided by the coroner. The beneficiary felt that a "counselling" service was not necessary. The wife explained that she overheard this conversation between her husband and the coroner and said that she wanted support. They then both re-referred for support from the service. This example highlighted the importance of having a good working relationship with referrers as services relied on referrers to refer into the services. Referrers must have a good understanding of what the service was and how the service could support bereaved families and people exposed to suicide.

> "*Well, they've got leaflets at GPs, at doctor's surgeries. And they connect with doctors, so a doctor will give a leaflet to someone. I mean, when the doctor came*

> *to see me, I was a wreck… I don't know whether it was a week or a week and a half, that I rang If U Care Share, after that. So, they are being referred. They're so well-known in this area”* (B8, pg.7, line 14-20).

The variety of referral opportunities made available to individuals bereaved by suicide was demonstrated as services attempted to reduce barriers to facilitate easy and quick access to support. An early alert system supported these efforts, and allowed services to be aware of suspected suicides very quickly. However, potential beneficiaries needed to be made aware of the service before they could be referred in or refer themselves. This awareness then showed help-seeking behaviours which suggested a commitment to live which could be nurtured by postvention services and therefore could prevent thoughts of suicide becoming acts of suicide within the suicide bereaved population.

4.10.3 The ongoing debate on useful data collection

4.10.3.1 The 3 Questions - The why, the what, the how?

The services were asked about how they evaluate their service. Beneficiaries provided testimonial feedback about the support they had received, which was often collected at the conclusion of the support. The scope of this study was also to find out about the quantitative measures used by the services to assess their effectiveness in reducing adverse consequences of suicide bereavement. Services discussed having difficulty finding an appropriate tool to measure their effectiveness. Most of the services did not use quantitative tools, it was only two of the services that used the tools consistently. These tools were psychometric scores (CORE10 and SWEMWBS) and were given to beneficiaries at the start of the support and at the end of the support, to assess if the service was reducing symptoms of depression, anxiety, post-traumatic stress disorder, and grief. This data was discussed elsewhere in this thesis. However, the quote below showed the services’ difficulty in finding an appropriate means to evaluate their service but also the need to do so, which often comes from commissioners.

> *“We've looked at a range of measures and I think, we pick them up and we’re like Oh my God, we can't use that… And it just, it just feels like a really*

> *difficult thing to measure. We're gonna have to put something in place, because we need to start demonstrating some degree of impact.*" (CEO6, pg. 6, line 18-26).
>
> "*We give a percentage of the outcomes for the people who have worked within that area over that time period. This is what the outcomes have been and that support. We've got better at doing that over the years. But we don't have sort of at the moment, a specific evaluation or feedback structure that we use. We are we did have back in 2018, an external evaluation done, which we paid for… We're looking at some point to do another one of those to have an actual external evaluation done of the service. Just to keep that sort of updated really, that was back a couple years ago now. We want to refresh that and look at it for the people who've engaged with the service since that evaluation.*" (SuicideLiaisonOfficer 17, pg. 16, line 33-pg. 17, line 8).

The findings highlighted that services needed to develop a standardised way of measuring impact. Two services used CORE-10 and SWEMWBS which measured risk and well-being. They used these measures with some degree of success, as discussed in chapter six and seven. However, the acknowledgment of the importance of evaluation and the ongoing efforts to improve assessment methods reflected a commitment to quality improvement and accountability within the sector.

4.10.3.2 The need for data on cost-effectiveness

The cost-effectiveness of these services was also a prominent feature in the interviews. The Centre for Mental Health estimated that one suicide costs the UK economy £1.5 million. One of these services cost £500-800 to support a family system until just after the inquest. Another service costs £202,000 a year. The services also discussed not having one single follow on suicide from all the people that they have supported, suggesting that they are preventing further suicides in this at-risk population. The quotes below suggested that the services can be cost-effective, and the services wished to highlight this to potential commissioners and funders. Therefore, these quotes highlighted the value of assessing cost-effectiveness of these services.

> *"I just hope that other areas, if they can get funding, if they, because they have to look at the bigger picture, they have to think about it, if they can prevent future suicides, then that in itself is a saving so they can't be looking at, oh it costs this amount, they need to think about the implications when people do take their own lives and the overall costs there so they do need to look at the bigger picture and give Amparo an opportunity"* (Referrer1, pg. 9, line 5-9).

> *"I think, daily people are on bridges, threatening to take their own lives and the amount of resources that goes in to try and prevent that loss of life and the police and the other emergency services do a fantastic job, they really do but if we can prevent it, actually what you've just said, if we can prevent people from getting to that moment, where they are on a bridge, thinking about ending their life, there's a cost saving, in effect. The local authorities need to look at the bigger picture, really."* (Referrer1, pg. 9, line 16-21).

> *"based upon the outcomes that are measurable and the outcomes that are qualitative is that, yes, they're cost-effective. They're cost-effective particularly when you look across the economy. So, it makes logical sense that they'd be very cost-effective across the whole health and social care economy, proving individual organisational cost-effectiveness. So, whether they're effective for the NHS, I think that's even harder still, though I still think it's probably true, but overall, absolutely, yes" (Commissioner3, pg. 7, line 6-12).*

These quotes suggested that the services are perceived to be cost-effective, however there is a lack of empirical evidence to support this. As highlighted in other themes, a cycle was emerging: postvention support requires research to assess pre and post outcomes, the lack of evaluative research may have detrimental effects on whether the services are re-commissioned. The availability of good quality data and services assessing their own impact was key, in order to assess the impact and effectiveness of suicide postvention across the country. Research on cost-effectiveness cannot be conducted unless good quality data is collected.

4.10.4 The sustainability and longevity of the service

4.10.4.1 Funding avenues available to postvention services

Services discussed where their funding came from and funding avenues available to postvention services. This varied between Local Authorities, Directors of Public Health, fundraising, creating private charities and NHS funding. One service was funded via the lottery fund; however, this is time limited to five years. The service would then have to find funding elsewhere. NHS commissioned services had considerable policies that they must adhere to such as evidencing the services were having a tangible and quantifiable change. There were issues with this as suicide bereavement is not something you recover from, it's something you learn to live with. As many services were not collecting this data, it was extremely difficult to access this funding. Public health and local authorities were a common source of funding; however, priorities changed within local authorities and funding was stopped and money allocated elsewhere. For example, for one service, one local authority did not opt into the service and therefore, if a bereaved individual lived in this area, they would not receive this support. Then another local authority opted out, which was the biggest source of referrals, resulting in anyone living in that area not being able to access this support. This sudden decrease in funding could have resulted in the service no longer operating. However, these local authorities then opted into the service. Independent charities in the case of one organisation, was originally created by a family who were bereaved by suicide who made wrist bands for people to wear if they were affected by suicide. They sold these, fundraised, and it eventually snowballed into a nationally recognised charity. However, this was extremely difficult to do. As explained, all funding avenues had problems and funding can be extremely unstable and inconsistent.

> *"I think that the sustainability of investment is what is required. As I stated, the Director of Public Health have funded this but as public health funds have been cut, every time the service comes up for recommissioning, it will be whether public health will still be able to fund it. As you may well be aware that NHS England has provided some additional money. But that money again is, is temporary*" (Commissioner1, pg. 4, line 4-8).

> *"But we try really hard to not let that be our only source of funding. We also*

> *apply for grants on a very regular basis, to look for particular opportunities to grow, expand and cover things that we are doing. We also provide training. We have a contract with Public Health England to provide suicide awareness training and that helps provide a little bit of funding to help keep everything that we are doing going. We work really hard to make sure we are not relying on any one particular source. That gives us a little bit of flexibility, but obviously if you take that leap of faith and hire someone, which we are actually going to hopefully do in January, you then do need to work hard to make sure that gets covered"* (SuicideLiaisonOfficer 10, pg. 9, line 4- 12).

To overcome funding anxiety, participants discussed the importance of having multiple sources of funding and bidding for more funding and other projects, such as training. This ensured that services were economically viable. These quotes illustrated the need for an understanding of sources of funding as long-term funding could not be guaranteed.

4.10.4.2 Funding concerns for the continuation of services

Funding concerns were prevalent throughout the interviews. Those running these services lived in a state of never knowing if the charity would continue to be funded, which caused considerable anxiety about the longevity and sustainability of the services. This was also felt by beneficiaries who witnessed the strain on the services who were often at capacity. Beneficiaries wanted to ensure the services continued to support those bereaved by suicide and wanted to support areas who did not have a service (see the first quote below). Services also wanted to ensure there was enough funding to meet the changing demands of both their beneficiaries and their commissioners. Funding could also be impacted by the lack of evaluation as services struggled to prove their effectiveness to commissioners.

> *"when she originally came to us, there were 3 people doing the job, she said there were 3 counsellors and unfortunately I think one of those left and she said she knew that nobody else would be employed and therefore, 3 peoples workload went onto 2 people… it's like any area of mental health, it has no funding which is so incredibly sad because it's an incredibly supportive thing, I wouldn't say I would improve on her service because she was fantastic but I*

> *know she was very limited on her time because she was being stretched so far, it would be more helpful to have people in those areas"* (Beneficary3, pg. 2, line 27 – pg. 3, line 3).

> *"The contract has remained the same sum of money that we were given in 2010. I sat down with our managers, senior managers and accountant and actually put together a bid, because I had said that this is not sustainable to continue, I need, we need to have additional hours and we need to have flexibility to develop more support… So right now, I don't know what's going to happen… And certainly, we're operating on a shoe strong. Certainly, they will have to look at increasing the funding because it's just not sustainable to continue on the same amount of money that we were funded for in 2010. But it's a political situation so we'll just to have to wait and see"* (CEO4, pg. 6, line 8-23).

> "*I don't know what's gonna happen the next two years of NHS funding, at the moment we don't know where the next lot will come from.*" (Commissioner1, pg. 4, line 14-15).

This demonstrated the profound impact of funding uncertainties on organisations providing postvention support, as well as on the individuals reliant on these services. It elucidated how the perpetual instability in funding engenders profound anxiety among service providers, who grapple with the uncertainty of whether their essential work will continue to receive financial support. This uncertainty not only jeopardised the sustainability of the services but also exacerbated the strain on already overstretched staff, as illustrated by the example of staff being overburdened due to staffing shortages. Moreover, it underscored the poignant reality faced by beneficiaries who witnessed the repercussions of underfunding first-hand, often experiencing services operating at full capacity. Thus highlighting an urgent need for adequate funding to ensure the continuity and effectiveness of these vital services, echoing the sentiments of both service providers and beneficiaries who expressed concerns about the repercussions of inadequate funding on the support provided to those bereaved by suicide. Additionally, it shed light on the bureaucratic challenges faced by organisations in securing funding, with the lack of evaluation exacerbating difficulties in proving effectiveness to commissioners. Overall, this underscored the critical importance of sustained and sufficient funding for services to meet the evolving needs of both beneficiaries and providers in the face of uncertainties.

4.10.5 Lessons learnt: Challenges and improvements

4.10.5.1 The limitations and constraints in service delivery

The limitations in service delivery were perceived to be caused by funding. Services highlighted the issue of not being able to support people outside their area of operation, as services were only able to offer the support if the bereaved people lived in their area of operation. Services felt this put them in a difficult position of not being able to support people who needed support and knowing that if there was not a postvention service in the bereaved person's area, they would not receive any specialist suicide bereavement support.

> *"To run it across a wider footprint, yeah. I think it really does need [investment]. It's happening slowly. But part, part of the problem is when the investment is coming from NHS England, it's expected that after the investment has happened, public health will pick it up. I don't know if it's public health will have the budget to pick it up. That's a big thing, there might be this big investment. And then it could all drop off a cliff at the end, because all the funding could just stop. And that will be a real negative situation to go into, but after all the work that has been done to, to demonstrate that this is this is a nationally, this is a service that's required across the whole population. It gets the funding, and then public health to say no, we can't afford that anymore, that will be the real wasted opportunity" (CEO1, pg. 7, line 31-39).*

> *"It's really heart wrenching when you know that they need your support and you have to say "I'm sorry but we don't cover your area" that's something I hate doing. I really hate doing it so I will always offer that phone support and I will send information out to them, even though we're not supposed to but I just couldn't leave that person… It's a service that's well used but could be*

> *used more”* (SuicideLiaisonOfficer1, pg. 6, line 18-24).

These quotes highlighted the limitations placed upon the services, often due to funding. This then impacted the number of referrals and the number of beneficiaries supported by the services. It also supported the notion that suicide postvention is a postcode lottery, if a bereaved individual resided in an area which has an active postvention service, they would receive support. If a bereaved individual was not in an area that offered this, they would not receive specialist suicide postvention research. Further research comparing the outcomes of those receiving and not receiving postvention would evidence effectiveness of the support.

Furthermore, participants reflected on the stigma surrounding suicide and conflicting feelings about a service delivering support to individuals bereaved by suicide after a suicide where the deceased did not receive support before they died. This was particularly so for services commissioned by the NHS, where a death may have occurred in the care of the NHS.

> *“Anybody who's providing a service like this, and particularly if someone has died in use of the NHS, you have to be prepared for all those kinds of emotions. But once spending a period of time was the family, the anger dissipated towards me, the anger still remained towards the NHS, but you can see they were that it was starting to get across that my role wasn't there to defend the NHS, my role was to see how we could support them at this difficult time.*” (CEO3, pg.4, line 26-31).

Other challenges of service delivery included the prospect of services offering further support, after the postvention support has ended, such as counselling, trauma-focused therapies, and group support. There were ongoing discussions across postvention services about changing from an “opt-in” to an “opt-out” approach. Services were considering adopting this approach. Furthermore, one service piloted an emergency response service for immediate suicide bereavement support, at the scene. However, this was not funded in the long term and the service hoped that this will be funded in the future.

> *“I think it's something that’s needed afterwards. Trauma focused counseling,*

> *it's very hard to get from, like a GP, it's such a specialist need, and just trying to get people into these services is tough. It’s a problem and maybe it’s something that [service] as a group could offer, as most of the people who work for them are trained counsellors”* (SuicideLiaisonOfficer5, pg. 4, line 7-10).

> *“you aren’t in the right headspace, are you? To reach out so early. The midwife just comes, don’t they? It’s a matter of course, isn’t it? Perhaps by them doing that, they may be hit with a no too soon”* (Beneficiary1, pg.19, line 21-23).

These quotes highlighted the challenges faced by services and the considerations they must explore in order to continue to adapt and meet the needs of the beneficiaries and the community.

4.10.5.2 Coproduction and multi-agency working

Services reflected on the benefits of coproduction and multi-agency working, in particular improving links between other services and professionals, ensuring referrers explained the service appropriately, and the process of being referred by other agencies.

> *“I think one of the biggest ones is knowing who we are so things like the GP stuff... It is not through wont of trying and through wont of sending information in and phoning people and saying “we will come and talk to you about the service and we will send you all this information!” You still have people that say “no we don’t know who we are”* (SuicideLiaisonOfficer16, pg. 12, line 31-pg. 13, line 6).

> *“I think relationships with other services. I think we need to massively improve our relationship with the police because they are dealing with them straightaway, dealing with our beneficiaries straight away and so if they knew more about our services, if every police in the areas knew about us, we’d get a lot more referrals in, it wouldn’t just be next of kin, we’d get finder of the bodies or people who were around that witnessed it and things like that”* (SuicideLiaisonOfficer1, pg.6, line 10-15).

The inclusion of a lived experience group was believed to be key as that could support the services in ensuring a good standard of service delivery. Resources such as the By Your Side booklet and care packs have been created to provide informational support materials to those bereaved by suicide. The inclusion of a lived experience panel also helped to ensure the services were meeting the needs of those bereaved by suicide, particularly if the service was led by someone who was not personally bereaved in this way.

> "*I haven't been bereaved by suicide, personally, some of our staff have been and not all. That's another thing that sometimes commissioners want everyone to do with the service to be bereaved by suicide. And I don't think that's personally relevant, for everyone. I think people can look at running a service, but they don't have to be bereaved by suicide, to know how to run the service. So that's why it's important that we've got a lived experience panel that we can, when we need to, we can flag things up with them*" (CEO1, pg. 5, line 12-18).

In summary, the importance of a bespoke service that adapted to the needs of each individual, incorporating both practical and emotional support, cannot be underestimated. Services differed in referral pathways, as some services relied on a coroner-led referral system, others adopted a police-led referral system and others operated a self-referral system. The consequence of each referral system was discussed, however, to mitigate any concerns relating to the referral pathway, services should attempt to have multiple referral points, have good working relationships and ensure that all relevant agencies and organisations are aware of the local postvention service. Funding concerns were evident throughout the interviews, as services strived to meet the demands of both beneficiaries and commissioners. Funding may also be impacted by evaluation outcome measures. It was only a few services that used any psychometric scales to assess well-being and changes in well-being that evidenced the perceived effectiveness of the support given to individuals bereaved by suicide. Services that did not use measures may struggle to show their effectiveness to commissioners. Finally, challenges faced by the services were discussed and improvements the services wished to make or were in the process of making were highlighted. Anyone wishing to commission or create a postvention service may wish to use these challenges and improvements when building a business plan for a postvention service.

Chapter 5: Qualitative Findings: Participant Group

In this chapter, the qualitative findings by participant type will be discussed. The experiences of the beneficiaries, commissioners, referrers (such as police officers, coroners, GPs, and social prescribers), service CEO's and suicide liaison officers (SLO's) and the themes that emerged from each participant group are highlighted.

5.1 Beneficiaries

Eighteen beneficiaries were interviewed, 14 women and four men. Table 15 below outlines the themes for this participant group.

Table 15: Beneficiaries themes and subthemes.

Themes	**Suicide: a different kind of bereavement**	**The beneficiary experience of postvention support**	**The availability of postvention services**
Subthemes	Stigma and suicide bereavement specific attitudes	Difficulty understanding the process following the suicide of a loved one	Knowledge of postvention services
	Grieving for someone who died by suicide	Initial expectations and appreciation for the support received	Help is at hand as a tool for postvention
		Lessons that need to be learnt	The concerns of inequity across different regions

5.1.1 Suicide: a different kind of bereavement

Suicide as a form of bereavement was distinct due to the stigma, intense emotions, complicated grief, and the need for specialised support. Suicide-bereaved grappled with complex feelings and questions that required understanding and compassion from their support network and community. This theme included subthemes of stigma and suicide specific attitudes and grieving for someone who died by suicide.

5.1.1.1 Stigma and suicide specific attitudes

Stigma and suicide-related attitudes also compounded their grief experience and the need for a postvention service. Beneficiaries reported that due to stigma and suicide-related attitudes, they felt unable to reach out for informal support within their communities and families, and postvention services filled this gap.

> *"there were other bits of stigma that I brought up [with service] that I really struggled with… unbeknownst to me there had been a reporter at my dad's inquest and then it made its way into a feature on this press. Which itself was difficult enough because it was unexpected for me. But the hardest thing then was the fact that it was one of the websites where you could leave comments, and there were people, complete strangers, that were leaving comments saying, "Oh, what a selfish man. How could he do it to his family?" … And it was so difficult for me to manage… But for me these things kept coming and there was no way of stopping them. I have had lots of practical advice [from service]" (Beneficiary11, pg. 4, line 15-29).*

The following quote was in the context of the participant discussing the differences of grieving for a family member who died of cancer, and a family member of died by suicide. The participant described how this was different and her reaction to the death by suicide.

> *"I was so angry at him. So so angry that how it happened, [my daughter] could have gone upstairs and found him. And I don't think I'd ever forgive him for that. It was bad enough that that my husband found him but to put my daughter and my husband through that. It's unforgiveable really … I'm nowhere near as bitter to him as I was, I feel, as I say, still got a bit of guilt, and I feel immensely sorry for him. I mean, my dad fought tooth and nail to*

> *stay alive and then, six months later, my father in law stepped out of life. And I really struggled to put the two together. Why couldn't it have been the other way around? Why can't my dad have lived if he wanted to live? And the father in law didn't, he did what he did, but my dad wanted to live, why couldn't he carry on living?"* (Beneficiary14, pg. 5, line 15-32).

The quotes lend support to previous research that concluded that suicide is a different type of bereavement. Thus, if suicide is a different type of bereavement, it may require specific support that is tailored to the specific needs of people bereaved by suicide.

5.1.1.2 Grieving for someone who died by suicide

The effects and impact of the grief were also wide-reaching and spread into many areas of the beneficiaries' lives. Many beneficiaries reported feeling as if they couldn't remember the days and weeks after the death. Other's felt that being supported so early on alleviated the effects of the grief.

> *"To be honest, I actually have no idea whatsoever [how they were referred]. Obviously, because my partner had taken his own life, all I remember is that day, and then literally being in the flat, and next thing I know, [Petes Dragons Support Workers] were there. So I couldn't tell you how I came- I can't even remember (Laughter) at all. It's quite strange. It's just like blank"* (Beneficary12, pg.1, line 27-30).

> *"The impact that they had was just outstanding in the first month because that was the toughest time of all and I don't think I could have… I wouldn't be where I am now if they weren't there at such an early stage. I really, really don't. I don't think I could have gotten through all of the practical things that I did get through, without them"* (Beneficiary9, pg.4, line 1-4).

Others reported the impact their grief had on the sessions themselves, and how the suicide liaison workers had to adapt to ensure the beneficiary felt comfortable and able to participate.

> *"I did have issues with flashbacks and images… I had issues with blank walls. And it was in a particular room, there were two rooms that we had our*

> *sessions in when we were visiting when I was visiting and the way the chairs was that one of them I was facing a blank wall that had a round clock. And I just kept getting the image of my father in law's face in that clock. Because where he was when he was found... all I associate white walls with is that image. She said, you seem a little bit uncomfortable, you're not really giving me any eye contact. And I said, I said I can't, I said I'm so sorry. I just cannot look at the wall. And she got me to explain why, what the issue was and then as I say, we moved the room around and the clock went down and wherever possible we didn't go in that room at all… they facilitated putting it right" (Beneficiary14, pg.3, line 26-39).*

These quotes supported the notion that postvention must be timely and appropriate given the bereaved person's emotional state. This therefore gives further credence to the efforts of governmental policies and organisations such as SASP who advocate for timely and appropriate support for people bereaved by suicide.

5.1.2 The beneficiary experience of postvention support

The beneficiary experience of postvention support was marked by a compassionate, immediate response to their emotional needs, connection with resources, and a supportive community. This assistance helped them navigate the complex terrain of grief and trauma, fostering healing and resilience as they move forward. This theme included the subthemes of difficulty understanding the process, the initial expectations and appreciation for the support received, and lessons that can be learnt from the beneficiary experience in improving postvention support.

5.1.2.1 Difficulty understanding the process following the suicide of a loved one

Beneficiaries reported having difficulties understanding the process that must take place following a suicide, including the police and coroners' involvement, the media and the inquest process. The support often alleviated these concerns. This therefore suggested that the complex process which must take place following a suicide may add to the emotional turmoil and sensitive nature of a suicide bereavement. A recommendation is that suicide support services should include this information within their support packages.

> *"It was the process with the whole coroners' situation. I didn't have a clue. I didn't know. Nobody was really telling us. They gave us guidance. When they came on board, they took over a little bit and they were my link with the coroner. They started to help us with things that were going on with the coroner."* (Beneficiary9, pg. 2, line 17-20).

> "*Because you are so dead inside, a little bit, aren't you? You need to have something spelt out to you really*" (Beneficiary2, pg. 4, line 13-14).

5.1.2.2 Initial expectations and appreciation for the support received

Many beneficiaries reported having no expectations before they accessed the service, however felt that the service exceeded any expectations they had. All of the themes discussed in this section contributed to beneficiaries providing heartfelt testimonials regarding how they have personally benefited from the services. They also reported that they are still supported in some way by the services, including receiving anniversary cards, being invited to events, and knowing they could contact the service again if needed. Finally, beneficiaries felt compelled to give back to the services, whether that be by fundraising, donating time or money to the services or taking part in research. These quotes indicated the fear of being a burden and the importance of having someone who is trained to handle the emotional reaction to a suicide bereavement.

> *"Being able to sit and cry in front of them, as well. I held my tears back for the family. A lot of people didn't understand. A lot of people are frightened to speak to you. They don't want to upset you, but really, what you really are crying out for is people to listen. And to be able to- to be empathetic with you, which is hard for people to do sometimes. But knowing they were there was a big impact on me. I went every week, at first. And there was no timescale."* (Beneficiary8, pg. 4, line 18-23).

> *"It was absolutely crucial to me coping, absolutely, and I think it must have*

> *saved money in the end… Certainly, protected me and my physical and mental well-being and kept me from, being a burden on the state and stuff in that way. Because you are really, really vulnerable yourself at the time. So, I think having a service that was bespoke like that, is, is fantastic in some way and hopefully part of it will also be looking at training to prevent people taking their own lives as well. And there it can't be in every circumstance because some people aren't even on the radar when it happened. I'm sure that that suicide liaison service could also help, funded to be training professionals to assist as well, so maybe these things don't happen so often*" (Beneficiary15, pg. 8, line 16-25).

Overall, these quotes highlighted the profound impact of suicide bereavement support services on beneficiaries' lives. They emphasised the importance of empathy, understanding, and consistent support in navigating the complex emotions and challenges associated with suicide bereavement. Additionally, they underscored the broader societal benefits of investing in postvention services, not only in providing essential support but also in potentially preventing future tragedies through education and intervention.

5.1.2.3 Lessons that need to be learnt

Beneficiaries suggested that there was feeling of resentment and upset about support being offered to them for their bereavement but experiencing a lack of support for their loved ones before they died. Similarly, if a postvention service was part of an NHS service and the death involving an NHS trust, beneficiaries felt that they needed to know that the service was separate in some way.

> *"I think that was the probably for us, suddenly we had a lot of support services which could have also been helpful to [daughter]. To find all those things after the fact is a little bit of a kick, really.*" (Beneficiary1, pg. 4, line 27-29).

Beneficiaries also suggested further lessons could be learnt from the potential for missed referral opportunities. Suggested lessons included: multiple referral points, sending out letters that outline what the service offers, getting the timing of the referral correct as some people were offered the service two days before the inquest and funeral directors as a referral source.

Some beneficials felt that the service discharged them too early and wanted follow-up appointments sometime after the inquest and/or after a check-up phone call six weeks after they were discharged. This issue was also closely linked to funding as beneficiaries saw how stretched the services were and although they claimed they received a good standard of care, they reported that they did see the consequences of the services at capacity. Furthermore, lessons were learnt from the COVID-19 pandemic as many beneficiaries who were supported by services during the pandemic felt that they missed face-to-face support and events which offered beneficiaries an opportunity to meet with others bereaved by suicide. This supported the inclusion of these components in suicide postvention as they were missed when they were temporarily suspended.

> *"Six weeks after is not good enough. I was fortunate enough to have heard about them before and self-refer, so I believe the biggest problem is that, when someone dies from suicide, your first involvement is normally with the police because it's normally the police that come to see you. At that point, I feel like there's not enough done by the police. Granted, the police just say, "There you are. This person has died. You'll be in touch with the coroner," so there wasn't enough information from the coroners' service, and definitely there was no support from the police whatsoever. I'm not saying that the police have got to sit and counsel you, but my argument was that, if someone is murdered, then there would have been a… You would have been given a police liaison officer, but when someone dies from suicide, and until there's an inquest, you don't know whether or not there are any suspicious circumstances or anything. So, the point of call for these services to be involved should be immediately. It shouldn't be six weeks down the line or if you happen to know someone who knows about the service"* (Beneficiary9, pg. 6, line 34-46).

5.1.3 The availability of postvention services

The availability of postvention services was vital for supporting individuals and communities during the aftermath of traumatic events, reducing the risk of further deaths, and promoting mental health awareness and resilience. It contributed to a compassionate and informed response to crises that was essential for the well-being of those affected. This theme included knowledge of postvention services, help is at hand, and the concerns of inequity.

5.1.3.1 Knowledge of postvention services

Knowledge sharing about the services was key to beneficiaries. Knowledge of available services allows individuals to access the help and support they need. Being aware of services enables early intervention, which can prevent problems from escalating into more serious issues. Some beneficiaries originally rejected the offer of the service due to the information given by a referrer, which impacted the support they received. To mitigate this, many individuals were able to self-refer but others did not know about this option or felt unable to self-refer. This also highlighted the needs for postvention services to have ongoing mutually beneficial working relationships with relevant organisations and referrers.

> *"I think the explanation of [the service] itself wasn't clear, wasn't very good but I think it depends who are speaking to. I think most men tend to be very insular, I'll take care of my family, this is my family, I don't need any support or help and just ignore the offer. I think if you talk to most women, then I have the opposite feeling, they are more willing to be open and listen"* (B1, pg. 2, line 20-24).

> *"I heard about [the service] loads actually. As soon as the first police person came around. They asked if I'd be open to support and I said yeah, so they, I think they just wrote down the website. And then also, I got copies of the… booklet. And I got loads of copies of that from different organisations. Even off the police, maybe twice, I think... But I just seem to remember there was a few of them around. And I didn't look at it for ages, because I assumed that it would just be rubbish but as soon as I opened it up, I realised that it was not rubbish. And it was really helpful" (B5, pg. 1, line 14-20).*

Knowledge is known to be empowering. When individuals know about available services, they can advocate for their own needs and make informed choices. This empowerment leads to greater self-determination and control over one's life, perhaps during a time when they feel a sense of loss of control due to an unexpected and/or traumatic death.

5.1.3.2 Help is at hand as a postvention tool

This subtheme highlighted the beneficiaries need for services to hold people, help people and signpost them to other relevant organisations and services. Beneficiaries reflected that they felt their grief was held in the hands or the postvention services, often filling a gap with the support they so badly needed, that they wouldn't be able to receive elsewhere, within statutory services.

> *"I thought what a great service to people like that who haven't got… [support workers] say "I'll come, I'll come and see you, I'll come and talk to you, I'll help you, I'll take you there", I thought that was a marvellous thing for people who haven't got anyone because if I'd have been on my own, I couldn't see me getting to that coroner's" (B2, pg. 6, line 7-10).*

> "*It just shows the gap that they fill as well, because there is no way that that information or that level of counselling would have been provided by my GP I don't think. And even as medical professionals we have a degree of understanding and training in this area, but it fell far short of certainly what I needed at that point. And a big part of my own process was that realisation that, "You have got to stop being a [occupation] because you are overthinking this. You are trying to fit this into various textbook models of bereavement that you read in 1997 and not what is actually going on today*" (Beneficiary 11, pg. 11, line 31-37).

Signposting was also felt to be a crucial aspect of the service being a conduit and link to others who may be able to help build a solid ring of support around a family whilst they are grieving in this way. Postvention services acted as a gatekeeper to facilitating other support for families affected by suicide. Beneficiaries discussed receiving this information verbally and via leaflets. Beneficiaries discussed receiving information about the following agencies and organisations: mental health support, Child & Adolescent Mental Health Service (CAMHs), Survivors of Bereavement by Suicide (SOBS) and other peer support groups. They also made interested beneficiaries aware of conferences and research.

> *"I think it was almost a sort of whenever it's needed to, did you realise there was a group, did you realise it was this, did you realise, and did you want... I actually felt I didn't need to do much else beyond that… I remember a comprehensive booklet. And that had lots of information in it. Lots of written down stuff, lots of other organisations as well. From time to time they would ask were I interested in… to make a connection with them. And then other relevant services, the general bereavement charities and different ones but to be honest, I felt that they kind of covered most things that I was needing them to at the time"* (Beneficiary15, pg. 6, line 22-30).

> *"Other mental health services she was brilliant with. She contacted them directly and she helped us get so much help as a family that we needed from other mental health services… I mean I had so much information from her which I know you can always go and find yourself but you aren't in that state of mind so she just gives you links to so many places whether they are locally or they are online and you realise there is an awful lot of support out there"* (Beneficiary3, pg. 3, line 6-8, pg. 5, line 9-12).

The service is seen as a lifeline for those who lacked other sources of support, offering companionship and guidance during a challenging time. Feedback highlighted the limitations of traditional medical support in addressing the complexities of grief after suicide loss. Beneficiaries recognise the postvention service's ability to provide specialised support that exceeded what was typically available through general practitioners or medical professionals. Put simply, the services offered what no one else could and knowing that help was available was crucial.

5.1.3.3 The concerns of inequity

Beneficiaries reported feeling concerned about the services' funding and wanting to ensure the longevity of the service. Beneficiaries felt that everyone in the UK should receive the support that they have had and reported feeling lucky they were supported through this experience. Although beneficiaries reported having a positive experience with the services, they were also aware of the strain on their support workers.

> *“it’s like any area of mental health, it has no funding anyway and this is another area, she said that has a huge lack of funding which is so incredibly sad because it’s an incredibly supportive thing, area… it would be more helpful to have people in those areas, really”* (Beneficiary3, pg. 2, line 27- pg. 3, line 3).

> *“I do feel that it is something that should be country-wide. Because it's seen as a problem for everywhere, isn't it? People taking their own lives and so and even obviously prevention as well, I mean, the prevention, treatment, which really is important for professionals as well”* (Beneficiary15, pg. 7, line 18-22).

This subtheme delved into the concern among beneficiaries regarding the equity and accessibility of mental health support services across the UK. It highlighted the sentiment that mental health services were underfunded and insufficiently available, echoing the broader societal issue of resource scarcity in mental health care and postvention support. Despite expressing gratitude for the support personally received, beneficiaries exhibited a sense of empathy and awareness of the systemic challenges facing services. They articulated a desire for universal access to postvention support, emphasising the importance of addressing this need on a national scale. This reflected a recognition of suicide bereavement as a pervasive issue that affects communities nationwide, transcending regional boundaries which impacted service delivery. This evidenced the pressing need for change and increased investment in services to ensure that suicide-bereaved individuals, regardless of their geographic location or circumstances, have access to the support and resources they require.

5.2 Commissioners

Three female commissioners were interviewed. Table 16 highlights the themes and subthemes for the commissioners interviewed.

Table 16: Commissioners themes and subthemes.

Themes	**The evolution of postvention services**	**The moral reasons to commission a postvention service**
Subthemes	Original scope and current provision	Collaboration and multiagency working
	Funding and sustainability	Community benefit and impact
		Motivation and expectations of commissioners

5.2.1 The evolution of postvention services in the UK

The evolution of postvention services in the UK had undergone a significant transformation over the years, reflecting a growing awareness of the importance of supporting those affected by suicide. This progression reflected an increasing understanding of the importance of providing specialised support to individuals and communities affected by suicide, with a focus on reducing stigma, increasing access to services, and promoting mental health and well-being, responsibilities that were felt by commissioners of these services. This theme included the subthemes of the original scope and current provision, funding and sustainability, and motivation and expectations of commissioners.

5.2.1.1 The original scope and current provision

The original scope of the services was seemingly quite wide in terms of who would access the service as it was envisioned that “anyone” affected by a suicide would be supported. However, geographical locations were very specific, as services were originally commissioned to deliver support in select areas. The services were often based upon previous services in existence such as the Northern Ireland service. However, the evolution of the services could not be underestimated, *"it's grown legs and walked across the whole of Devon"* (Comms3, pg.3, line 25-26). As the services grew, they learnt how to respond to the needs of the community and current provision was significantly different to what was originally envisioned. Services delivered more wide-ranging support, to additional areas. The fact that these services were ran by local communities allowed for more flexibility in service delivery, particularly for services who are in the voluntary sector. Furthermore, real time surveillance and data collecting became more important as commissioners wanted to see that the services were delivering what they were commissioned to deliver and were able to gather real-time information on a suspected suicide death in the area. Community response plans and supporting wider communities were also part of the evolution of these services.

> *"this is a service that's rapidly grown… we're now pushing them to occupy this space with the real-time surveillance where they need to connect to lots of potentially big entities in the councils and public health, and they're rising to that challenge, but I don't think we should underestimate how big an ask that is to know what's helpful to share with your public health colleagues. That's something commissioners take a long time to get our heads around. So, I think they're rising to the challenge, but we don't underestimate the challenge that we've put in front of them"* (Commissioner3, pg. 6, line 27-34).

This quote suggested the evolution that can occur rapidly for postvention services and how new services should use this to understand the dynamic nature of postvention. The ongoing efforts to adapt, improve, and be responsive to the community and the evolving expectations from commissions and stakeholders should be incorporated into business proposals for postvention services.

5.2.1.2 Funding and sustainability

As previously discussed, finances have evolved. However, commissioners were concerned about the sustainability of the funding as funding came from Public Health and the NHS. Commissioners reported being unsure of where the next round of funding would come from. Funding was closely tied to current events and governmental and local authority priorities, thus if it was not seen as a priority, it would not continue to be funded. This quote suggested the need for sustainable investment in suicide prevention and bereavement support services. The reliance on ad-hoc funding and the absence of dedicated budget lines for these services created an uncertain environment for their continuation. Feedback from commissioners reflected the broader struggle within the mental health sector to secure consistent and adequate funding to address the growing demand for support and intervention programs, suggesting political and cultural issues surrounding funding and mental health.

> *"I think that the sustainability of investment is what is required… the Director of Public Health have funded this but as public health funds have been cut, every time the service comes up for recommissioning, it will be whether public health will still be able to fund it. As you may well be aware that NHS England has provided some additional money. But that money again is, is temporary. So, as far as we know, Cheshire and Merseyside, will get some of that additionality for two years. It's how both the NHS and public health maintain funding for suicide bereavement in the long run. Well, suicide bereavement and suicide prevention because overall suicide prevention is the responsibility of public health, it's up to public health to coordinate it. Public Health doesn't get any specific funding for this. It's a difficult position when everybody says it's a good idea. But actually, if there's no budget line stipulated, you're always in an uncertain position. I don't think I can say anything more than that, because I don't know what's gonna happen the next the next two years of NHS funding, at the moment we don't know where the next lot will come from"* (Commissioner1, pg. 4, line 4-15).

5.2.2 Moral reasons to commission postvention services

The moral obligation to commission a postvention service was rooted in the recognition of the fundamental duty to support individuals and communities affected by suicide. The moral obligation to fund a postvention service was rooted in compassion, empathy, and the ethical principles of protecting life, promoting well-being, and reducing suffering. It reflected a commitment to a compassionate and just society that stood together to support those in need during times of crisis and loss. This theme had 3 subthemes: motivation and expectations, community benefit and impact, and collaboration and multiagency working.

5.2.2.1 Motivation and expectations of commissioners

The motivation to commission a postvention service varied between moral reasons, the suicide and self-harm rates in the area, deprivation and poverty in the area, research suggesting that people bereaved by suicide are at an increased risk of dying by suicide, personal passion and experience in preventing suicide. Furthermore, the belief that this can prevent future suicides and improve well-being was a motivating factor. This was closely tied to funding and cost-effectiveness as prevention is deemed more cost-effective. This therefore suggested a tension between what is right and what is feasible given funding constraints.

> *"Yes, I think it's necessary. When we first looked at the potential to commission, there were a number of different reasons that we identified. So, one was from a moral point of view, that those who have been bereaved by suicide should be able to access a support service. And then in terms of suicide prevention, we recognised that bereavement support is also preventative in itself. And then if you look at the economic argument, there's also a reason there so we approached it"* (Commissioner1, pg. 1, line 18-23).

Overall, commissioners did not have any expectations, with some believing the service would be like a counselling service. However, as the services grew and evolved, it became apparent that they were not a counselling service and provided both emotional and practical support. Commissioners reflected that any expectations were exceeded and were pleased that beneficiaries felt supported, and the data indicated that the services were potentially preventing further suicides and alleviating distress. This was crucial as commissioners were responsible for continuing to commission the services. Therefore, commissioners with a strong commitment, who valued the work that was being done and could support growth would aim to support the longevity of the service.

> *"I was just going to say, initially, I thought it was just a counselling service for somebody who's lost somebody to suicide. That actually isn't the service. It's much, much more than that. So, that was my initial thoughts"*
> (Commissioner2, pg. 3, line 13-15).

> *“I think the service is clearly met expectations in how rapidly they respond to a referral and how the support the individual receives and the feedback is very positive from individual bereaved person. I think that is all fine. I think that there could be more proactive work done by the service to ensure that key referral agencies have a very good understanding of the service. I think they could develop more communications that would actually support a wider range of agencies referring into them. They do some of this to ensure that GP’s, other health professionals, members of the faith community, social work, there is a whole range of key workers that those bereaved may have some contact with. I think that the service has been more proactive than that”* (Commissioner1, pg. 3, line 9-16).

5.2.2.2 Community benefit and impact

Commissioners reflected on the impact the services’ seemed to be having and how beneficial they were to the community. Commissioners felt that there were no negative effects of the service. They felt that the services were moral, effective, cost-effective, collaborative and supportive. These quotes highlighted the benefit of these services, from the commissioners’ perspectives.

> *“One standout positive is that one of the aims was that those bereaved themselves go on to consider suicide or take their lives. And as far as we know from internal audits that the coroner's have done, none of the beneficiaries of the service have taken their lives. And we, I think there's a statistic that we'd expect that 9% of those who take their lives have been bereaved. In terms of the aims of the service to prevent further suicides, its performing there, economically, again, performance you look at the cost of service against the cost of one suicide. Morally, it's supporting people at times of crisis.”* (Commissioner1, pg. 3, line 34-40).

> *“From my perspective, as a commissioner, it’s knowing that if the unthinkable has happened to someone, if they’ve lost a child or a parent through suicide, that they are not left without somewhere to go that is a safe pair of hands to support them. I know that sounds a bit wishy-washy, but we see the impact*

> *through the data. We value that, but for me, it's knowing that that person is not left without support in a time that's unthinkable for most of us. So, I really value that confidence that we have that they're doing that job well"* (Commissioner3, pg. 6, line 2-8).

Overall, these quotes demonstrated the positive perception of suicide bereavement support services among commissioners. They highlighted the services' effectiveness in preventing further tragedies, their economic value, and the moral imperative of supporting individuals during times of crisis. Therefore, it was not only the beneficiaries that reported the individual perceived effectiveness, but commissioners informed on the wider perceived effectiveness.

5.2.2.3 Collaboration and multi-agency working

Collaboration and multi-agency working were key, as previously discussed, many services were based upon services already in existence in Northern Ireland and in Australia. Furthermore, working with the Directors of Public Health, coroners and police enabled services to be funded and supported by local partners. Coroners and police were particularly important as they were often sources of referrals as everyone bereaved by suicide were contacted by both. Collaboration between commissioners and the services also impacted funding, service delivery, and flexibility as this allowed for communicating when the service needed further funding or would like to incorporate different ways of supporting beneficiaries. Involvement in real-time surveillance and data collection could also support both commissioners and the services in ensuring they were delivering support in the areas that need it and in the ways in which the community needed support. The services also had close connections with other local services, including SOBS. Commissioners also had a unique perspective in terms of improvements. Commissioners reported pushing the service for creative ideas, engaging with the community, and how the services can *"inform both partners and local communities about the service"* (Commissioner1, pg. 3, line 20). Commissioners were concerned about ensuring the service was offered at the right time and not causing further distress to families. Commissioners wanted to ensure that this was explored by the services.

> *"Not only are they out there connecting with our local services, but they're out there connecting with other bereavement services, trying to learn what they're doing that's better, and just trying to bring that home to Devon. So, I just don't*

> *know what more you could ask of a provider"* (Commissioner3, pg. 8, line 36-39).

> *"I guess I've always been struck by how much our partners do value the service. And so for example, as far as they can they be, the coroner's officers generally always attend the multi-disciplinary team meetings. And one of the previous coroner's officers who retired but she carried on doing some work for coroner's service, so she went on to provide training to coroner's officers around suicide bereavement and spoke at a number of conferences. So given the given the demands on the coroner's service that's better than expected"* (Commissioner1, pg. 3, line 47 – pg. 4, line 2).

The following quote also suggested the close link between the benefit and impact and the importance of multi-agency working, to work together to prevent suicides.

> *"It feels like as the commissioner I'm always having to push the service for creative ideas about how they can inform both partners and local communities about the service. I don't know whether it's just this particular service or part of the being in the voluntary sector, if you map where we have suicides in Cheshire and Merseyside, you could then do some thinking about well, this particular community over the last 10 years has seen so many, is there a different way in which we could engage with that community? Some of that happens, but a bit of a closer working in each area could enhance people's understanding of what the service is" (Commissioner1, pg. 3, line 19- 26).*

Collaboration with local partners such as Directors of Public Health, coroners, and police was essential for funding, referrals, and support. Commissioners played a significant role in fostering collaboration, advocating for creative ideas, and ensuring services met the needs of the community while minimising further distress to families. Overall, these quotes emphasised the significance of collaboration, learning from other services, and engaging with partners and communities in delivering effective suicide prevention and bereavement support services. It underscored the importance of a holistic, multi-agency approach to addressing complex mental health challenges.

5.3 Referrers

Thirteen referrers were interviewed. This included five males and eight females, five coroners, one GP, one public health official, one social prescriber and five police officers. All participants had experience with referring into the service and/or supporting someone who had been referred into the service. Table 17 outlined the themes and subthemes for referrers.

Table 17: Referrers themes and subthemes

Themes	**Co-production in designing postvention services**	**The benefit of collaborative working**
Subthemes	First contact with the services and expectations Referral pathways	Responsive, reactive and valuable support Challenges and improvements The impact of limited resources

5.3.1 Co-production in designing postvention services

Co-production in designing postvention services involved a collaborative approach that actively engaged service users, individuals with lived experience, and relevant stakeholders in shaping and improving support for those affected by suicide. This process promoted a more inclusive, effective, and empathetic service delivery model. Referrers such as police and coroners were often involved in the designing and implementation of the service, as well as referring into the service. The relationship referrers had with the services was key.

5.3.1.1 First contact with services

Participants were asked about their first contact with the services. Some were involved in the creation of the service, whilst others were introduced to the service later, when in multi-agency meetings or when the services contacted referrers to introduce themselves. Referrers reported gaining a detailed knowledge of what the services do and how they support people. They also reported on the usefulness of information materials such as websites, videos and leaflets. However, the most important aspect was arranging meetings with the services as this helped to build trust and open dialogue between the services and relevant agencies. Referrers discussed their expectations, many reported that they thought it sounded like a great initiative, with the overwhelming expectation that the services would prevent and reduce suicides. There was an understanding amongst referrers that individuals bereaved by suicide are very vulnerable and needed emotional and practical support in ways that the referrers either could not give, or it was not their role to give that support. In the case of coroners and police officers particularly, they were very aware that they had a job to do in terms of investigating the suicides and it was not their role and they did not have the time to give emotional support and they had the expectation that the services would provide this. It was felt by the referrers that this would take pressure off their services and give beneficiaries the support that they simply could not give. Referrers felt that their expectations were either met or exceeded.

> *“I think it means that we’re not- We deal with a lot of dead bodies and a lot of bereaved families. So, for us, we’re not just dealing with numbers. We’re genuinely trying to make life better for people who have been bereaved by suicide. Whilst we have a certain amount of tact and expertise around the matters, we don’t have the time to pick up the pieces to help the family rebuild their lives. So, it’s offering that. It’s going that extra step to say, “Right, here are the tools to help you rebuild your lives,” which obviously we don’t have to do. Unfortunately, in our role, it is very factual. We investigate the incident, deal with it, done. But that doesn’t necessarily mean to say it closes the book for us. We need to know that the family are going to be okay. So, for us, by giving them that contact, we know that they’re going to have that care that they need after we’ve finished our intrusive investigation.”* (Referrer8, pg. 2, line 9-19).

This quote therefore suggested that the first contact was crucial, and this was co-designed specifically with referrers. The importance of seeing beneficiaries as not just a number or a statistic, but as human beings was highlighted. This view was shared by referrers and service providers who both had a job to do, one was investigative, the other supportive. Together, they needed to manage complex and sensitive situations and heightened emotions within their contact with the bereaved.

5.3.1.2 Referral pathways

Referrals were the most prominent theme discussed by the referrers. Coroner vs. Police led referral systems differed. Coroners discussed their referral pathway, which included ringing the family to discuss the inquest process and offering postvention support. They then completed a Sudden Death Form which was then sent to the service. Police-led referral systems consisted of a police officer either offering the support at the scene, or a police officer telephoning the family sometime later and offering to refer them into the service. In some areas, they have designated police officers dealing with suicide and it is them that liaises with the family and refers into the service. Services also allowed self-referrals and referrals by other parties such as social prescribers and general practitioners. Referrers were concerned about when was the appropriate time to refer into the service and bereaved families not consenting to a referral to the suicide postvention service. Referrers discussed reasons for not consenting to a referral, which included stigma related to suicide as families did not want to believe the death was a suicide and therefore, did not want to be referred to a suicide bereavement support service. Another reason was the family having support elsewhere including within their family. Police officers specialising in suicide felt able to discern whether they should offer the family a referral after not consenting to a referral previously.

> *"Not on the very first time that the coroner's officers speak to the family, because it's always to arrange a post-mortem because inevitably with a suicide, there's a post-mortem. I normally get my staff, once the post- mortem has happened and they speak back to the family, they then mention Amparo and ask if anybody would like to be referred and quite often it's a no at that time because again, it's probably only 2 days afterwards. We don't get much take up then. But then during the sort of 8, 10, 12 weeks until it comes to inquest, if the officers speak the family, they will offer them the service."*

> (Referrer2, pg. 2, line 8-17).

Therefore, it was imperative that the pathway has opportunities for multiple referral points and an understanding of why a potential beneficiary may not initially consent to the services' involvement. This gives further credence to services' having a community presence and opportunities for self-referrals as it may be that beneficiaries would like support after some time has passed.

5.3.2 The benefit of collaborative working

Collaborative working offered a wide range of benefits, including increased efficiency, improved problem-solving and enhanced communication. It fostered a sense of shared purpose and led to more effective decision-making, ultimately contributing to the success of postvention services. This theme included three subthemes of responsivity, reactivity and value, challenges and improvements, and the impact of limited resources.

5.3.2.1 Responsive, reactive and valuable support

Referrers recognised that services were preventing suicide and providing a good standard of support, as such the longevity of services in existence was a concern. Referrers felt that all areas should have a service and that the services were an "investment". Referrers felt the services were beneficial, were an "amazing resource" and they "always have every confidence" when referring into them. Referrers felt that the services served the "greater good, to prevent future suicides". They recognised that whilst they had to fill in a form, the services alleviated pressure upon them, their organisations and statutory services. They felt that they wanted to continue to support the services and the most crucial improvement was to raise awareness of the service.

> "*From a coroner's officer's point of view, there's slightly more work because we have to cover a lot when we speak to families so we are then covering that as well. That's not a problem because it's for the greater good, to prevent future suicides. I can't say that we're seeing a decline in suicide rates because we're not, we've seen a slight increase but that increase may be even bigger if it wasn't for Amparo but it's so hard to measure that, it's really really hard. All we do know is that for the people who have been referred and*

> *been in the service, they have then, as yet, touch wood, not taken their own lives which is a really positive indicator but it's really really hard to measure*" (Referrer1, pg. 6, 20-27).

Referrers discussed the support provided by the services, in particular support surrounding the inquest. This included attending the inquest with the family. Additional community support included sitting on multiagency prevention groups that provide oversight on prevention strategies in local areas. Attending these prevention groups gave the services an opportunity to engage with others working in this area and introduce themselves to potential referrers who also sit on these groups. Referrers and postvention groups also worked together to identify populations and areas at risk. As there was little information sharing between police forces and coroners, referrers felt that the services often had knowledge of suicides and potential clusters. Some services also operated real time surveillance and shared this data with relevant authorities such as police and coroners. This highlighted how important the relationship between referrers and postvention services has to be, a sentiment reflected in the interviews. Referrers felt that the services were "approachable", "reduced their workload", "responsive, reactive" and "valuable".

> *"Some of the things that cause the biggest stress for individuals is the property of their loved ones who have passed away. Now, when officers go to the scene, they complete a coroner's report, they might seize some things for the coroner and book him into the police property store, a police station, but then they work on different shifts. So as far as they're concerned, all those they've done that job, they move on to the next job. With them working shifts, it's really hard for relatives to get in touch with that person. By having the relationship we have with Amparo and their staff know that they can come to me and say so and so needs keys for property, or they want they're asking about mobile phone or some piece of property, or can they have a copy of the note that was left? We're able to work that out for them, due to that relationship we have if they just tried to contact the officer in the case, that that they would struggle because the officers are on night shifts or on days off, they're constantly out responding to jobs, so it's really difficult for them to reach them. By having a point of contact within the police service, it's really helpful. It helps to reduce some of the stress that people might feel about*

> *recovering a car belonging to a loved one or, having access to property that's been seized"* (Referrer7, pg.5 line 49 – pg. 6, line 11).

5.3.2.2 Challenges and Improvements

Challenges and improvements that referrers felt were important to note included the relationship with coroners and police, as one challenge was the need to be conscious of roles and responsibilities and how they all have their part to play but should avoid conflicts. For example, there was specific information that should only come from coroners. Other concerns included when was the right time to offer the service, some referrers felt it was too soon to offer the service at the scene and that this would increase the bereaved denying consent to refer into the service. To prevent this, it was felt that coroners should refer into the service. Furthermore, referrers were concerned about offering the support too soon or too late and having multiple referral points in case bereaved individuals changed their minds about being supported by the service. However, referrers were concerned that they could not keep offering a service that the family had not consented to. Another concern was stigma associated with suicide as potential beneficiaries were "offended by the mere thought of suicide" and therefore, were not offered the support. Another concern was surrounding changes in priorities and funding in areas, as Amparo had two main areas suddenly withdrew and as such, individuals in these areas were no longer supported. Referrers also wanted to increase awareness of the services. Referrers felt that it was sometimes time consuming to refer people into the service, especially when they had to refer multiple family members for the same bereavement. However, they reflected that the referral process was simple. This therefore suggested that although the referrers perceived the services to be effective, there continued to be some challenges in service delivery that caused some concern amongst the referrers.

> *"No, not at the moment. As long as we can get the initial conversation, so I'm not so sure at the scene, I think that's too raw, too soon. The initial conversation with the coroner's officer so either before or after the postmortem. Sending these [leaflets] with the interim death certificates and then meeting them in person when we take statements because we don't see them at inquest, we probably wouldn't mention it again so I don't know, there's something there if the inquest clerk could do but by then they will have been asked a number of times."* (Referrer1, pg. 8, line 29-33).

5.3.2.3 The impact of limited resources

Referrers were concerned about the impact of limited resources. At times they had attempted to refer someone who was out of the service's area of operation and as such, they were unable to support that person. They discussed cases of one sibling being referred and other sibling being out of area and the impact this had on being able to refer people into the service. This was closely tied with funding, as services lacked funding in supporting people outside of their area of operation. There may not be another service in a different area, which prevented other bereaved people from accessing support.

> "*Petes Dragons aren't able to pick up anyone that's outside the area defined to them. So if there were agencies that Petes Dragons could refer me to for the specific area that these people live in, that would be a great help. Because I don't have a directory, I mean, I'm just thinking I've got a family member, a lady committed suicide, two children one's in Plymouth, the daughter can access Pete's Dragons. But the son who's suffering the same bereavement lives in Bristol, he's asked for help. And we don't have any contacts in that area, other than Cruse who've got a really long waiting time. Having sort of a national directory, I suppose, would be really good*" (Referrer12, pg. 3, line 8-15).

> *"The only improvements I would say could be made is to get more funding and more staff to do the amazing work they do, but that obviously isn't a reflection on them. I think they do amazingly with the resources that they've got, and I always have every confidence when I refer into them."* (Referrer11, pg. 3, line 27-30).

The systemic challenges faced by referrers in accessing support services for individuals affected by suicide bereavement was discussed. These included limited resources and funding constraints. They emphasise the importance of addressing these challenges to ensure that all individuals in need of support, regardless of their location, could access the help they require. This also calls into question the funding allocation for these services and the recommendation that all local authorities should have a postvention service, which further showed the political and cultural tension of needing a service and the limited resources available.

5.4 Service CEOs

Seven service CEOs/creators of the services were interviewed, five males and two females. Table 18 below described the service CEOs themes and subthemes.

Table 18: Service CEOs themes and subthemes.

Themes	**The lifespan of the service**	**Relationships with key organisations**
Subthemes	Creation and legacy of the service	Strong and collaborative working
	Staff skills and experience	Contractual obligations and streamlining referral pathways
	Funding and further investment	
	Challenges and improvements for setting up postvention services	

5.4.1 The lifespan of the service

The lifespan of the postvention service had been a journey marked by inspiration, growth, community engagement, continuous improvement, and a commitment to supporting those affected by suicide death. It stood as a testament to the power of compassion, resilience, and the importance of providing much-needed support during times of crisis. This theme included four subthemes: creation and legacy, staff skills and experience, funding and further investment, and challenges and improvements for setting up postvention services.

5.4.1.1 Creation and legacy of the service

The creation and legacy of the service was the theme most discussed by this participant group. The services differed in how they were created, however a common thread emerged as they had all looked at an existing service to help create their model. In the case of the Northern Ireland service CEO, he modelled his service on a service in Baton Rouge in the USA as there was no existing service in the UK. The other services then modelled their service on the Northern Ireland service, deciding which aspects of that service could be adapted to their area and disregarding aspects which they felt would not fit. All services were set up in response to either a personal bereavement, suicide rates in the area and the need for postvention support, this then became the motivation for setting up the area, which can be separated into personal and professional motivation. Some services created a business case for setting up a service such as this (Amparo, Outlook Southwest, Every Life Matters, Northern Ireland). Other services began by fundraising and the services grew organically from that (Pete's Dragons, IFUCARESHARE, SBSUK). This evolution of the services was crucial, as they found that to meet the demands of the community, they adapted their services to include aspects such as community response plans, memorial and events days, data collection and evaluation, consultancy and training. Some of the services also had an early alert system in place which was not part of the original scope of the service. The support offered by services therefore evolved from what was first envisioned to what the service now provides. Referral pathways varied in whether coroners or police should refer into the services. However, most of the services hoped to be extremely responsive and timely, by making contact with a potential beneficiary within 24-48 hours of receiving a referral and meet the beneficiary within a week of that referral. Service CEOs also wanted to have multiple referral points and ensure that other relevant agencies were aware of the services and could refer into the services. As the service matured, considerations turned towards its legacy and sustainability. Creating a framework for future leadership in the sector and ensuring the services' continuation became a priority. This was now the legacy of the services, as they ensured they were responsive to the needs of the community they served. They also wanted to ensure this knowledge was passed onto other services so that the legacy continues, as services worked towards having a postvention service in all areas of the UK, preventing a postcode lottery of support.

> *"Quite quickly on, we became aware that it wasn't just next of kin, there were significant family members, and colleagues, and again, that we had to change lanes in order for it because we thought it'd be next to kin. We had to bring in that significant family member kind of category into the into the work that we*

> *did. We've also done, we wrote the original community response plan that didn't exist. We'll be doing much more community response plans. And what else have we been doing? Those are the main points that I think have changed the potential beneficiaries. But we get so few finder of the bodies it's unbelievable, that you always hear the story of man walking dog.*
> *We've never heard that story and then thinking reality or, and they're not being made aware of the service for them. If someone does come across the body, I imagine that's really quite traumatic. Because finding someone, their body, must be traumatic, but to be completely random"* (CEO1, pg. 6, line 46-pg. 7, line 5).

> "*I do like setting up new things. So to have this completely new service to set up is really… So two new services to set up. It was exciting, because, it challenges your thinking and problem solving a lot. And it's like, how is this going to work? And you've got to toy the idea around in your head. And then say, yep, got it. This is how this service will work. So it was it was it was interesting to set it up. And also to meet with all the different stakeholders in the service is that, you meet with a whole new bunch of people. I don't think I've worked with coroners before. Because that's not the sort of service we were, in a reactive bereavement service… That was the thing that was very good to see, it's taken the kind of what the agency does up a notch really, because you're working with more services in a different way"* (CEO1, pg. 8, line 28-39).

Overall, the dynamic nature of service provision in addressing complex issues such as suicide bereavement was highlighted. The quotes outlined the importance of adaptability, innovation, and collaboration in effectively meeting the needs of individuals and communities affected by suicide, while also acknowledging the challenges and complexities inherent in this work, faced by service CEOs.

5.4.1.2 Staff skills and experience

Service CEOs were asked about the skills and experience they looked for when recruiting staff. This included confidence, active listening skills, empathy and reflective practices. Self-reflection and good instinctive behaviour were key to responding in a timely and appropriate manner. Counselling skills were felt to be useful but not essential. A background in some kind of caring profession, with some examples given of mountain rescue service dog handler, counsellor, prison officer, social worker. Time management was crucial as staff often had to manage their own diaries and time effectively, whilst dividing their time between multiple beneficiaries. An experience in bereavement was important, in particular suicide bereavement. However, this does not have to be personally. Some services recruited staff who had been bereaved by suicide and it was important that enough time has passed, and they had dealt with this sufficiently. CEO's also felt that staff needed to demonstrate a commitment to suicide prevention and passion for the role. Working with confidentiality and demonstrating discretion was key. Finally, it was desirable for staff to have experience in handling evaluation outcome measures and data collection, particularly as CEO's were beginning to think about how to do this effectively, as requested by commissioners and funders. CEO's were concerned about staff leaving as it was difficult to recruit for this role. One CEO reflected that it took three rounds of recruitment to find one suitable person to do the role due to the nature of the job and the specific skills they were looking for.

> *"Oh, yeah, one of the first things I said to [employee] was, if you are ever thinking of leaving, please tell me like about six months in advance. So we can manage your exit from this charity and manage getting somebody else, that is a real concern for us. I mean, we've got I think, because of the nature of our charity, we need to staff with very particular skills that I think are certainly in the suicide bereavement work, they need to build up those skills, and they're really hard to replace, really hard… we took three rounds of recruitment, and we've just taken three rounds of recruitment to get another support worker in the south. We've had low numbers of applications and poor quality"* (CEO6, pg. 9, line 30-36).

This quote highlighted the difficulty in hiring an appropriate staff member to deliver suicide postvention support and ensuring they had the skills and experience necessary to support people in this way. It also seemed that service CEO's would rather wait and find someone qualified, than to hire someone unqualified who may not be able to deliver the support in the way that it was needed.

5.4.1.3 Funding and further investment

Funding was a concern as the service CEO's felt that this area needed more investment. The longevity and sustainability of the services was also a concern, as many services wanted to ensure they could meet the changing demands of both their commissioners and the community they serve. There was a concern that commissioners could see budget cuts, or the political landscape could change and prevention and postvention would no longer be a priority. Service CEO's felt that they were often chasing funding, as they were constantly preparing for their next 6 or 12 months of funding. They described this as *"chasing their tail"* (CEO2) as they fear *"dry spells of funding"* (CEO7). The biggest piece of advice offered by this group was to ensure that services had multiple streams of funding and did not just rely on one avenue of funding. The experience of commissioning and relationship with commissioners was important as services needed to show that they are delivering the service that the commissioners require and pay for. The uncertainty faced by commissioners and the services was often felt by the service CEO's. Service CEO's felt that although there was an initial cost to setting up a service, in the long term it was cost-effective, and it was hoped that commissioners were aware of the benefits. For services commissioned by the NHS, it was crucial that postvention services were seen as separate entities to avoid conflicts of interest and distress that beneficiaries who were bereaved following a death within an NHS facility. The impact the political and financial situation of the country could affect funding and service provision. This was an interesting finding, as governmental policies suggested a need for services, but there seemed to be a lack of and inconsistency of funding.

> *"I don't know what's going to happen. So, hands tied right now, I'd hope to at least increase [Employee's] hours by April 1st but that's not going to happen by April 1st. And certainly, we're operating on a shoe strong. But that is because of circumstances, now that it's become a mandatory provision under NHS England. Certainly, they will have to look at Increasing the funding because it's just not sustainable to continue on the same amount of money that we were funded for in 2010. But it's a political situation so we'll just to have to wait and see. Probably, if you talk to me in a year's time, hopefully I'll have to say "no, we've got more money"* (CEO4, pg. 6, line 16- 23).

5.4.1.4 Challenges & Improvements for setting up postvention services

Service CEOs were concerned with the challenges they faced and how they could improve their service. IFUCARESHARE had piloted an early response service which was based upon a service in Germany. This service would respond at the same time as the emergency services and deliver immediate support to a bereaved family and/or finder of the body. Unfortunately, this was not funded further and IFUCARESHARE's service CEO would like to do this in the future. Service CEOs would also like to deliver the services for longer, across a wider area and additional support such as counselling or trauma-focused therapies. It was felt that by offering therapy and trauma-focused therapy such as EMDR "in house" would reduce the strain on statutory services and beneficiaries being placed on lengthy waiting lists. Challenges included when there has been a death within an NHS facility and the service is commissioned by the NHS, this can cause mistrust and upset within the family. Other challenges included the service being too reliant upon the service CEO, families not wanting to be supported by a suicide specific service due to not wanting to believe the death was a suicide, struggling to recruit staff with the appropriate skills and experience, changing the stigma surrounding suicide. Service CEOs discussed the lessons they had learnt and that they wanted to pass on to people who might be interested in setting up a service such as this. Working with professionals such as coroners and police was crucial as the relationship with relevant agencies must be strong in order to work effectively. Furthermore, learning appropriate language surrounding suicide was key, as was having good self-care and delegation skills. Service CEOs recognised the importance of having good supervision and line management and also offered staff benefits such as massages. It was also recognised that the pay was often lower than what they would like to offer and as such, it was important to be passionate about the job. Service Leads reflected that it is incredibly difficult to recruit and find staff and therefore, they are concerned about providing consistent support if a member of staff was to leave.

> "*So, the services is kind of funded by the lottery for five years. What we couldn't do, which became we kind of had an inkling might happen is we really struggled to recruit appropriate workers for the service. We've got quite a skill shortage in Cumbria. So, we've sat on the funding for about, probably about nine months before we actually recruited a kind of a permanent staff member."* (CEO6, pg. 2, line 18-22).

Another lesson and challenge was the introduction of outcome evaluation measures. Some service CEOs found it difficult to find an appropriate measure to assess changes in well-being associated with being supported by a suicide postvention service. However other service CEOs reflected an awareness of the importance of using these measures. The below quote reflected this sentiment and the positives of using psychometric scales such as CORE-10.

> *“When we brought in the introduction of CORE-10, my first thoughts about it were I was a bit nervous. I didn't think our beneficiaries were going to like this. It would make us much too clinical. We would feel like mental health services, and bearing in mind a lot of our beneficiaries have issues with mental health services because they feel they might have failed their loved one. So, we can't afford to feel NHS-y in any way. So, I was concerned about it, but we just developed a way of using it that was very relaxed. We don't read it out and all of that. We just hand it over on a clipboard, and we just ask them to tick, multiple choice, just tick the results. We take it back. We might use it to… If there's a concern on there, we'll just quickly scan it. Yes, if they're having suicidal thoughts, we will address that, but the chances are they're going to tell us anyway. We’re very offhand about it. We don't make a big thing of it. I know in mental health services they will talk people through each and every question. It's quite intense, so I wanted to make sure that didn't happen. Our beneficiaries have adapted to that really quickly. They know they've got to do their clipboard sometimes, and they just do it and hand it back. Then it's forgotten about. They don't even ask the results, most of the time. They're not interested. But on a positive, personally, I've had some experiences where I've been trying to advocate for a young person that they may need some more specialist mental health, or that actually things at home are so bad that they, maybe, need to be removed from the house. By being able to back up what I'm saying with CORE-10 scores, I get results from the other agencies that I never got before. So, overwhelmingly, I think it's an absolute positive”* (CEO7, pg. 8, line 17-37).

5.4.2 Relationships with key organisations

Strong relationships allowed organisations and individuals to expand their network and build valuable partnerships, which could be beneficial for future projects and opportunities. Building strong relationships with key organisations working in suicide could mitigate risk by drawing on the expertise of various members to identify potential issues and develop strategies to address them. This risk management could lead to more successful outcomes in preventing suicides. Two subthemes were identified: strong and collaborative working, and contractual obligations and streamlining referral pathways.

5.4.2.1 Strong and collaborative working

Service CEOs felt that their relationships with a variety of professionals must remain strong and collaborative, to successfully prevent suicides across the UK. Firstly, CEOs wanted to have good working relationships with their commissioners. This included the need to be flexible and to be able to demonstrate the service's success with the individuals who commission the service. Service CEOs should be able to justify the model they were using and highlight the impact they were having on individuals bereaved by suicide and the wider community. Relationships with referrers needed to remain strong as without these links, individuals would not be referred into the service. The services should also have good relationships with other relevant agencies and other postvention services, particularly in relation to referring people to receive further support and out of area referrals. Without services having an awareness of external agencies and postvention services in other areas, services were unable to ensure that beneficiaries were supported in the way that they needed.

> *"I think ultimately, for us, the overwhelming experience with commissioners has been good, I think, overwhelmingly, but I think the biggest thing I would like to say to commissioners, and unfortunately this isn't even commissioners' fault, but that working such tight deadlines, with the uncertainty of where you're looking in the future, can be really, really difficult. We are chasing our tails quite often and delivering a service where we haven't had money yet. We're very much in that hard place and biggest rock because we're not going to say, "No" to somebody, but we also have a service that needs to be funded. So, I think, ideally, if I could blanket send the message out, it would be a system where there is that clarity and that security, but, unfortunately, I am*

> *realistic that the response to that is, "Unfortunately, it's above our heads." So, yes, I'm realistic with that, but yes, I think this is something for commissioners that should already be a priority. However, if it isn't, I would very much encourage that it is made a priority and that postvention is up there as a service that is offered to people within the area"* (CEO2, pg. 7, line 39-49).

> "*It's been variable, it depends on the officers involved, we had a fantastic liaison officer out in the West Coast, very passionate about the work. And really keen to make sure the families got support. She was our main referrer. The police in the north, it's been, we probably had half the amount of referrals, in the south will struggle to engage with the police, although we haven't had a worker in place until recently. There's quite a bit of work in terms of building up relationships with the police and ensuring that they're making referrals*" (CEO6, pg. 8, line 3-8).

These quotes underscored the significance of maintaining positive relationships with commissioners, who played a crucial role in funding and supporting postvention services. They highlighted the importance of building and strengthening relationships with the police to ensure consistent and effective referral processes. There seemed to be challenges in engaging with police in certain regions and an ongoing effort to improve collaboration and communication. Overall, these quotes emphasised the crucial role of collaborative partnerships between service CEOs and professionals from various sectors, including commissioners, referrers, and police officers, in effectively delivering support services for suicide prevention and bereavement support. They highlighted the need for ongoing communication, cooperation, and advocacy to address challenges and improve the accessibility and quality of services for individuals and communities affected by suicide.

5.4.2.2 Contractual obligations and streamlining referral pathways

Information regarding referrals had been discussed elsewhere, and as such, the researcher will avoid repeating the same information. However, Service CEOs discussed the need to meet contractual obligations and streamline referral pathways from other agencies. Their desire and contractual obligation to make contact with a new referral within 24-72 hours and the importance of a streamlined referral process was important when considering relationships with other key organisations. Some Service CEOs were concerned about the impact of the General Data Protection Regulation (GDPR) on their ability to be proactive and reach out to bereaved families to offer support. Under GDPR, consent was defined as “any freely given, specific, informed and unambiguous indication of the data subject’s wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her”. Therefore, individuals must consent to their information being shared with postvention services. However, if a bereaved individual did not believe their loved one died by suicide, they felt shame or denial, they were less likely to consent to a suicide support service, preventing them from accessing the support they were entitled to. However, this must be carefully balanced as the service encountered the risk of causing distress. Service CEOs discussed their concerns surrounding this, as seen in the below quote:

> *“It's all around GDPR and data, to be honest. The police share that data with us, on the condition that we do not contact families ourselves. Actually, that's something that goes to the very… For me, even in the early days, I never wanted to be approaching the families before consent, before they gave their consent. Now, it was easy in the early days because, if they picked up the phone and rang us, that was them saying they wanted us. With referral, with the alerts coming in from the police, there are some people who still feel incredibly ashamed that their loved one might have taken their own life. Therefore, they would be horrified if someone rang and said, “I'm suicide bereavement support. Would you like our support?” because they do not want to accept that that happened. I would hate to think that we would ever increase someone's level of distress by doing that, so I’m quite happy with the way it works at the moment that they get to decide and choose. Then the police let us know”* (CEO7, pg. 4, line 7-18).

Other services were considering the option of having an opt-out service, where everyone is offered the service and they are automatically contacted by the service if there is a suspected suicide:

> *“But I have been talking to other agencies about this, because it's an opt in service at the moment, I think it should be an opt out service. I understand*

> *that there's some people think that it shouldn't be opt out, you should be given the choice to opt in. But what we've been able to see is because people don't know the choice that they're making at the time, maybe an opt out service might work better. But I understand there’s certain areas will think that's not an appropriate approach to take. And I get that, but I think it's just all part of the conversation. Opt in or opt out services have been a bit kind of poopoo’ed a little bit, but is this one that should be an opt out service? It’s a discussion that is interesting. I think it's beginning to people are beginning to think, yeah, that might be the way to do it”* (CEO1, pg. 6, line 35-42).

Overall, these quotes highlighted the ethical and practical considerations involved in the referral process for suicide support services, particularly in navigating data protection regulations and respecting the autonomy and emotional needs of bereaved individuals. Therefore, it is important to find a balance between providing support and respecting individuals' privacy and autonomy. This balance affected the referral processes and the practicalities of delivering support to individuals who may be reluctant to accept support for a variety of reasons.

5.5 Suicide Liaison Officers (SLO)/Employees

Seventeen suicide liaison employees were interviewed, fifteen females and two males. Table 19 outlined the themes that emerged from the interviews with SLOs.

Table 19: SLO themes and subthemes.

Themes	**Suicide Liaison Officers Role**	**The needs of the Suicide Liaison Officers**
Subthemes	Adherence to confidentiality procedures	The desire to make a difference
	Emotional and practical support	Self-care and appropriate clinical support
	Wider community outreach support	Skills and experiences
	Service evaluation and data collection	Recruitment and staffing challenges

5.5.1 Suicide Liaison Officers role

The role of a Suicide Liaison Officer was focused on crisis intervention, risk assessment, education, and collaboration to prevent suicide and provide support to those affected by it. This theme discussed the aspects of this role, including confidentiality, support, wider community outreach support, and service evaluation and data collection.

5.5.1.1 Adherence to confidentiality procedures

Confidentiality is crucial, especially when the services supported multiple members of the same family. To ensure confidentiality, where possible different SLO's supported different people. However, in smaller teams this was not possible. SLO's discussed making careful notes of their sessions and ensuring they see different members of the family at different times. The General Data Protection Regulation (2018) was adhered to by the services. For services who support children, careful consideration was taken to make sure that information that is shared is done in the best interest of the child.

> *"We try not to see the same family members, we will have different support workers take on different family members, if say it's a really big family, and that's just not doable, then we kind of work together to see which support workers should take on which clients, I've had it before where a couple didn't want to be seen by the same support worker. We basically said okay, then we'll have to wait for another support worker comes available, while one is taken on which they're absolutely fine with."* (SuicideLiaisonOfficer14, pg. 3, line 37-42).

5.5.1.2 Emotional and practical support

Most of the services offered support at the beneficiaries' home, however one service supported beneficiaries at the service's offices. The services delivered a similar service as they all offered bespoke practical and emotional support in a timely manner. The practical support included support with police, coroners, inquests, media, finances, government benefits, business and employment, funeral arrangements. Anything that occurred that the beneficiary felt overwhelmed or needed support with, their SLO offered support. Emotional support included supporting with any adverse mental health consequences of the suicide such as depression and anxiety. SLO's describe themselves as being a "listening ear", to "hear their story", "provide reassurance and understanding".

> *"It's very much initially, it might be that practical support. It could be a sort of linking in with funeral directors explaining the process from the coroner to the funeral to the inquest, what the inquest will be like, sort of a very much liaison as well. I know with some clients at the moment, I'm liaising with the police to pick up the belongings so they don't have to go and collect the belongings and then I will take them to them and drop them off. It's very much a practical side, but then there's also the emotional side. We provide a lot of emotional support whilst they're waiting for possibly counselling or waiting to decide whether that that is something that they want to do. And so yes, so it's very practical and*

> *emotional based"* (SuicideLiaisonOfficer 6, pg. 1, line 44-51).

This therefore suggested that the role of a suicide liaison officer needed to incorporate the appropriate skills and knowledge to offer both emotional and practical support. The role was not just one of liaison and advice, but also to guide and support emotionally. This was the standard set by all service providers and this was supported by policy outlined by SASP in their Core Standards, suggesting that postvention services were meeting the standards set, specifically in terms of service provision.

5.5.1.3 Wider community outreach support

Wider community support included community response plans if there had been a suicide within a high-risk community group such as school. SLO's arranged a drop-in, where they can offer support to the wider population and assess the risk of further suicides. SLO's attended networking meetings and suicide prevention meetings. They also arranged and attended events such as fundraising events, World Suicide Prevention Day events, memorial events and larger group events such as family days. They also utilised remote video conferencing tools such as Zoom and Microsoft Teams, especially during Covid-19.

> *"We have a community action plan or community response plan that is activated if there's been a suicide within a, maybe high risk community group, if there's going to be lots of people affected or if there's a contagion or cluster but that's obviously when the worst happens. We are involved in the suicide reduction action planning meetings in each of the areas. We go to any networking meetings between agencies, there's a child bereavement UK meeting on the Wirral that we attend. We make sure that we are going along to any events that people have, any drop in events. Runcorn or Widnes often have them, they call it a marketplace of different services in the area so we go a long and we make sure we are very visible"* (SuicideLiaisonOfficer16, pg. 10, line 17-25).

This wider community support showed a commitment to being visible, making themselves known and support for those not just bereaved, but also affected by or exposed to suicide.

5.5.1.4 Service evaluation and data collection

Evaluation and data collection was conducted in some manner by all the SLO’s. All of the services collected data such as beneficiary demographic information, including age, gender and location. This was in compliance with GDPR. However, many of the services relied on beneficiary testimonials to evaluate their service at the end of the support given. Three of the services included in this study also used psychometric tools to evaluate their service. These tools are given to clients at their first and final appointment with their SLO to assess beneficiaries’ wellbeing. One service uses a short version of the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS). Another service uses Core-10. The third service had difficulty finding a psychometric scale that they felt was suitable and as such, had not been using the scale consistently. SLO’s had expressed their concern with using psychometric scales to assess well-being and finding a scale that they feel reflects their beneficiaries’ experiences.

> *“I think is something which is a little bit on the backburner in terms of setting up a service, but it’s something that we do want to focus on increasingly. At the moment, it's tended to be not that structured, although we want to make it more structured. It's tended to be where we've perhaps invited feedback from various individuals, for example, to where people have either offered freely their own particular feedback to us, when we've kind of asked them feedback... it’s something that we are kind of looking at, in terms of what's the most helpful way of trying to kind of gather feedback over time. We're interested in terms of the kind of almost on the national level, what constitutes good, really, and obviously, there's a lot more now that that started to be available around that in terms of the kind of national suicide sort of postvention kind of networks that are out there. We'll certainly be looking at that... Certainly, work in progress. But we're very conscious of needing to do more.”* (SuicideLiaisonOfficer 12, pg. 7 line 34- pg. 8 line 9).

This quote demonstrated a knowledge that it was best practice to be measuring effectiveness and impact, however services were collecting qualitative feedback as their only source of evaluation. This suggested a need for further information to be shared with postvention services on what data they should be collecting to measure the impact of the support being provided.

5.5.2 The needs of the Suicide Liaison Officers

Suicide Liaison Officers required a combination of training, emotional support, access to resources, a supportive work environment, and a well-defined framework to effectively address the difficult challenges they face in their role. Recognising the importance of their work and providing the necessary support helped them carry out this vital role more effectively. This theme included subthemes of the desire to make a difference, self-care and appropriate clinical support, skills and experience and recruitment and staffing challenges.

5.5.2.1 Wanting to make a difference

SLO's motivation for working in this area was discussed, this was separated into personal and professional motivation. For some SLO's they were motivated by their own personal experience of being bereaved by suicide and "wanting to make a difference". Other SLO's had previously worked in a similar profession felt they had the skills and experience to work in this field. Whether SLO's had a professional or personal motivations, they discussed feeling "it was a good fit", "use my experience to help" and being "passionate" about the role.

> *"My background is probation. I've been working in a probation service for about 18 years. I delivered offending behaviour programmes, I was a manager of a team there, delivering those programmes. And for the last five years, I was delivering high risk programmes to a number of sex offenders. And throughout all of that work, there was links to trauma and past loss and bereavement. So I've always been interested in that" (SuicideLiaison6, pg. 1, line 30-34).*

> *"I think it was an opportunity to really make a difference to people's lives. It was an area of work, which in terms of my own sort of personal experience of knowing loss, and, and bereaved by suicide, had lost a number of friends and people I'd worked with over a number of years. And so it was an area which I felt that I wanted to support"* (SuicideLiaisonOfficer12, pg. 1, line 30-33).

These quotes suggested that this role is a vocation and a commitment to suicide and suicide postvention. The interest and passion in this work often stemmed from previous experience, which then led to the desire to work in this field. This research suggested that the desire to make a difference was a crucial ingredient in staffing and staff having the appropriate skills and experience to work in suicide postvention.

5.5.2.2 Self-care and appropriate clinical support

Due to the nature of the SLO role, SLO's discussed the importance of their own self-care. This included supervision provided by external supervisors, as SLO's used this supervision to discuss their caseload and any issues that arose. SLO's also felt supported by their colleagues and the service leads. They were given regular line manager support. This self-care also related to the skills and experience of the SLO's. As many of the SLO's had personal experience with suicide bereavement, self-care and appropriate clinical support was crucial in SLO's keeping their personal experience separate from their professional role. The topic of personal experience seemed to be controversial and differed across the services. Some of the services actively recruited individuals bereaved by suicide.

> *"Myself and everyone else who sees beneficiaries gets clinical supervision. We get to see monthly a qualified professional, who sits and helps us process what has been going on and talk about things. My team obviously have me as well, who they can speak to and come to, both for advice but also if they have had a particularly difficult session in a particularly difficult time, or somebody that they know is in a risky situation. I have got the CEO that I can go and speak to when I need to as well"* (SuicideLiaisonOfficer10, pg. 6, line 36-41).
>
> *"Aromatherapy massages offered to us once a month. And they are really, really good. And we have got a brilliant team that, again, have got shared experience. We're a really close-knit team, everybody is really approachable. So, we always, always check in with each other. If we ever come out of a tough appointment or anything, I don't think any of us would ever feel that we've just got to get on with it and, "It's just part of our job, I've had a bit of a hard day." We always know we've got someone to talk to"* (SuicideLiaisonOfficer8, pg. 4, line 33-38).

Despite the desire to work in this field, the demands of the role were both physically and mentally challenging on staff wellbeing. Appropriate supervision for staff was reported and services seemed to have considered this as a standard component of working for suicide postvention. Thus, services should work towards supporting their staff in order for them to provide a service to those who are suicide-bereaved.

5.5.2.3 Skills and experience

SLO’s were also asked about the skills and experience necessary to do this role. Their feedback suggested that they needed practical problem solving and organisational skills to manage caseloads and travel to different locations. They needed good communication skills for liaising with different professionals to provide the appropriate support to families. The professionals may have included coroners, police and staff at the department of work and pensions. Knowledge of statutory services and processes including NHS, police and coroners was key. Good listening skills, being non-judgemental, adaptable and versatile were also important principles for SLO’s to hold. Empathy and compassion were crucial to developing a connection and enable beneficiaries to feel heard and supported. This was also related to a commitment to being person-centred, particularly for those who had a background in counselling. Experience of a caring profession such as counselling was helpful, however it was expressed that this was not a counselling role and SLO’s were not required to provide counselling. SLO’s came from a variety of occupations such as counselling, nursing, physical fitness, probation and prison services. An understanding of being bereaved by suicide was a much-debated topic, as some reported this not being necessary, but others thought that it helped SLO’s to empathise with beneficiaries. Experiences with grief, theories of grief, mental health, traumatic experiences and risk assessing were thought to be desirable prerequisites for this role. Finally, experiences with relevant systems such as data monitoring, GDPR and psychometric scores were thought to be helpful, however the services often provided training to staff to support their understanding of these systems and procedures.

> *“That empathy, that compassion, care, the responsibility to take on a difficult role and the safeguarding, training and safeguarding we do we actually do a lot of training here. So, safeguarding training, the suicide intervention, Mental Health First Aid, and suicide bereavement. All that is training that we do ourselves and that I've done. I think everyone here has kind of a personality that really, really wants to help other people”* (SuicideLiaisonOfficer14, pg. 5, line 16-21).

> *“I don’t think you necessarily do, I think it can probably help. And as long as you are a compassionate person who is open and non-judgmental. Who challenges stigma when it comes to suicide, I don't think you necessarily need to be bereaved by suicide. But I think it kind of gave me a different understanding of the role” (SuicideLiaison14, pg. 5, line 35-38).*

5.5.2.4 Recruitment and staffing challenges

SLO’s faced the difficulty of staffing for these roles and advertising the service. Staffing challenges included when areas withdrew and opted out of the service, only being funded to support beneficiaries up until just after the inquest. Further staff challenges were also related to funding as SLO’s only supported beneficiaries in the services’ specific areas and SLO’s often received out of area referrals, in areas where there was perhaps no other specific suicide bereavement support service, leaving the bereaved to not being supported at all. Stigma was another challenge the SLO’s faced, as the stigma surrounding suicide was a reason for potential beneficiaries declining support. Boundaries were essential as SLO’s were not providing a crisis service, but were faced with beneficiaries who were in crisis.

> *“I think it's just those boundaries sometimes. The staff are only available between nine and five, we're not a crisis service. And sometimes that crisis, support gets very blurred, those lines get blurred. For example, the client that might, a member of my team has turned the phone on, there's lots of sorts of really concerning messages from a client that was received over the weekend. Well, she wouldn't have had her phone on at the weekends. So, it's just sometimes we have to also remind people that we only work between these hours, and we aren't a crisis service, there are the numbers, here are the numbers for those services. And I think sometimes that is, that's a struggle for clients, because we're developing a relationship with them.”* (SuicideLiaisonOfficer 6, pg. 3, line 1-9).

To be able to do the role fully, SLO’s also wanted to improve their referral numbers for finder of the body, irrespective of relation to the deceased. SLO’s wanted to ensure they were offering the best service possible and wanted to be able to offer additional support after the postvention support. For example, for beneficiaries who had received the postvention support but wanted group support or specific bereavement counselling. There was also a desire to develop training that they could deliver to communities.

> *"Oh, yeah, I think it's something that's needed afterwards. And again, trauma focused, counsellor, it's very hard to get from, like a GP, or, its only specialist services, just trying to get people into these services. It's a problem and maybe it's something that Amparo as a group could offer, as most of the people who work for them are trained counsellors."* (SuicideLiaisonOfficer 5, pg. 4, line 7-10).

These quotes therefore suggested that despite the desire and commitment to work for suicide postvention, there must be boundaries and considerations. These limitations must be understood by others in this field as they can affect beneficiaries, potential beneficiaries seeking support and key stakeholders in this field. The highlighted challenges could be solved by clear communications of expectations and boundaries, as well as additional support and training for individuals and communities.

5.6 Summary of themes

Beneficiaries reported that suicide was a different kind of bereavement, due to the stigma and suicide bereavement specific attitudes and the concept that grieving for someone who died by suicide was specific, requiring a tailored response. They experienced difficulty understanding the process. The availability of postvention services was key and knowing that help was at hand brought comfort. However, there were lessons that needed to be learnt and a concern of inequity. Commissioners valued the evolution of postvention services and discussed funding and sustainability. Collaboration and multi-agency working was crucial and was motivated by personal and moral reasons to commission a postvention service. Commissioners often witnessed the community benefit and impact that postvention services had. Referrers saw the benefit of collaborative working with a responsible, reactive, and valuable support services. Discussions on the referral pathways brought a meaningful understanding to how beneficiaries should be referred into the service. The impact of limited resources was a concern. Service CEOs were focused on the legacy of their service, the staff that were needed to support vulnerable people bereaved by suicide, and the funding and further investment needed to continue their work. Strong and collaborative relationships with others enabled the service to create a village of support surrounding the bereaved. They outlined challenges and improvements for those who wished to set up a postvention service in other areas. Finally, SLO’s had a desire to make a difference, but needed appropriate self-care, clinical support and skills and experiences. Their focus was on adherence to confidentiality, individual support and wider community outreach. However, service evaluation was a concern, as it was for other participant groups.

Common themes across all participant groups included the support received by beneficiaries and given by the SLO’s. This support consists of emotional and practical support, as well as wider community support. The theme of referrals and referral pathways was also common across all groups. Improvements and conflicts or challenges were also a common theme for all participants. Funding and finances were a common theme or sub-theme, as all participants wanted to ensure that existing funding remained, whilst advocating for further funding for areas wanting to set up a postvention service. The overarching theme of benefit and impact was also frequently discussed as all participants wished to highlight the impact and importance of the services. All professionals (commissioners, referrers, CEOs and SLOs) mentioned motivation for working in this field, as this varied between moral, personal and professional motivations. Furthermore, professionals also discussed the importance of collaboration and multi-agency working when preventing suicide. Service CEO’s and SLO’s had themes in common which did not feature in other participant groups, mainly surrounding the employee care and skills and experience necessary to do this role. Similarly, they both discussed evaluation and data collection as they were concerned with how they prove their effectiveness to commissioners. Figure 11 illustrates the common themes across participant groups.

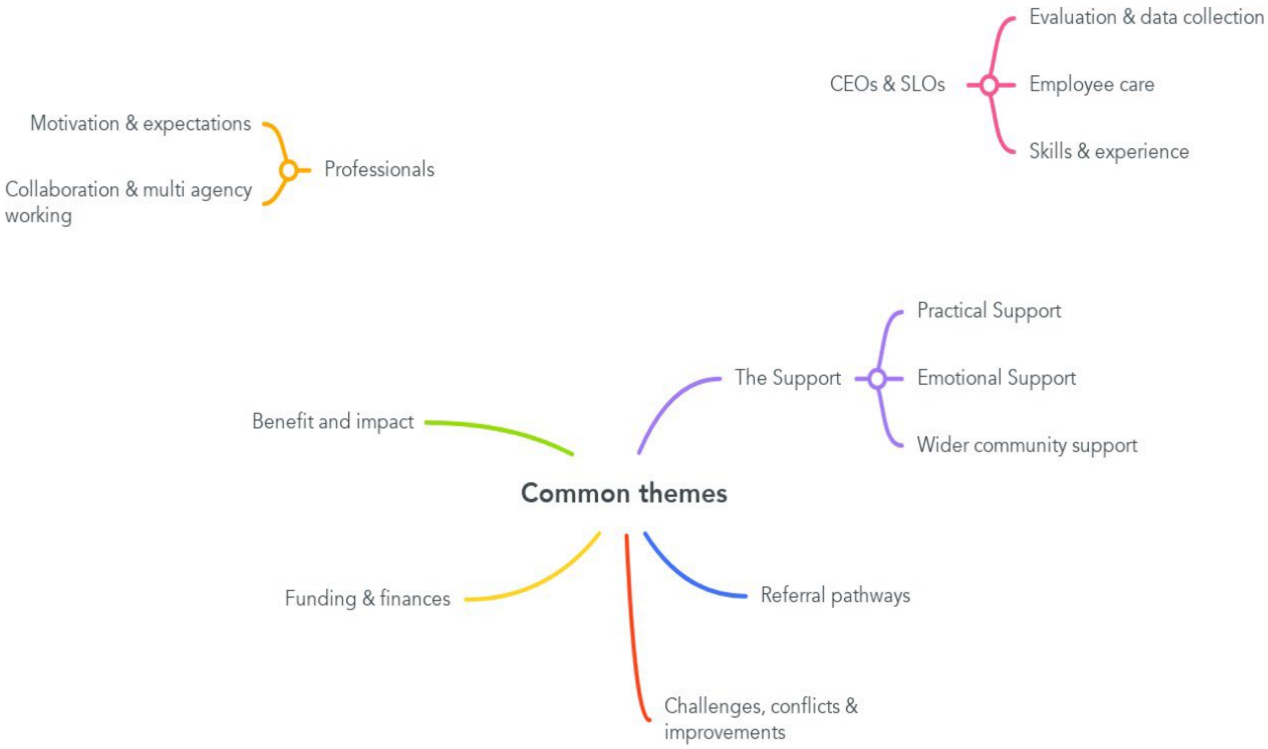


Figure 11: Common themes across all participant groups.

Chapter 6: Quantitative Findings

The aim of this chapter is to discuss the quantitative findings of this study, which included an analysis of demographic information and evaluation data from two services: Amparo and Pete's Dragons.

6.1 Amparo

6.1.1 Demographic Findings

Cheshire & Merseyside

Amparo in Cheshire and Merseyside received 163 referrals between 2018- 2019, 98 of those translated into beneficiaries supported by the service. Reasons for referrals who were then not supported by Amparo included declining the service (n=30), out of area (n=11) and information only (n=20). Between 2019-2020, Amparo received 113 referrals and supported 92 of those referrals. Reasons for this included declining the service (n=9), information only (n=5), and outside remit (n=7). Between 2020-2021, Amparo received 132 referrals and supported 114 of those referrals, n=10 declined the service, n=2 was out of the area, n=2 was information only, and n=2 outside of remit. More recently, between 2021-2022, 200 referrals were received, and 159 beneficiaries were supported. 33 declined the service, two were out of the area and six were information only. See table 20 for demographic information of Amparo referrals in Cheshire and Merseyside.

Table 20: Demographic characteristics of referrals received by Amparo, Cheshire and Merseyside (2018-2022).

Demographic	2018-2019 N (%) (N=163)	2019-2020 N (%) (N=113)	2020-2021 N (%) (N=132)	2021-2022 N (%) (N=200)
Age				
10-19	6 (16.7)	3 (2.7)	3 (2.3)	3 (1.5)
20-29	16 (9.8)	15 (13.3)	5 (3.8)	23 (11.5)
30-39	28 (17.2)	15 (13.3)	21 (15.9)	41 (20.5)
40-49	26 (16)	19 (16.8)	26 (19.7)	34 (17)
50-59	25 (15.3)	29 (25.7)	30 (22.7)	52 (26)
60-69	17 (10.4)	14 (12.4)	30 (22.7)	31 (15.5)
70-79	2 (1.2)	6 (5.3)	7 (5.3)	13 (6.5)
80-90	3 (1.8)	2 (1.8)	1 (0.8)	2 (1)
No age given	40 (24.5)	10 (8.8)	9 (6.8)	1 (0.5)
Gender				
Female	27 (16.6)	75 (64.6)	91 (68.9)	147 (73.5)
Male	18 (11)	31 (27.4)	40 (30.3)	51 (25.5)
Not given/other	113 (69.3)	7 (6.2)	1 (0.8)	2 (1)
Relationship to deceased				
Child	38 (23.3)	22 (19.5)	18 (13.6)	18 (9)
Parent	36 (22.1)	23 (20.4)	40 (30.3)	70 (35)
Sibling	20 (12.7)	13 (11.5)	18 (13.6)	33 (16.5)
Partner	18 (11)	23 (20.4)	17 (12.9)	20 (10)
Spouse	16 (9.8)	15 (13.3)	19 (14.4)	24 (12)
Friend	11 (6.7)	5 (4.4)	2 (1.5)	7 (3.5)
Other	15 (9.2)	10 (8.8)	10 (7.6)	19 (9.5)
Colleague	2 (1.2)	1 (0.9)	1 (0.8)	0
Extended family	2 (1.2)	1 (0.9)	5 (3.8)	9 (4.5)
Not given	5 (3.1)	0	2 (1.5)	0
Finder of the deceased	44 (27)	33 (29.2)	51 (38.6)	55 (27.5)

Referral sources in Cheshire and Merseyside showed that coroners were the most common referral source across all four years. Other professionals were the second most common referral source. Other professionals often included health and social care agencies, other charities and organisations working in suicide and mental health, Citizens Advice and other postvention services. Police referrals were less common, as were re-referrals, referrals from family and other relatives. Referrals from schools and Survivors of Bereavement by Suicide (SOBS) peer support groups were both more recent additions to referral sources. See table 21 for referral sources in Cheshire and Merseyside.

Table 21: Referral sources of referrals into Amparo, Cheshire and Merseyside (2018- 2022).

Referral Sources	2018-2019 N (%) (N=163)	2019-2020 N (%) (N=113)	2020-2021 N (%) (N=132)	2021-2022 N (%) (N=200)
Source				
Coroner	109 (66.9)	61 (54)	81 (61.4)	76 (38)
Professional	22 (13.5)	24 (21.2)	26 (19.7)	35 (17.5)
Self	19 (11.7)	14 (12.4)	10 (7.6)	37 (18.5)
GP	12 (7.4)	5 (4.4)	3 (2.3)	5 (2.5)
Police	1 (0.6)	5 (4.4)	7 (5.3)	18 (9)
Re-referral		2 (1.8)		
Family		1 (1.9)	3 (2.3)	7 (3.5)
Other		1 (1.9)		20 (10)
School			2 (1.5)	1 (0.5)
SOBS				1 (0.5)

South Yorkshire

Amparo in South Yorkshire, between 2018-2019 received 14 referrals, with 10 beneficiaries supported. Reasons for this included declining the service (n=3) and being out of area (n=1). Between 2019-2020 88 referrals were received, 76 of those were beneficiaries, n=9 declined the service, n=1 was out of area and n=2 were outside remit. Between 2020-2021, 115 referrals were received, 94 of those were supported by the service, n=19 declined the service, n=1 was outside of area and n=1 was outside of remit. In 2021-2022, 144 referrals were received, 115 of those were supported, n=19 declined the service, n=2 was out of area, n=7 were information only and n=1 were outside remit. See table 22 for demographic information of Amparo referrals in South Yorkshire.

Table 22: Demographic characteristics of referrals into Amparo, South Yorkshire (2018-2022).

Demographic	2018-2019 N (%) (N=14)	2019-2020 N (%) (N=88)	2020-2021 N (%) (N=115)	2021-2022 N (%) (N=144)
Age				
10-19	0	1 (1.1)	1 (0.9)	2 (1.4)
20-29	0	4 (4.5)	17 (14.8)	32 (22.2)
30-39	6 (42.9)	11 (12.5)	29 (25.2)	30 (20.8)
40-49	1 (7.1)	11 (12.5)	25 (21.7)	28 (19.4))
50-59	3 (21.4)	17 (19.3)	24 (20.9)	25 (17.4)
60-69	1 (7.1)	13 (14.8)	9 (7.8)	15 (10.4)
70-79	0	5 (5.7)	2 (1.7)	7 (4.9)
80-90+	0	3 (3.4)	0	0
No age given	3 (21.4)	23 (26.1)	8 (7)	5 (3.5)
Gender				
Female	7 (50)	73 (83)	88 (76.5)	104 (72.2)
Male	5 (35.7)	13 (19.3)	26 (22.6)	37 (25.7)
Not given/other	2 (14.3)	2 (2.3)	1 (0.9)	3 (2.1)
Relationship to deceased				
Child		15 (17.1)	12 (10.4)	24 (16.7)
Parent	7 (50)	23 (26.1)	28 (24.4)	
Sibling		8 (9.1)	13 (11.3)	18 (12.5)
Partner	1 (7.1)	13 (14.8)	24 (20.9)	24 (16.7)
Spouse	5 (35.7)	7 (8)	8 (7)	9 (6.3)
Friend		6 (6.8)	11 (10)	13 (9)
Other	1 (7.1)	11 (12.5)	16 (13.9)	16 (11.1)
Colleague				1 (0.7)
Extended family		5 (5.7)	3 (2.6)	3 (2.1)
Not given				
Finder of the deceased	6 (42.9)	28 (31.8)	39 (33.9)	41 (28.5)

In South Yorkshire, referrals increased each year, particularly for coroners, professionals and police. Self-referrals were non-existent in the first year, but more frequent in the second year, however they slightly decreased in the third year but rose in the fourth year. Coroner referrals were less frequent and police referrals were more common. Other professionals and self-referrals increased over the four years. SOBS did not refer anyone into the South Yorkshire Amparo service. There were also very few re-referrals, family referrals and school referrals (see Table 23).

Table 23: Referral sources of referrals into Amparo, South Yorkshire (2018-2022).

Referral Sources	2018-2019 N (%) (N=14)	2019-2020 N (%) (N=88)	2020-2021 N (%) (N=115)	2021-2022 N (%) (N=144)
Source				
Coroner	3 (21.4)	3 (3.4)	3 (2.6)	13 (9)
Professional	2 (14.3)	19 (21.6)	22 (19.1)	35 (24.3)
Self		23 (26.1)	20 (17.4)	30 (20.8)
GP		10 (11.4)	6 (5.2)	3 (2.1)
Police	9 (64.3)	26 (29.5)	62 (53.9)	51 (35.4)
Re-referral				1 (0.7)
Family		5 (5.7)		
Other			1 (0.9)	10 (6.9)
School		2 (2.3)	1 (0.9)	1 (0.7)
SOBS				

Lancashire

Between 2019-2020 Amparo in Lancashire received 50 referrals, of those 35 beneficiaries were supported. Reasons for this included declining the service (n=8), out of area (n=2), information only (n=3) and outside of remit (n=2). Between 2020- 2021, 65 referrals were received, n=24 declined the service, n=1 was out of area and n=1 were outside of remit. Therefore, 39 beneficiaries were supported. In 2021-2022, 96 referrals were received, and of those 64 beneficiaries were supported. Reasons for this included declined service (n=25), out of area (n=1) and information only (n=6). Table 24 outlined demographic information for referrals in Lancashire.

Table 24: Demographic characteristics of referrals into Amparo, South Yorkshire (2019-2022).

Demographic	2019-2020 N (%) (N=50)	2020-2021 N (%) (N=65)	2021-2022 N (%) (N=96)
Age			
10-19	8 (16)	5 (7.7)	4 (4.2)
20-29	12 (24)	9 (13.8)	19 (19.8)
30-39	6 (12)	12 (18.5)	16 (16.7)
40-49	8 (16)	11 (16.9)	23 (24)
50-59	7 (14)	14 (21.5)	19 (19.8)
60-69	3 (6)	8 (12.3)	10 (10.4)
70-79	4 (8)	3 (4.6)	3 (3.1)
80-90+	1 (2)	2 (3.1)	1 (1)
No age given	1 (2)	1 (1.5)	1 (1)
Gender			
Female	37 (74)	49 (75.4)	68 (70.8)
Male	9 (18)	16 (24.6)	26 (27.1)
Not given/other	4 (8)		2 (2.1)
Relationship to deceased			
Child	8 (16)	10 (15.4)	12 (12.5)
Parent	9 (18)	18 (27.7)	24 (25)
Sibling	6 (12)	9 (13.9)	15 (15.6)
Partner	7 (14)	8 (12.3)	11 (11.5)
Spouse	9 (18)	8 (12.3)	13 (13.5)
Friend	6 (12)	2 (3.1)	7 (7.3)
Other	2 (4)	7 (10.8)	11 (11.5)
Colleague	1 (2)		
Extended family	2 (4)	3 (4.6)	3 (3.1)
Not given			
Finder of the deceased	13 (26)	16 (24.6)	19 (19.8)

In Lancashire, coroner referrals were more frequent and police referrals were less common, similarly to Cheshire and Merseyside. As with other locations, family, school and SOBS referrals were either less frequent or non-existent. Referrals increased each year, particularly for referrals from coroners, professionals and self-referrals (See table 25).

Table 25: Referral sources of referrals into Amparo, Lancashire (2019-2022).

Referral Sources	2019-2020 N (%) (N=50)	2020-2021 N (%) (N=65)	2021-2022 N (%) (N=96)
Source			
Coroner	18 (36)	20 (30.8)	33 (34.4)
Professional	9 (18)	16 (24.6)	23 (24)
Self	10 (20)	15 (23.1)	19 (19.8)
GP	2 (4)	1 (1.5)	
Police	9 (18)	12 (18.5)	12 (12.5)
Re-referral			
Family			1 (1)
Other	1 (2)		8 (8.3)
School	1 (2)	1 (1.5)	
SOBS			

Coventry & Warwickshire and Kent & Medway

In 2021, two additional Amparo services began to support people bereaved by suicide. Between 2021-2022 in Coventry & Warwickshire, 17 referrals were received, with 15 of those supported as n=2 declined the service. In Kent & Medway, 51 referrals were received, and 48 beneficiaries were supported as n=2 declined the service and n=1 was information only. Table 26 outlined demographic information of referrals for these two areas of operation

Table 26: Demographic characteristics referrals into Amparo, Coventry & Warwickshire and Kent & Medway (2021-2022).

Demographic	C&W 2021-2022 N (%) (N=17)	K&M 2021-2022 N (%) (N=51)
Age		
10-19	0	3 (5.9)
20-29	6 (35.3)	5 (9.8)
30-39	6 (35.3)	4 (7.8)
40-49	2 (11.8)	9 (17.7)
50-59	1 (5.9)	7 (13.7)
60-69	1 (5.9)	13 (25.5)
70-79	0	5 (9.8)
80-90+	0	6 (11.8)
No age given	1 (5.9)	0
Gender		
Female	13 (76.5)	33 (64.7)
Male	3 (17.7)	14 (27.5)
Not given/other	1 (5.9)	4 (7.8)
Relationship to deceased		
Child	2 (11.8)	8 (15.7)
Parent	2 (11.8)	15 (29.4)
Sibling	1 (5.9)	8 (15.7)
Partner	7 (41.2)	3 (5.9)
Spouse		2 (3.9)
Friend	1 (5.9)	3 (5.9)
Other	3 (17.7)	7 (13.7)
Colleague		1 (2)
Extended family	1 (5.9)	4 (7.8)
Not given		0
Finder of the deceased	1 (5.9)	4 (7.8)

As Coventry and Warwickshire, and Kent and Medway are newer services, it was not possible to report an increase in referrals over time. However, coroner referrals were significantly less than in other Amparo locations. Police referrals were also considerably less frequent. The main referral sources for these locations were professionals and self-referrals (see table 27).

Table 27: Referral sources of referrals into Amparo, Coventry & Warwickshire and Kent & Medway (2021-2022).

Referral Sources	C&W 2021-2022 N (%) (N=17)	K&M 2021-2022 N (%) (N=51)
Source		
Coroner	1 (5.9)	
Professional	4 (23.5)	19 (37.3)
Self	10 (58.8)	12 (23.5)
GP		
Police		4 (7.8)
Re-referral		
Family	1 (5.9)	
Other	1 (5.9)	16 (31.4)
School		
SOBS		

All Amparo services

Between 2018-2019, the two Amparo services in operation in Cheshire and Merseyside, and South Yorkshire received 177 referrals and supported 108 beneficiaries. Reasons for this included declining the service (n=33), out of area referrals (n=12) and information only support (n=20). Between 2019-2020, an additional Amparo service was commissioned in Lancashire. The three Amparo services received 251 referrals and out of those, 203 beneficiaries were supported, n= 26 declined the service, n=3 were out of area, n=8 were information only and n=11 were outside of remit. Between 2020-2021, the three Amparo services received 312 referrals and supported 247 beneficiaries, n=53 declined the service, n=4 were out of area, n=4 were information only and n=4 were outside of remit. In 2021, two new services were commissioned in Coventry and Warwickshire, and Kent and Medway. Between 2021-2022 all five services received 508 referrals, out of those Amparo supported 401 beneficiaries. Reasons for this included declining the service (n=81), out of area (n=5), information only (n=20) and outside of remit (n=1). In total, across five services in four years, 1248 referrals were received, and 958 beneficiaries were supported. 812 (65.3%) of those were females. The most common age of referral was 50-60 years old (n=255, 20.4%). The most common relationship to deceased was child (n=187, 15%). 350 (28%) referrals were finder of the body. Finally, the most common referral source was the coroners (n=421, 33.7%). The below table showed the demographic information for the overall referrals into all Amparo's locations of operation (table 28).

Table 28: Demographic characteristics of referrals into Amparo (2018-2022).

Demographic	2018-2019 N (%) (N=177)	2019-2020 N (%) (N=251)	2020-2021 N (%) (N=312)	2021-2022 N (%) (N=508)
Age				
0-9	0	1 (0.4)	0	3 (0.6)
10-19	6 (3.4)	15 (6)	9	14 (2.8)
20-29	16 (9)	38 (15.1)	31	84 (16.5)
30-39	34 (19.2)	32 (12.7)	62	102 (20.1)
40-49	27 (15.3)	44 (17.5)	62	94 (18.5)
50-59	28 (15.8)	49 (19.5)	68	110 (21.7)
60-69	18 (10.7)	22 (8.8)	47	61 (12)
70-79	2 (1.1)	12 (4.8)	12	29 (5.7)
80-90	3 (1.7)	3 (1.2)	3	3 (0.6)
No age given	43 (24.3)	34 (13.5)	18	8 (1.6)
Gender				
Female	34 (19.8)	185 (73.7)	228 (73.1)	365 (71.9)
Male	23 (13.4)	53 (21.1)	82 (26.3)	131 (25.8)
Not given/other	115 (66.9)	13 (5.2)	2 (0.6)	12 (2.4)
Relationship to deceased				
Child	38 (21.5)	45 (17.9)	40 (12.8)	64 (12.6)
Parent	43 (24.3)	55 (21.9)	86 (27.6)	146 (28.7)
Sibling	20 (11.3)	27 (10.8)	40 (12.8)	75 (14.8)
Partner	19 (10.7)	43 (17.1)	49 (15.7)	65 (12.8)
Spouse	21 (11.9)	31 (12.4)	35 (11.2)	48 (9.4)
Friend	11 (6.2)	17 (6.8)	15 (4.8)	31 (6.1)
Other	16 (9)	23 (9.2)	33 (11.6)	56 (11)
Colleague	2 (1.1)	2 (0.8)	1 (0.3)	2 (0.4)
Extended family	2 (1.1)	8 (3.2)	11 (3.5)	20 (3.9)
Not given	5 (2.8)	0	2 (0.6)	1 (0.2)
Finder of the deceased	50 (28.2)	74 (29.5)	106 (33.9)	120 (23.6)

Across all locations, the most common referral source was coroners and then referrals from professionals. SOBS peer support group referrals were rare. The different referral sources increased from five sources of referrals in 2018-2019, to ten referral sources in 2021-2022. The table below highlighted referral sources from all Amparo services (table 29).

Table 29: Referral characteristics of Amparo referrals (2018-2022).

Referral Characteristics	2018-2019 N (%) (N=177)	2019-2020 N (%) (N=251)	2020-2021 N (%) (N=312)	2021-2022 N (%) (N=508)
Source				
Coroner	112 (63.3)	82 (32.7)	104 (33.3)	123 (24.2)
Professional	24 (13.6)	52 (20.7)	64 (20.5)	115 (22.6)
Self	19 (10.7)	47 (18.7)	45 (14.4)	108 (21.3)
GP	12 (6.8)	17 (6.8)	10 (3.2)	8 (1.6)
Police	10 (5.6)	40 (15.9)	81 (26)	85 (16.7)
Re-referral		2 (0.8)		1 (0.2)
Family		6 (2.4)	3 (1)	9 (1.8)
Other		2 (0.8)	1 (0.3)	56 (11)
School		3 (1.2)	4 (1.3)	2 (0.4)
SOBS				1 (0.2)

6.1.2 Amparo Cheshire & Merseyside SWEMWBS Findings

Four hundred and thirty-nine referrals SWEMWBS scores from 2016-2022 were obtained. After removing beneficiaries with missing data, 270 complete SWEMWBS scores from the earliest and most recent appointments were analysed.

Level of well-being was assessed using the SWEMWBS cut-off points as: low well- being of 0-19.5, medium well-being of 19.6-27.4 and high well-being of 27.5+. At the earliest time point, 131 (48.5%) participants had low well-being, 112 (41.5%) participants had medium well-being, and 27 (10%) had high well-being. At the most recent appointment, 86 (31.9%) participants had low well-being, 129 (47.8%) had medium well-being and 55 (20.4%) participants had high well-being. Earliest total mean 20.09, SD 5.57. Recent total mean 22.47, SD 5.58. The average single score for the earliest appointment was 2.87. The average single score for the most recent appointment was 3.21, suggesting a rise in well-being over time.

To compare the effectiveness of the service on well-being, means were taken, and a paired samples t-test was conducted to compare mean difference in well-being at the earliest appointment and the most recent appointment with Amparo. The analysis revealed a significant increase in SWEMWBS scores (see table 30) from the earliest appointment (M=20.09, SD=5.71) to the most recent appointment (M=22.47, SD=5.58), t(269) = 8.904, p<.001 (two tailed). The mean increase in SWEMWBS scores was 2.38 with a 95% confidence interval rating from 1.85 to 2.90. The eta squared statistic (0.228) indicated a small effect size.

Table 30: Amparo paired samples t-test results (SWEMWBS).

Outcome	Mean, Initial	Mean, Recent	T	P	Partial eta squared
Well-being	20.09	22.47	8.904	p<.001	0.228

The table below (table 31) suggested participants improved in well-being as the number of individuals in high and medium well-being increased at the most recent appointment with Amparo. The number of individuals with low well-being decreased.

Table 31: Change in well-being in Amparo beneficiaries (N=270).

	Well-being Scores, N (%)	
Severity Category	Initial	Recent
High well-being	27 (10%)	55 (20.4%)
Medium well-being	112 (41.5%)	129 (47.8%)
Low well-being	131 (48.5%)	86 (31.9%)

However, it’s crucial to ascertain whether participants remained in their category of well-being and whether their well-being had increased to such an extent that their scores were in the higher category, for example, did they move from medium well-being to high well-being or did they remain in medium well-being. The table below (table 32) suggested that the majority of beneficiaries in this sample remained in low or medium well-being after the support. Some beneficiaries increased from low to medium and medium to high. Others remained in the high well-being category after the support. Two individuals decreased in their well-being from medium to low and high to medium. One individual decreased from high to low well-being. We were unable to make any inferences about the causes of this.

Table 32: Table outlining how many participants improved or declined in their well- being after Amparo support (N=270).

Well-being (SWEMWBS)					
Low N (%)		Medium N (%)		High N (%)	
Low-Low	84 (31.1)	Medium-Low	1 (0)	High-Low	1 (0)
Low-Medium	39 (14.4)	Medium-Medium	89 (33)	High-Medium	1 (0)
Low-High	7 (2.6)	Medium-High	23 (8.5)	High-High	25 (9.3)

Table 33 showed the change in category of well-being in terms of moving between low, medium and high well-being between the earliest and recent appointments with Amparo. Minus two and minus one evidenced the number of participants who got worse, for example moving from medium well-being to low well-being. Zero evidenced no change in well-being category, for example participants stayed in low, medium or high well-being when completing the most recent SWEMWBS scale. Finally, plus one and plus two shows an improvement in well-being category in one or two points, for example they moved from low to medium or high well-being, therefore evidencing that the Amparo service improved well-being.

Table 33: Frequency of participants improving or declining in well-being category (SWEMWBS).

Change in well-being	N (%)
-2 change in well-being category	1 (4%)
-1 change in well-being category	2 (7%)
0 change in well-being category	197 (73%)
+1 change in well-being category	63 (23.3%)
+2 change in well-being category	7 (2.6%)

An ANOVA was conducted on the effects of year and location of the service to assess whether the location of the support or year of support received affected the well-being. There was no significant effect for year of referral (p=.754), and location (p=.894). There was also no significant interaction between year and location (p=.283). See table 34 and 35 for descriptive statistics on location and year.

Table 34: Mean and Standard Deviation (SD) for Earliest SWEMWBS scores and Location of the referral in Merseyside & Cheshire.

Location	N (N=270)	Mean	SD
Cheshire East	47	22.21	5.30
Cheshire West and Chester	56	22.73	6.06
Wirral	33	22.58	4.73
Warrington	39	22.33	5.66
Sefton	17	21.71	6.05
Liverpool	16	22.94	5.66
Halton	17	23.88	4.74
St Helens	25	22.92	6.11
Knowsley	16	20.63	6.10
Trafford	1	22.00*	
Wigan	1	17.00*	
Newcastle-under-Lyme	1	18.00*	
Missing value	1		
Total	270	22.44	5.56

**Single participant only in this area*

Table 35: Mean and Standard Deviation (SD) for Earliest SWEMWBS scores and Year of the referral in Merseyside & Cheshire.

Year	N (N=270)	Mean	SD
2016	8	21.75	3.45
2017	25	20.32	4.90
2018	30	21.80	6.24
2019	37	23.43	6.64
2020	42	24.07	5.71
2021	49	22.37	5.50
2022	41	22.02	4.47
Missing	38		
Total	270	22.47	5.58

In summary, these findings suggested that the Amparo service improved well-being of people bereaved by suicide. However, these changes may be subtle and may not be reflected in improvements in moving between low, medium and high well-being categories. Location and year of referral did not positively or negatively impact an increase in well-being. Each year Amparo services increased the number of referrals by 187% and the number of beneficiaries by 275%. Each service had multiple referral opportunities from a variety of agencies, with the coroner's being the most common referral source (n= 421, 33.7%). On average, the Amparo service did seem to support more females (n = 812 65.3%) than males, with the average age of referrals being 50-60 years old (n=255, 20.4%). The most common relationship to deceased was child (n=187, 15%). Finder of the deceased represents only 28.04% (n= 350) of their total referrals. In total, across five services in four years, 1248 referrals were received, and 958 beneficiaries were supported.

6.2 Pete’s Dragons

6.2.1 Demographic Findings

Pete’s Dragons received 520 referrals in a year period between 2021-2022. Of those, 85 were signposted to other relevant agencies, 91 were support enquiries and 344 beneficiaries were supported by Pete’s Dragons. Of the 344 beneficiaries, 12 were re-referrals and therefore, 332 beneficiaries' data was included. All of their referrals were contacted within two working days of receiving a referral. See table 36 for demographic information.

Table 36: Demographic characteristics of Pete's Dragons referrals (N=332).

Demographic	Pete's Dragons 2021-2022 N (%)
Age	
Under 18	65 (20)
18-24	42 (13)
25-44	111 (33)
45-64	85 (26)
65+ years	22 (7)
Not disclosed	7 (2)
Gender	
Female	207 (62)
Male	93 (28)
Not given/other	32 (10)
Relationship to deceased	
Brother/Step	15 (5)
Daughter/Step	50 (15)
Father/Step	18 (5)
Friend	48 (14)
In-Law	3 (1)
Mother/Step	36 (11)
Nephew	2 (1)
Niece	9 (3)
Other	27 (8)
Partner/Spouse	59 (18)
Sister/Step	34 (10)
Son/Step	30 (9)
Finder of the deceased	1 (0)

Pete's Dragons referrals mainly consisted of self-referrals and referrals from family and friends. In contrast to Amparo, there were no coroner referrals and 26 (7.6%) were police referrals. His Majesty's Prison Service (HMP) accounted for one referral. See table 37 for referral characteristics.

Table 37: Referral characteristics of Pete's Dragons referrals (N=344).

Referral Characteristics	Pete's Dragons 2021-22 N (%)
Source	
CAHMS	0
Coroner	0
Family/Friend	42 (12)
GP	4 (1)
HMP	1 (0)
Mental health service	8 (2)
Other	5 (1)
Police	26 (8)
School	16 (5)
Self	225 (65)
Social Services	11 (3)
Third sector	3 (1)
VCU	3 (1)

The most common reason for case closure (table 38) was that the service met the needs of the beneficiary, and the support is no longer required. In some cases, the support was declined. It was not possible to make any inferences as to why the support was declined. These figures also showed that none of their referrals then went on to die by suicide themselves. The most common length of service was under three months, and 6-11 months. Very few beneficiaries were supported longer than 35 months. These findings suggested that the service was effective at supporting individuals bereaved by suicide, particularly in relatively short periods of time.

Table 38: Reasons for case closure and support length of time for Pete's Dragons (N=348).

	Pete's Dragons 2021-2022 N (%)
Reason for case closure	
Deceased	0
Moved from area	7 (2)
Needs met	231 (66)
Needs More Appropriate	8 (2)
Support	43 (12)
Other	59 (17)
Support Declined	
Length of time in service	
Under 3 months	103 (30)
6 – 5 Months	94 (27)
6 – 11 Months	103 (30)
12 – 23 Months	35 (10)
24 – 35 Months	9 (3)
36 – 47 Months	*6* (1)
48+ Months	1 (0)

In summary, Pete's Dragons service had multiple referral opportunities from a variety of agencies, however self-referrals were most common (n= 225, 65%). On average, Pete's Dragon's did seem to support more females (n = 207, 62%) than males, with the average age of referrals being 25-44 years old (n= 111, 33%). The most common relationship to deceased was partner/spouse (n= 59, 18%). The most common reason for case closure was "needs met" (N=231, 66%). Under 3 months and 6-11months were the most common length of time in service (N=103, 30%, respectively).

6.2.2 Pete's Dragons Core-10 Findings

Of the 332, thirty-four (10%) individuals completed CORE-10 more than twice and were included in this analysis. More beneficiaries completed CORE-10 however, they completed it only once or had completed the assessment in previous years and were not included in the analysis. The researcher was unable to access any additional scores from other beneficiaries and was also unable to access CORE-10 scores from any other years and was therefore unable to make any comparisons between years. Level of well-being was assessed using the CORE-10 cut-off points as: healthy (0-5), low levels of distress (6-10), mild distress (11-14), moderate distress (15-19), moderate to severe (20-24) and severe (25 and above). Table 39 showed the number of participants in each severity category at the initial and most recent appointments with Pete’s Dragons. The number of participants in severe and moderate-severe decreased. The number of participants in health and low levels of distress increased. Over 60% had moderate to severe levels of distress at the earliest time point. At the most recent time point, 40% had moderate to severe levels of distress, indicating that distress decreased over time. However, the time between initial and recent assessments was not collected and therefore, we cannot ascertain the effects of time on the change in well-being.

Table 39: Pete’s Dragons beneficiaries’ CORE-10 levels of distress, pre- and post- support.

	Well-being Scores N (%)	
Severity Category	Initial	Recent
Healthy	1 (2.9)	3 (8.8)
Low Levels	3 (8.8)	6 (17.6)
Mild	4 (11.8)	3 (8.8)
Moderate	5 (14.7)	7 (20.6)
Moderate-Severe	7 (20.6)	6 (17.6)
Severe	14 (41.2)	9 (26.5)

To compare the effectiveness of the service on well-being, means were taken, and a paired samples t-test was conducted to compare mean difference of well-being at the earliest appointment and the most recent appointment with Pete’s Dragons. The analysis revealed a significant decrease in CORE-10 scores from the earliest appointment (M = 4.65, SD=1.50) to the most recent appointment (M=4.00, SD=1.71), t(33) = 3.012, p=.005 (two tailed). The mean increase in CORE-10 scores was 0.65 with a 95% confidence interval rating from 0.21 to 1.08. The eta squared statistic (0.216) indicated a small effect size.

Further analysis was done on the change in well-being (table 40). This table shows how participants moved from one well-being category to another, as per the cut off points for CORE-10. One individual remained in the healthy category. Individuals in the low well-being category either improved slightly or worsened. A similar pattern was seen in the mild distress category. Participants in moderate and moderate- severe distress pre-support also either improved or worsened. Participants in severe distress pre-support either improved or remained in the severe distress category.

Table 40: Changes in well-being from the initial and most recent appointments with Pete's Dragons (CORE-10).

Healthy		Low Levels		Mild		Moderate		Moderate Severe		Severe	
Healthy-Healthy	1 (2.9)	Low-Healthy	1 (2.9)	Mild-Healthy	1 (2.9)	Moderate -Healthy	0	Moderate Severe – Healthy	0	Severe – Healthy	0
Healthy- Low	0	Low-Low	2 (2.9)	Mild-Low	1 (2.9)	Moderate -Low	2 (5.9)	Moderate Severe - Low	1 (2.9)	Severe – Low	0
Healthy-Mild	0	Low-Mild	0	Mild-Mild	0	Moderate -Mild	1 (2.9)	Moderate Severe – Mild	0	Severe – Mild	2 (5.9)
Healthy-Moderate	0	Low-Moderate	0	Mild-Moderate	2 (5.9)	Moderate - Moderate	0	Moderate Severe – Moderate	3 (8.8)	Severe – Moderate	2 (5.9)
Healthy-Moderate Severe	0	Low-Moderate Severe	0	Mild-Moderate Severe	0	Moderate - Moderate Severe	2 (5.9)	Moderate Severe – Moderate Severe	1 (2.9)	Severe – Moderate Severe	4 (11.8)
Healthy-Severe	0	Low-Severe	0	Mild-Severe	0	Moderate -Severe	0	Moderate Severe – Severe	2 (5.9)	Severe – Severe	6 (17.6)

The below table (table 41) showed the change in category of well-being in terms of moving between low, medium and high well-being between the earliest and recent appointments with Pete's Dragons. Three, two and one evidences the number of participants who got better, for example moving from severe distress to mild distress, therefore indicating that the Pete's Dragons service improved well-being. Therefore, these results showed that most of the beneficiaries improved at least one point on the CORE-10 scale. Zero evidenced no change in well-being, for example participants stayed in healthy, low, mild, moderate, moderate-severe or severe distress when completing the most recent CORE-10 scale. Finally, minus one, two or three showed a decrease in well-being category in one, two or three points, for example they moved from moderate distress to moderate-severe or severe distress and thus did not improve after being supported by Pete's Dragons.

Table 41: Changes in distress in Pete's Dragons beneficiaries (N=34).

Changes in distress	N (%)
3.00	3 (8.8%)
2.00	5 (14.7%)
1.00	11 (32.4%)
.00	10 (29.4%)
-1.00	4 (11.8%)
-2.00	1 (2.9)
-3.00	0

In summary, these findings suggested that the Pete's Dragons service improved the well- being of people bereaved by suicide. However, these changes may be subtle and may not be reflected in improvements in moving between CORE-10 cut off points. As the researcher was unable to obtain data for other years of operation, it was not possible to compare the services' effectiveness across years. The researcher obtained 34 beneficiaries' CORE-10 scores. Due to this, it was difficult to determine long-term effectiveness or sustained effects and generalise to all beneficiaries supported by Pete's Dragons. However, one year's data showed that beneficiaries improved in well- being between their first and most recent appointments.

6.3 Triangulation Summary

To integrate the interpretation and reporting of the qualitative and quantitative data, an integration through narrative method has been used. Overall, postvention services in the UK had a positive effect on individual's bereaved by suicide. This was evidenced in SWEMWBS and CORE-10 scores, which showed a significant, positive effect on well-being. However, these effect sizes were small and may not be truly reflected in movement between the well-being categories, as some people remained in the same well-being category from the initial and recent appointment. Reasons for this were discussed in chapter 7.

The qualitative interview data complements and converges the quantitative results. Interviewed participants reported having a positive, impactful experience of postvention services. They highlighted the importance of a bespoke, tailor-made service, that incorporates both practical and emotional support. As evidenced in both qualitative and quantitative aspects of this study, some services were using psychometric measures to evaluate their perceived impact. These services showcased the benefits of their service. However not all services implemented these and therefore, struggled to show their effectiveness to funders and commissioners. There was considerable funding anxiety in all participants supported by and involved in postvention. This was closely linked to evaluating effectiveness. There was also anecdotal evidence for the cost-effectiveness of postvention services and further research should attempt to address this gap in postvention research. The qualitative findings suggested that the skills, experience and self-care of those delivering the service is important. Referrers reported their relief that postvention services existed and that postvention services delivered the support that referrers and other agencies can't provide. Collaborative working was key as suicide prevention and postvention efforts are a multi-disciplinary responsibility. This was also evidenced by the quantitative findings as different agencies referred into the services. Finally, improvements, challenges and conflicts were discussed by participants, which was also reflected in the poor-quality data collected by services. Furthermore, there were significant gaps in service delivery, such as finder of the body and male beneficiaries. The qualitative data supported this, as services were aware of this and were actively attempting to address these gaps. Research such as this gave services further evidence to focus their efforts in addressing these concerns. The honesty displayed by those discussing these issues gave a unique perspective on challenges faced by postvention, the conflicts that can arise and facilitate improvements in existing and new services.

A discrepancy in the data was evident, as the testimonial qualitative evidence suggested effectiveness of these services, however as discussed, the quantitative data was poor and inconsistent, leading to this research being unable to find evidence of effectiveness. The findings of the systematic review also supported the notion that the research did not find ineffective services, rather it found that the poor quality of the data collected had a direct impact on whether the service was deemed as an effective service. We should not ignore the testimonial qualitative findings; we can only conclude that the services were perceived to be effective. Further research in this area must be conducted, using consistent and good quality data. The first step to this being rectified is reviewing the available data and using the qualitative findings to support the rationale for the need for further research, which this thesis has done. The next step would be to develop recommendations for what that future research should focus on, which is presented in Chapter 7.

Chapter 7: Discussion

This mixed methods study aimed to assess suicide postvention services in England, evaluate their perceived effectiveness and create a model to advise those seeking to create a postvention service. Interviews with relevant stakeholders were conducted using semi-structured interviews. Audit data and outcome evaluation measures such as psychometric scales were also collected and analysed. In this chapter, I will consider the research questions and findings, how they contributed to research and relevant policies. Finally, the strengths and limitations of this study will be evaluated and clinical implications and directions for future research will be considered.

7.1 Findings in relation to the research questions, considering pre- existing research

7.1.1 What is the current suicide postvention service provision in England?

Postvention had been described as “an integral and indispensable component of... prevention programs” (Andriessen & Krysinska, 2012). Postvention services across England provided timely emotional and practical support to individuals bereaved by suicide and services and/or organisations affected by suicide. This was a core recommendation made by SASP, set out in their Core Standards (2020). They recommended that services were a single point of contact, have real time responsive referrals and have continuity of support. This research found that the services did meet the core standards set by SASP, particularly in relation to the support provided by the services. This study found that the services give timely and appropriate practical and emotional support to people bereaved by suicide, in the areas they service. However, this research found that they did not serve every local authority within the UK and there were gaps in service provision and areas of operation. Andriessen et al., (2019) recommended that a public health model of postvention allowed for a tailor-made approach to service delivery and meet the needs of bereaved individuals. This thesis also found that postvention should be a tailor-made public health initiative, as supported by all participants. Dyregrov (2011) recommended that postvention support should adapt to meet the needs of each individual bereaved by suicide. Professionals working with those bereaved by suicide characterised their grief as a unique experience, requiring specific intervention (Schuyler, 1973; Batzler, 1988; Knight, 1992). The present study aimed to evaluate the perceived effectiveness of existing suicide postvention services in the UK and create a model for commissioners and service creators who were attempting to create a service in another area. The present study found that suicide postvention in the UK offered a bespoke service and services tailor their support to the presenting needs of beneficiaries. Furthermore, Harwood et al., (2002) found that individuals bereaved by suicide were highly distressed by legal procedures, in particular the coroner's office and inquest. The media reporting also caused considerable distress. They concluded that postvention should address this. The present study also found that suicide postvention in the UK did address these experiences through providing support and liaison dealing with the coroner's office and the media. However, Hardwood et al., (2002) reflected on the disadvantages of their study and found that the control-group participants were more likely to be spouses. As kindship is an important determinant of grief reactions (Cleiren et al., 1994; McIntosh, 1993), this led to problems in interpreting the findings of the study. This suggested that there may be in-group differences in grief reactions and thus, support requirements, when considering factors such as relation to the deceased. Postvention services should consider this when supporting family systems. However, the fact that the services were bespoke and tailored the support to the specific beneficiary was an important factor in ensuring the service meets their needs. Further research should consider these differences in grief reactions and ensure properly matched controls.

Postvention services in the UK also attended the inquest with the beneficiaries, if requested. Campbell (1997) suggested that adequate and early postvention support normalised the grief process after suicide, identified more at-risk individuals bereaved by suicide, and reduced the risk of further suicides. Suicide postvention services in the UK also met this recommendation, as they were contracted to make first contact with referrals within 48-72 hours of receiving that referral and had the first appointment within seven days of receiving a referral. Therefore, they were providing support within a week of the death. Thus, postvention services met the recommendations made by previous research.

As there had been very little research conducted on suicide postvention services in the UK, it is difficult to highlight previous research in this area. However, a systematic review conducted by the researcher (Abbate et al., 2022) found two studies conducted in the UK (Ali & Lucock, 2020;

Hawton et al., 2012). Ali & Lucock (2020) evaluated a peer support group known as SOBS through interviews with members of the group and found that peer support is beneficial. Hawton et al., (2012) evaluated an online resource, Help is at Hand, and found that respondents reported that the resource was helpful, however there was often a delay in receiving this resource. After rating these studies using MMAT, one was found to be medium quality (Ali & Lucock, 2020) and the other was high quality (Hawton et al., 2012). The systematic review concluded that studies rated as low quality reflected poor reporting of evaluations, rather than ineffective services. This gave further evidence that the quality of data used to evaluate these services was poor and had considerable weaknesses. A strength of this systematic review was the inclusion of qualitative and mixed methods studies that evaluated the perceived effectiveness of suicide postvention, as previous systematic reviews did not include these methods. Furthermore, this review also assessed studies which evaluated specific services, and models of postvention services, such as community postvention support, school-based postvention, creative postvention services and informational resources to assess which models of postvention were effective. This gave further credence to the use of community-based suicide postvention and further rationale for assessing their effectiveness in the UK.

Another study explored the experiences of suicides in higher education and found that “tailored postvention support was required to respond to the range and complexity of HEI staff needs following a student death by suicide” (Causer et al., 2021). This study suggested that postvention needed to be tailored and understand the complexity of a suicide death when delivering postvention. ONS (2022) statistics on the highest suicide rates per region in 2021 include the Northeast, Northwest and Southwest regions. These areas had a postvention service that took part in this study, working to prevent further suicides and improve well-being in individuals bereaved by suicide in these areas. This suggested that postvention services were supporting the people most affected by suicide in England. However, there was a lack of research comparing the outcomes of people supported by a specialist service, people receiving no support or people receiving care from a GP or non-specialist service. There was also a lack of research comparing well-being in people bereaved by suicide in a location with and without a postvention service.

The present study also found some support for the multi-level social-ecological framework (Cramer & Kapusta, 2017) as the researcher found that the presence of support and the perception of that social support was crucial to beneficiaries and key stakeholders. Community involvement was valued, as was trained gatekeepers and reasons for living. Beneficiaries reported that coping skills, problem solving skills and hopefulness were key. The aforementioned factors were all believed to be incorporated by the support packages delivered by the postvention services who took part in this research.

7.1.2 Are the services perceived to be effective in reducing further suicides and improving the wellbeing of the people they support?

Research suggested that people bereaved by suicide were 65% more likely to attempt suicide than people who were bereaved by natural causes, increasing the absolute risk to 1 in 10 (Pitman et al., 2016). Interviews highlighted that the services were perceived as effective in improving the well-being of beneficiaries. Interviews with key stakeholders also reported that the services seemed to improve well-being and reduce the pressure on other relevant organisations. Furthermore, outcome evaluation data from two services found that well-being significantly improved between the initial appointment and the most recent appointment. This data was collected using SWEMWBs or CORE-10, which measured well-being and psychological distress. Suicide Liaison Officers completed these scores at the first and last appointment to assess changes in well-being. This study was able to access some of this data and found some evidence that the services were effective in improving well-being. In the case of one of the services, location and year did not affect this improvement. This suggested that regardless of when and where this support took place, it was effective. Furthermore, a systematic review conducted by this research found that postvention services were effective, as were models of postvention such as group support, community support, art support and web-based support. Studies rated as low quality were due to poor reporting of evaluations, rather than ineffective services (Abbate et al., 2022). However, the data accessed by the researcher was limited, as it only came from two services. The data was also not consistent, as some beneficiaries completed the outcome measures twice, and others completed it more than twice. However, the researcher used the first and most recent scores. The data from the two services was also not appropriately matched, as one service had 270 participants well-being scores, whilst the other had 34. The outcome measures data did not include every beneficiary supported in the years of operation. Extraneous variables were not controlled for, such as the impact of time since the death, length of time receiving postvention support, relationship to deceased and other supportive measures received by beneficiaries. Furthermore, the qualitative data collected from 58 interviews found that beneficiaries, referrers, commissioners and commissioned service CEOs perceive the postvention services to be beneficial in improving well-being and preventing further suicides. However, we must exercise caution as this research cannot provide definitive evidence that the services were effective. Together, the qualitative and quantitative data suggested a positive relationship between well-being and postvention. It was encouraging that the services were perceived to be beneficial and future research should address this gap.

As mentioned, there was variation in the data that was collected and how it was collected. Some services collected testimonial data to point to their perceived effectiveness. Some services also gathered quantitative descriptive data on referrals and the assistance provided, indicating the viability of the service's usefulness. Finally, some services collected quantitative outcome data in terms of SWEMWBs and CORE-10 to assess their well-being at two or more timepoints and derive changes in well-being. The aim of collecting any outcome data also varied. Some services hoped that outcome data allowed them to gain an understanding of what was and was not working, find out what aspects of service delivery needed further development and what else they could offer beneficiaries. Some services did not want to use evaluation measures such as SWEMWBs and CORE-10, as they did not believe these measures could adequately reflect the experience of suicide bereavement and since suicide bereavement cannot change or improve, a scale could not ascertain change. However, this study showed that these measures can highlight improvement in well-being and reflect aspects of well-being, such as distress, suicidal ideation and risk. Subsequently, informing increased levels of risk that may need addressing. Other services used these measures and data collection because it was a requirement of commissioning and receiving funding, suggesting the importance of these tools when commissioning a postvention service. This was further outlined by commissioners interviewed as they used these measures to understand the services' effectiveness and make inferences about cost-effectiveness.

Further research found that a postvention service in Australia known as Standby was effective in improving the wellbeing in individuals bereaved by suicide (Visser et al., 2014). Standby was cost-effective as it dominated usual care with a cost saving of AUS $803 and increased quality-adjusted life years by 0.02. When accounting for confounding variables, the likelihood that the service would be cost-effective was 81% (Comans et al., 2013). Another study evaluated a postvention service in the USA in their first year of operation, known as LOSS and found that the service connected the bereaved with crucial resources and fostered a sense of belonging. Connecting the bereaved with others bereaved by suicide was another important factor that LOSS facilitated with (Aguirre & Terry, 2013).

In 2021 in England and Wales, there were 5,583 registered suicides (ONS, 2022). Research suggested that 135 people were directly affected by one suicide (Cerel et al., 2018). Therefore, 753,705 people were affected by suicide in 2021 and may require support to prevent further suicides and improve well-being in those bereaved by suicide. As previously discussed, it was believed that exposure to suicide was on a continuum, which varied between being exposed, affected and bereaved by suicide. Research suggested that services should no longer focus on next of kin, but the wider community around the deceased, whom may have been exposed to the trauma of a suicide death (Cerel et al., 2014, p.4). Data collected from Amparo found that across five locations in four years, 1248 referrals were received, and 958 beneficiaries were supported. They supported many people with different relationships to the deceased, including child, parent, siblings, partners, spouses, friends, colleague, extended family members and relationships described as “other”. Of the people they did not provide the full postvention support to, some were given information about suicide bereavement and some lived outside the area of Amparo’s operation. Furthermore, in one year Pete’s Dragons received 520 referrals and supported 344 individuals bereaved by suicide. Relationship to the deceased also varied, including siblings, stepsiblings, children, stepchildren, parents, stepparents, friends, in-laws, nephews, nieces, partners, spouses and relationships described as “other”. These results showed that postvention services support anyone exposed, affected and bereaved by suicide, as defined by Cerel et al., (2014; 2018). Pitman et al., (2016) suggested that the effects of suicide are not confined to blood relatives, as other research found that friends can be at risk of suicide and adverse mental health issues (Bartik, Maple & McKay, 2020), 10–19-year- olds who died by suicide had been previously bereaved by suicide (Rodway et al., 2020), children bereaved by the suicide of a parent may have attachment difficulties and problems relating to adults (Jordan, 2001) and children bereaved by the suicide of a parent before the age of six years were affected by the suicide for 25 years and were at an increased risk of suicide throughout their lives (Guldin et al., 2015). Finally, a large- scale national survey on suicide bereavement in the UK found that 7,158 people exposed or bereaved to suicide, including in a professional capacity, 77% felt it had a major impact on them. The most common relationship was friend, with the second most common relationship was parent (McDonnell et al., 2022). This research supported the postvention services' efforts in supporting a variety of relationships to bereaved and not limiting their support to next of kin.

Despite the problems that this research faced in concluding effectiveness, this research provided support for the call to improve data and evidence to ensure that effective, evidence-informed and timely interventions continue to be developed and adapted, as set out by Public Health England (2023). Beneficiaries perceive their support to be timely and appropriate, however as discussed, further evidence is needed.

7.1.3 What impact did these services have on other organisations and the wider community in the areas they are located?

This study found that the services were well received by other organisations involved in suicide and the wider community. Referrers discussed having a good relationship and a simple referral pathway, that could at times be repetitive if they were referring multiple family members. Commissioners also discussed having a good relationship with the services and felt it was a positive experience. The overwhelming view of the services was positive, with all beneficiaries highlighting testimonials and positive narratives. The services offered additional community support that was not included in the original scope of the services but had been an additional avenue of support that had evolved. For example, memorial events, drop-in centres for communities affected by suicide, fundraising events, family events and a presence on important dates such as World Mental Health Day and World Suicide Prevention Day.

Collaborative working in suicide postvention has been shown to be beneficial. The LOSS evaluation found that referring police departments felt that LOSS was able to provide a service to the bereaved that the police just could not provide, due to the police's role and protocols in investigating the death. The police reflected that the finder of the body needed care beyond the police's scope, and the police felt the postvention service could offer that (Aguirre & Terry, 2013). This study found similar opinions in referrers who spoke of their relief that there was a postvention service to support the bereaved. This sentiment was also shared in commissioners, who discussed their motivation for commissioning a service such as this. Furthermore, the Core Standards set out by SASP (2022) suggest that partnership and collaboration was key and services must engage with local, statutory, voluntary and community organisations. Services needed to ensure that they attend multi-agency forums and promote awareness of their service. WHO (2021) outlined four recommendations one of which being collaboration between relevant organisations, including "health, education, labour, agriculture, business, justice, law, defence, politics and the media". Postvention in the UK is attempting to address this. Referral sources from two services included in the quantitative data showed that referrals come from many different avenues, including education and health. Furthermore, services involvement with the media was discussed by participants. Services used social media to their advantage as a means of communication, awareness raising and monitoring suspected clusters. Services also use the Samaritans (n.d) "media guidelines for reporting suicide" as an attempt to support the media in reporting suicides responsibly and support families in their communication with the media. Therefore, postvention services continued to meet the needs of individuals bereaved by suicide, as suggested by research and organisations working in postvention and prevention, such as the WHO. This was reflected by individuals bereaved by suicide and professionals working in suicide postvention within this research.

7.2 Model and Recommendations

The model and recommendations within this section were created by converging both the qualitative and quantitative findings. Key findings from chapters four, five and six were drawn together to create a 'bigger picture' and a holistic view of suicide postvention in the UK.

This was done using triangulation and a convergent research design (Creswell & Plano-Clark, 2007). This model aimed to address the lessons learned and shared knowledge on how to set up a postvention service, based on existing postvention services, beneficiaries, key stakeholders, employees, commissioners and service CEOs feedback. The process of creating this model also considered which information was key, reflecting on recommendations from SASP and key governmental policies, in essence asking what the sector and communities needed from a postvention service. This process could be summarised by paraphrasing one of the key themes "what do you need from us?" however, this was re-shaped by asking what did postvention need from this research? What knowledge was needed? How could this research provide useful information for postvention services and ensure a standardised, appropriate support package for people bereaved by suicide, as recommended by SASP and governmental guidance? A model was then created using this reflective and iterative process, using triangulation. This process was created with the foundations of pragmatism, as pragmatist inquiry begins with a practical problem and ends, hopefully, with for-now resolution of that problem (Morgan, 2007; Thayer, 1982). The researcher believed it was important to combine the theory and concepts with real experiences of those who have direct experience of postvention. Moreover, the researcher valued the research from its practical relevance and the purpose of the theory and the experiences to inform the practical actions. This connected with pragmatism that "stresses the relationship between theory and practice. For a pragmatist, theory is derived from practice and then applied back to practice to achieve intelligent practice" (Bougie et al., 2020, p.24).

The model below (table 42) highlighted components required for services to support individuals bereaved by suicide and provide data on services' effectiveness. It was important to note that there was no 'one size fits all', as expressed in the first recommendation. One of the most important aspects of these services was that they were bespoke, and this should remain as a crucial foundation for all postvention services.

Table 42: Model for postvention services.

Recommendations	
Recommendation 1	Services should offer bespoke practical and emotional support, that should adapt to each individual beneficiary.
Recommendation 2	Collaboration with all referrers to improve referral numbers.
Recommendation 3	Services should attempt to offer other support, after the postvention support has concluded. This may include bereavement counselling, trauma-focused counselling and peer support groups.
Recommendation 4	Funding should be sought from multiple avenues.
Recommendation 5	Services should choose an evaluation outcome measure such as SWEMWBS, CORE-10, the Adult Attitudes to Grief Scale or the Grief Experience Questionnaire. A staff member should be assigned the role of data collection and data monitoring and receive appropriate training for handling data. Data should be linked between demographic information and evaluation outcome measures at an individual level.
Recommendation 6	Gaps in who is not accessing the support should be addressed (men, finder of the body, other relatives, out of area referrals).
Recommendation 7	Future research should focus on cost-effectiveness, longitudinal studies, RCT’s.
Recommendation 8	Suicide Liaison Officers should have the adequate skills, experience and training to support individuals bereaved by suicide. Suicide Liaison Officers should also receive support themselves to prevent their experiences (personal and professional) from impacting their well-being.

7.2.1 The Support

It was clear throughout the interviews that suicide postvention services should offer bespoke practical and emotional support, that should adapt to each individual beneficiary. It would be ineffective and inappropriate to attempt to deliver a “one service fits all” approach as every suicide death was different, affected the beneficiaries differently and was a unique experience which required specific intervention. How this support was delivered differed between services, as many services operated within the community, visiting beneficiaries’ homes, schools and places of work. However, one service operated within offices and requested that beneficiaries visited the office to receive support. An additional service operated solely within the community and did not have an office and did not include homes visits either. This study did not find any evidence that the difference in the location of support (remote versus office-based) affected the effectiveness of the support. In addition, beneficiaries did not discuss a preference in where they were supported.

7.2.2 Referrals

Referral sources differed between police-led, coroner-led and self-referral. Services involved in this study were either coroner-led, police-led or mainly operated with a self-referral system. Many services accepted referrals from all three avenues, however services often had a system in place in which there was one main referral point. Data from the interviews revealed that police-led referrals consisted of the police referring individuals bereaved by suicide. This resulted in referrals for next-of-kin or whomever is at the scene. Some police forces had a dedicated officer for suicide deaths; however, this was not country wide. The police asked these individuals if they would like support from the postvention service in their area. If consented, the police send brief details to the service, who then made contact with the family. If they did not consent, they may not be asked again. However, some police officers had noticed the family were in distress and they offered to refer them into the service a second time. However, this was at the police officer’s discretion.

Coroner-led services were specific to England. In England and Wales, Coroners investigated all deaths where the cause was unknown, where there was reason to think the death may not be due to natural causes, or where an inquiry needed to take place. Each Senior Coroner was responsible for a geographical area. A coroner’s officer, on behalf of the coroner made contact with the family and tried to gain a better understanding of what happened, they began to gather evidence and information in order to “open an inquest”. They spoke to the police, witnesses, the family and anyone else who had information such as the GP or mental health professionals. A date was then set for the “full inquest”. It was decided on this date whether the death was to be ruled a suicide, accident or open verdict. The coroner must be satisfied that there was intention “beyond all reasonable doubt”. Data provided in interviews with coroners revealed that if potential beneficiaries were in an area with a coroner-led postvention service, when the coroner’s officer made contact with the family, they offered the family the postvention support. If consented, the coroner’s officer will then send brief details to the postvention service and the service will make contact with the family. If they did not consent, they are not asked again. Finally, self-referral led services mainly relied on word of mouth and awareness raising which enabled the bereaved to find out about the service. They had websites and telephone numbers that bereaved individuals referred themselves into the service. Coroner-led and police-led services sometimes had a self-referral option. Regardless of whom referred into the services, the services aimed to provide timely support and as such, within 48-72 hours of receiving a referral, they made contact with the potential beneficiary.

They aimed to have the initial appointment within seven days of receiving the referral. Issues and challenges faced by services in regard to referral pathways were highlighted in this research. These issues included missed referrals, bereaved individuals not consenting to the support and then perhaps not being offered the service again, other family members not being offered the support and stigma associated with suicide, as evidenced previously by Cvinar (2005) who found that individuals bereaved by suicide experienced greater levels of stigma. The reliance on organisations knowing about the service and offering the support was a concern. To combat this, services should aim to have all relevant organisations aware of the service and how to refer into the service, this may include GP’s, social prescribers, funeral directors, citizens advice bureau and anyone else who may come into contact with individuals bereaved by suicide. The importance of having a good working relationship with coroners and police in the area was highlighted. Research showed the differences between police- led and coroner-led services. An evaluation of a pilot police-led suicide early alert surveillance strategy in the UK (McGeechan et al., 2017) found that coroners were more consistent at identifying suspected suicides, however referrals were completed quicker by the police. Participants were more likely to share contact details and consent to referrals with the police (McGeechan et al., 2017). This suggested that services should consider which agency would be best placed to refer the bereaved. Increasing collaboration between relevant agencies and postvention services involvement at a local level would also support the Mental Health Taskforce in the NHS in England's recommendation that all local authorities must have a multiagency suicide prevention strategy as 40% of local authorities report not having a multi-agency suicide prevention group as police, coroner and GP involvement at a local level is inconsistent (The All-Party Parliamentary Group on Suicide and Self-Harm Prevention, 2015).

7.2.3 Signposting and further support

Postvention services play a key role in being aware of other relevant local avenues of support. Interviews in this study revealed that postvention services often work closely with peer support groups such as SOBS. However, to further evidence their effectiveness and provide support for longer, some services have started exploring the possibly of offering bereavement counsellor or trauma-focused counselling. This should take place after the postvention support has concluded and for beneficiaries who feel they need further support. This concept was a key recommendation of this research as this would further reduce reliance on statutory services and prevent individuals bereaved by suicide from being placed on lengthy waiting lists. This would also ensure that further support is suicide specific. As many of the services hire suicide liaison officers that have counselling backgrounds, this would be unchallenging to achieve. A study exploring the perspective, experience and support needs of parents bereaved by suicide found three key themes. Firstly, the importance of not feeling alone; secondly the perceived barriers to accessing support; and finally, the need for signposting to additional support (Wainwright et al., 2020).

7.2.4 Funding

There are four main avenues of funding, however some services have multiple avenues of funding, which was discussed in this section. Firstly, one service was lottery funded, however this was time limited, for around five years at a time. Secondly, NHS funded services were an option, however these services reflected that this resulted in hoops that have to be jumped through, such as evidencing the services are having a tangible and quantifiable change. There were concerns with this as there was a belief that suicide bereavement is not something one recovers from, it’s something that one learns to live with. Due to many services not collecting outcome evaluation data, it is extremely difficult to get this funding. Furthermore, conflicts were highlighted as beneficiaries felt angry and concerned when a death occurred within an NHS facility such as an inpatient psychiatric ward and they were now being offered support from an NHS funded postvention service. Thirdly, public health and local authorities funding was an option, however priorities could change within local authorities and funding can be pulled and given elsewhere. For example, at one point a Local Authority did not opt into a service, and as such, bereaved individuals in that area were unable to access support. Another Local Authority then also opted out, which was the biggest source of referrals in that region, resulting in bereaved individuals living in this area also unable to access support. Finally, independent charities such as IFUCARESHARE were originally set up by a family who were bereaved by suicide who created wrist bands for people to wear to raise awareness of suicide. They sold these, fundraised, and it eventually snowballed into a nationally recognised charity. However, this was extremely difficult to do, as reflected by the service CEO. As explained, all funding avenues had their problems and funding was reported as being extremely unstable and inconsistent. Those running these services lived in a state of never knowing if the charity will continue to be funded. This also prevented services from being as responsive as they would like to be. If there is an increase in suicide rates in their area, services may not receive an increase in their funding until the next funding year, if at all. Therefore, services often had to fundraise or find funding elsewhere to be able to continue to operate. Service CEOs discussed ensuring that that their service had multiple avenues of funding and continually searching for appropriate grants and funding sources. The anxiety surrounding this was reflected in interviews with CEOs, SLOs and beneficiaries. The latter often witnessed how stretched some of the services were.

7.2.5 Data collection

WHO (2021) reported that the quality and the availability of data on suicide was poor. Some services collected data on referrals and beneficiaries. This study accessed data from two services. However, other services reported that the data they held was not consistent and reliable enough to do any meaningful analysis. Therefore, this data was not included. Postvention services should aim to collect data on their referrals and beneficiaries. Furthermore, postvention services struggled to find an evaluation outcome measure that they were comfortable using and therefore, they found it difficult to indicate their effectiveness. Since this study was conducted SASP have created a Measurement and Evaluation Task Group, which aimed to explore evaluation methods and make recommendations. This study continues to support those efforts. All the services collected testimonial feedback from beneficiaries. One service used Microsoft PowerBi to collate referral and beneficiary information.

Data needed to be linked up at an individual level, services should be able to explore each beneficiaries' information to gain further insight into the backgrounds and experiences of their beneficiaries. Data linkage is a relatively new concept and is defined as "a merging that brings together information from two or more sources of data with the object of consolidating facts concerning an individual or an event that are not available in any separate record" (OECD, n.d). The Health Knowledge (n.d) advised that separate data can be linked together into "a seamless whole", this should be available on demand and as required. They suggested that difficulties in linking data and preserving confidentiality could be rectified through using identifiers similar to NHS numbers. Boyd et al., (2017) suggested that this was more efficient, it encouraged completeness of data and increased representativeness and coverage. In support of this recommendation, Boyd et al., (2017) stated that data linkage supported the study of sub-populations who were covered by the traditional data collection process, but still have substantial contact with service providers and for cohorts within populations to be studied. Therefore, linking data would allow for researchers to investigate the standardised data collected, alongside outcome evaluation data and other relevant data. This could then be used to assess whether certain sub-groups need further support, evaluate the services' own effectiveness and evidence the support given.

Services may find it useful to assign a specific data collection and evaluation staff member. This may take time and resources away from service delivery. However, if a beneficiary dies or an external audit is done, they could evidence the support given to that person. Data collection and evaluation would also impact future funding and evidence improvements in beneficiaries' well-being. This would also support the WHO's suggestion that improving monitoring of suicide is an important factor in effective postvention (WHO, 2021). There has been ongoing debate on the appropriateness of psychometric scores for suicide bereavement, particularly amongst the participants in this study. SLOs, CEOs and commissioners discussed using these measures at the first and final appointment with the SLOs, as a risk assessment tool and to evidence changes in well-being and therefore explore the effectiveness of the support. One service used SWEMWBS and the other service used CORE-10. SWEMWBS has been validated for use in the general population and clinical sample (Ng Fat et al., 2017; Shah et al., 2021; Vaingankar et al., 2017). Barkham et al. (2013) also validated the CORE-10 in primary care patients as well as the general population. However, both of these measures did not focus on grief. Another scale known as the Adult Attitude to Grief Scale (AA) devised by Machin (2001) gave a score of vulnerability by looking at the bereaved experiences of three dimensions: overwhelming emotions, desire for control and resilient coping responses. There were three questions for each dimension, with a total of nine questions. This included five responses, ranging between strongly agree to strongly disagree. An indicated vulnerability score was then computed, with low vulnerability being 0-20, high vulnerability as 21-23 and severe vulnerability as 24-36 (Sim, Machin & Bartlam, 2014). Sim, Machin and Bartlam (2014) found that internal consistency of the three dimensions of the AAG were acceptable. Construct validity and discriminative validity was also found. Therefore, the AAG is a psychometric score that can identify vulnerability in grief. A study conducted by Tomita and Kitamura (2002) evaluated sixteen psychometric scores of grief and in particular identified normal grief reactions and pathological grief. They found that the Grief Experience Questionnaire measured various aspects of grief and suggested it's use for suicide bereavement. It had been validated as a measure of grief (Bailley, Dunham & Kral, 2000).

Whilst two services are using clinical well-being measures, this research cannot disregard the concerns about an appropriate scale, used for this specific purpose. Previous research and the present research discussed in this thesis argues that suicide is a different kind of bereavement, requiring specific interventions. Therefore, it would be inappropriate to suggest that a generic well-being scale can measure the complex phenomenon that is suicide and suicide bereavement. Therefore, this research suggested using the AAG or the Grief Experience Questionnaire as they are specific to grief and can indicate normal grief reactions or pathological grief. However, a scale should be developed to measure suicide grief.

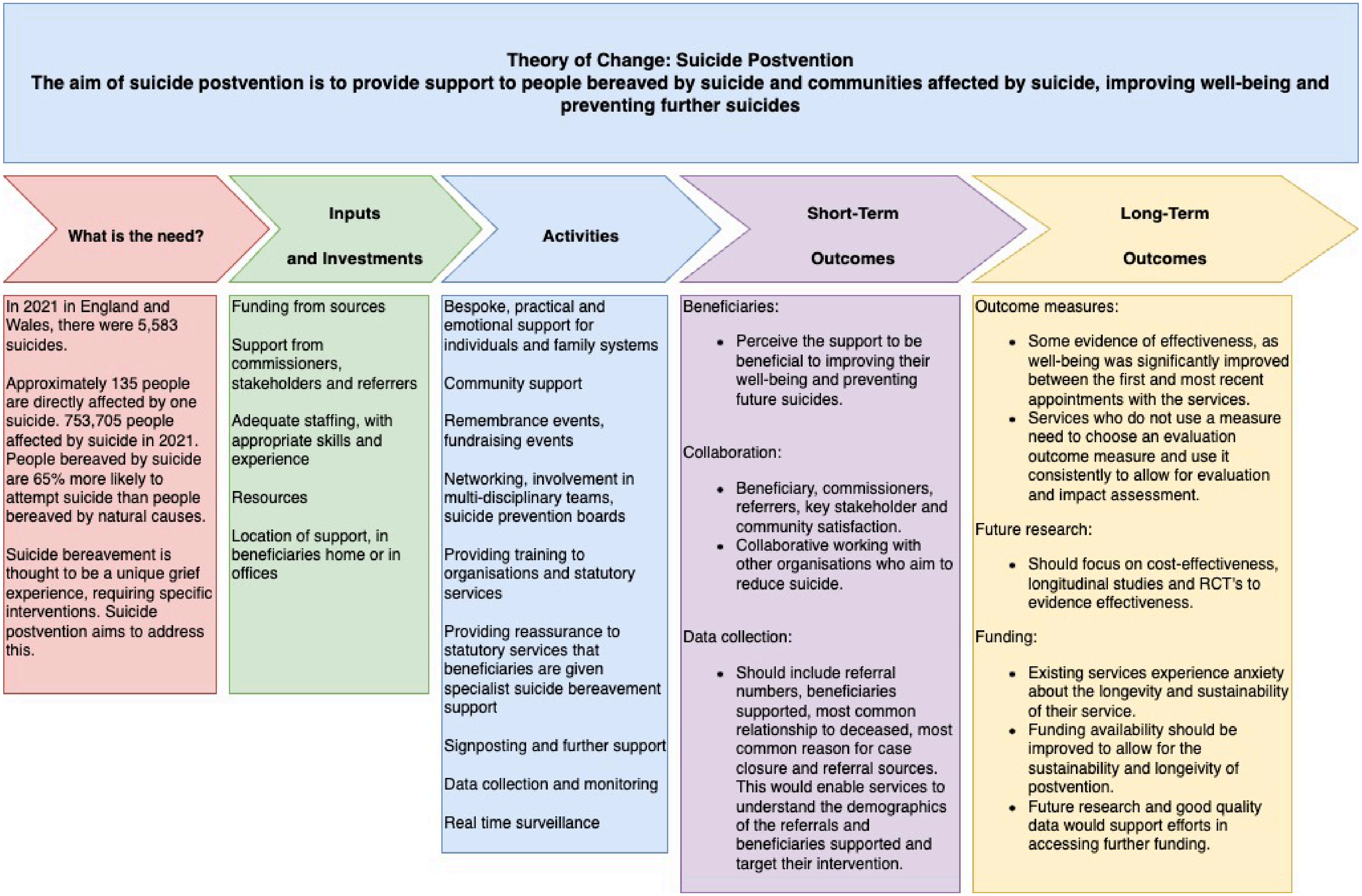
7.2.6 Demographics

Research suggested that one suicide affected many people and those affected by suicide werer at an increased risk of attempting suicide (Cerel et al., 2014; Pitman et al., 2016). It was important that services understand who was referred into their services, referral pathways and how they had been supported. The demographic and referral information assessed by this study found that females were significantly more likely to access postvention support. Furthermore, few referrals for finder of the body were received. This suggested that postvention services should consider how they could adapt their support to meet the needs of potential beneficiaries. One study found that young men were less likely to seek professional support for themselves and were more likely to access mental health support that is technology based, self-help and action-oriented (Ellis et al., 2013). A systematic review on help-seeking behaviours in men found that services should use role models to convey information, appropriate psychoeducation that highlighted improvements in mental health, knowledge in recognising and managing symptoms of distress, active problem-solving, motivation behaviour change and content that builds upon positive male traits such as responsibility and strength (Sagar-Ouriaghli et al., 2019).

Postvention services should use the data collected to understand gaps in who was accessing their service. Services could use focus groups and public advisory groups to develop strategies and interventions that would be of use to all individuals bereaved by suicide. For example, they may find that men would be interested in attending activity led support. Sagar-Ouriaghli et al., (2020) conducted focus groups on the support needs of males and found that men required a different format of support as they valued support being “informal and fun”. Participants also reported that brief interventions were easier to engage with and did not appreciate labelling the support as “mental health” intervention. Finally, this study found that men needed support that improved mental health knowledge and psychoeducation. Furthermore, the Core Standards set out by SASP (2022) suggested that partnership and collaboration were key and services must actively engage with people with lived experience to ensure the service meets the needs of the community. Numbers of referrals for finder of the body may be difficult to increase due to referral pathways. For example, if the service is coroner-led, the coroner made contact with the next of kin to discuss the coronial process that must take place and offered the postvention support and therefore had no contact with finder of the body. Police-led services may find it easier to refer finder of the body. As friends were also impacted by suicide bereavement (Bartik, Maple & McKay, 2020; Rodway et al., 2020), the importance of services offering drop-in appointments and memorial events to support wider communities affected by suicide was highlighted.

7.3 Theory of Change Model

As discussed in Chapter 3, a theory of change (TOC) can be useful in evaluation and it is an opportunity to aid services in understanding how change occurred and identified any barriers to a successful programme (Aromatario et al., 2019; Church & Rogers, 2006; Funnell & Rogers, 2011). A TOC model is seen as a valuable tool for organisations seeking to plan, implement, and evaluate their initiatives effectively. It provided a systematic and visual representation of the steps needed to bring about desired outcomes and illustrated the logical connections between inputs, activities, outputs, outcomes, and impacts (Aromatario et al., 2019; Church & Rogers, 2006; Funnell & Rogers, 2011). A TOC model was created, based on the data provided in this thesis. This TOC highlighted the inputs and investments required, the activities the postvention services offer and the short-term and long-term outcomes. This articulates how the change is created. This TOC model will help organisations to clarify their mission, goals, and intended impact. It will also allow stakeholders to gain a shared understanding of how and why change is expected to occur. The TOC is an aid to understanding the strategic plan by identifying the necessary preconditions for success and the sequence of activities required. It assists in aligning resources, activities, and timelines with the overall mission. The model helped define and articulate measurable outcomes at different stages, allowing for clear performance indicators. Furthermore, services can track progress and demonstrate accountability to funders and stakeholders using this TOC model. It also promoted a culture of learning and adaptation by encouraging services to reflect on their assumptions and learn from other services. The TOC provided a framework for evaluation, enabling organisations to assess the effectiveness of their intervention, as well as facilitating the identification of what works and what does not, supporting evidence-based decision-making. The visual nature of a TOC model made it an effective communication tool and it simplified reporting to stakeholders by presenting a clear narrative of postvention's TOC. In summary, this TOC model served as a dynamic and adaptable roadmap for services', guiding them in achieving their mission and creating positive social impact. It enhanced organisational effectiveness, fostered transparency, and supported continuous improvement through learning and evaluation processes. See Figure 12 for TOC Logic Model.



Theory of Change: Suicide Postvention

The aim of suicide postvention is to provide support to people bereaved by suicide and communities affected by suicide, improving well-being and preventing further suicides

What is the need?

In 2021 in England and Wales, there were 5,583 suicides.

Approximately 135 people are directly affected by one suicide. 753,705 people affected by suicide in 2021. People bereaved by suicide are 65% more likely to attempt suicide than people bereaved by natural causes.

Suicide bereavement is thought to be a unique grief experience, requiring specific interventions. Suicide postvention aims to address this.

Inputs and Investments

Funding from sources

Support from commissioners, stakeholders and referrers

Adequate staffing, with appropriate skills and experience

Resources

Location of support, in beneficiaries home or in offices

Activities

Bespoke, practical and emotional support for individuals and family systems

Community support

Remembrance events, fundraising events

Networking, involvement in multi-disciplinary teams, suicide prevention boards

Providing training to organisations and statutory services

Providing reassurance to statutory services that beneficiaries are given specialist suicide bereavement support

Signposting and further support

Data collection and monitoring

Real time surveillance

Short-Term Outcomes

Beneficiaries:

- Perceive the support to be beneficial to improving their well-being and preventing future suicides.

Collaboration:

- Beneficiary, commissioners, referrers, key stakeholder and community satisfaction.
- Collaborative working with other organisations who aim to reduce suicide.

Data collection:

- Should include referral numbers, beneficiaries supported, most common relationship to deceased, most common reason for case closure and referral sources. This would enable services to understand the demographics of the referrals and beneficiaries supported and target their intervention.

Long-Term Outcomes

Outcome measures:

- Some evidence of effectiveness, as well-being was significantly improved between the first and most recent appointments with the services.
- Services who do not use a measure need to choose an evaluation outcome measure and use it consistently to allow for evaluation and impact assessment.

Future research:

- Should focus on cost-effectiveness, longitudinal studies and RCT's to evidence effectiveness.

Funding:

- Existing services experience anxiety about the longevity and sustainability of their service.
- Funding availability should be improved to allow for the sustainability and longevity of postvention.
- Future research and good quality data would support efforts in accessing further funding.

Figure 12: Theory of Change Logic Model

7.4 Strengths and Limitations

7.4.1 Strengths

Andriessen et al., (2019) conducted a review and concluded that there is limited evidence of effectiveness of postvention interventions and service delivery. They reported that this was due to a relative shortage of research. This research aimed to address that gap in knowledge of the effectiveness of postvention. To the researcher's knowledge, this was the first large scale, mixed methods evaluation on suicide postvention services in the UK. This study used the same qualitative interview schedules across all services. This study also analysed the interviews twice, once to ascertain how each of the services delivers support and how they were set up. The interviews were then analysed a second time to understand the experiences of the participant groups and how they were impacted by the services. The mixed methods design provides an evidence-led contribution in an area where there has been little published research. The qualitative aspect of this study provides an understanding of the experiences of everyone involved in suicide postvention, including individuals bereaved by suicide who access postvention support. The quantitative research design aimed to understand whether the service improves well-being. An advantage of using the mixed methods design was that it fully explored research questions, from multiple angles (Kral et al., 2012; Kolves et al., 2021). Components can be examined simultaneously. For example, it would not be appropriate to conclude that services were effective without looking at qualitative data that evaluates effectiveness. It would also be inappropriate to conclude that services were having a positive impact without asking beneficiaries about their experience of the service. Furthermore, triangulation was used to interpret both the qualitative and quantitative data and highlight how these aspects can be brought together cohesively (Tashakkori & Teddlie, 2003; Heale & Forbes 2013). To enhance trustworthiness of the data and validity of the findings, each of the interviews was transcribed by the same person, however transcripts were read, codes and themes were developed in consultation with the research team (Braun & Clarke, 2006; Yardley, 2000).

Another strength was the sampling of both the services and the participants. The services evaluated offer support across a wide geographical area of the UK, which included cities and rural areas. The participants included service users (beneficiaries), anyone who refers into the service (coroners, police officers, GP's and social prescribers), creators of the services, individuals delivering the support and commissioners. A high number of interviews were conducted, using semi-structured interview techniques to allow for further exploration. One researcher conducted all the interviews and analysed the interviews, which allowed for continuity and standardised evaluation. Furthermore, research suggested that in qualitative research a sample size of one can be "highly informative and meaningful" (Boddy, 2016). 9-17 interviews were found to have reached saturation (Hennink & Kaiser, 2022). The present study included 58 interviews, analysed twice. This sample included people from a wide variety of backgrounds, ages and locations across England.

A further strength of this thesis was the creation of a model and a theory of change logic model (see Figure 12). This novel aspect of the thesis aimed to address the inconsistency found in service delivery (The All- Party Parliamentary Group on Suicide and Self-Harm Prevention, 2015; SASP, 2020) and encourage consistency and improvements to service delivery. Furthermore, this research suggested improvements to data collection, which had been called for by SASP (2020) and The Department of Health (2012; 2014). SASP (2020) and Public Health (2023) suggested that services should routinely collect and assess outcome data which reflected the use and the impact of the services. Future services should include testimonial and annual evaluation to ensure the service is meeting demand. The present research found that services are not meeting this core standard and made recommendations for how this can be done and its importance. Since this research started, the researcher became a member of SASP Measurement and Evaluation Taskforce to provide expertise on creating a toolkit for postvention services to improve evaluation efforts, suggesting the need for and importance of this research within suicide postvention. The Suicide Prevention: Cross-Government Plan (2019) recommended a coordinated plan and collaboration between health, education, community and other stakeholders to provide early intervention with improved evidence-based strategies and continuous evaluation to improve well-being and safety. The All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2015) and Public Health (2016; 2023) suggested a tailored approach may be beneficial, and similar findings were reported in this research. Furthermore, they suggested that timely and effective support and information for those bereaved by suicide, a local response and collaboration were all essential areas for action. This research found that this has been actioned by some of the existing postvention services. In light of existing policy, this thesis gives additional guidance on how improvements could be made and what should be considered when creating a postvention service. The key objectives and standards outlined by the aforementioned policies and guidance set the tone for national and local public health efforts, and this research has reported what further work needs to be done, what is perceived to be working well and has suggested areas for improvement. This thesis emphasised the integration of theory and policies with real-world applications, recognising the significance of bridging theory with practical instances to grasp the complexities of suicide bereavement. Additionally, it is important to conduct research that is pertinent to practical contexts and maintain the essence of theory in informing actionable strategies. This perspective aligned with pragmatism, which highlights the interplay between theory and practice, where theory emerges from practical experiences and is subsequently applied to further enhance practical endeavours (Bougie et al., 2020).

A final strength that must be highlighted was the context of which this research was conducted. This study was conducted during the Covid-19 pandemic and utilised remote means of communication such as telephone, Zoom and Microsoft Teams. Despite this set back, this research was completed in a timely and appropriate manner, ensuring that deadlines were met, and confidentiality was assured at all times. The researcher worked hard to ensure that services and beneficiaries understood the aims of this research, what participation entailed, and consent was appropriately procured.

7.4.2 Limitations

This study was reliant upon organisations providing the researcher with data and contact information for participants. This reliance included a commitment from the services for their time, enthusiasm for the project and contacts. Some services declined participation, citing Covid-19, the lack of time available to them to participate and commissioners not wanting to take part. It was not possible to interview any additional services from Northern Ireland. Furthermore, at the time of recruitment Wales and Scotland did not have any active professional suicide postvention services. A decision was made by the research team that services must have been in operation for over two years to be included, this was then changed to one year to allow for further services to be included. It was also envisaged that the researcher would gain access to evaluation outcome data from all the services. However, it became apparent that not all of the services collected this data. Therefore, the researcher was only able to access two services' evaluation outcome data. One of the services was only able to provide one years' worth of this data. The scope for evaluating outcome data, comparing these services and comparing this data by year, was impacted. Furthermore, some participant groups had a lower number of participants than others. This was often due to the way the service operated or participants declining to take part.

As previously mentioned, this study was conducted during the Covid-19 pandemic and this did impact the research. The original scope of this study envisaged that the researcher would embed themselves within each service, spending time at each service and observing the work that they did. However, the introduction of travel restrictions and many services reducing their service to a remote-only service prevented travel to each service. Conducting the research during this time relied upon telephone, Zoom and Microsoft Teams. Adequate internet access and telephone signal was needed. Therefore, participants who did not have access to the internet and telephone signal, and were not proficient in technology, were not able to take part.

7.4.3 Further research

Interviews conducted with those involved in postvention and data collected by services has found that postvention support is effective. Many researchers working in this field highlighted avenues for further research in this area. Andriessen & Krysinska (2012) reported that methodologically strong studies were needed to identify and meet the needs of people bereaved by suicide. They concluded that "conducting effectiveness studies of postvention activities... including health-economic studies". This study addressed that need, however further research is needed. The present study concluded that further research should aim to address how postvention can support finder of the body and other demographics, such as aiming to improve the rates of men accessing postvention support. Additionally, further research may aim to further support evidence of the effectiveness of UK postvention services by conducting a cost- effectiveness study, similar to the Australian Standby cost-effectiveness study.
Research should continue to support the development of a clear framework and model used by

services, that could then be evidenced. Services should continue to develop their own methods of evaluation to further evidence their effectiveness to commissioners. This should include the use of appropriate evaluation outcome measures in the form of psychometric scores that evidence changes in well-being in individuals bereaved by suicide supported by postvention services. Testimonial and beneficiary qualitative evidence should support this but should not be the sole source of evaluation. Whilst this study found evidence of effectiveness, the long-term effects of suicide postvention services was unclear. Research should address this by conducting longitudinal studies. Furthermore, comparison studies and randomised controlled trials would allow for comparisons between different support avenues for individuals bereaved by suicide. It would also be interesting to review suicide rates and the rates of “clusters” or follow-on suicides in areas with and without a postvention service to investigate whether postvention is indeed prevention for future generations. A specific suicide grief scale should also be created to address the gap in finding an appropriate measure.

7.4.4 Reflexivity

The journey of pursuing a PhD has been an intellectually enriching experience, marked by challenges, growth, and moments of profound insight. One key lesson learned is the importance of adaptability and resilience. Research plans often evolve, and unexpected obstacles could arise. Embracing flexibility and staying open to new directions has proven invaluable in navigating the complexities of academic inquiry. Additionally, effective time management and prioritisation emerged as critical skills. Balancing research, and personal life required constant calibration. Establishing a structured routine and seeking support from mentors and peers played a pivotal role in maintaining momentum. In hindsight, I would place a greater emphasis on building a robust network of collaborators early in the process. Collaborative endeavours could lead to diverse perspectives, enriching the research and fostering a sense of shared ownership. Establishing strong connections within the academic community could enhance the impact of the research and open avenues for future collaboration. The importance of having a critical, supportive and well established public advisory group was crucial to the success of the project. Secondly, immersing oneself into the research provided a deeper understanding of the issues faced by this sector, this included attending multi-disciplinary meetings, conferences, and additional training to support an understanding of postvention and suicide bereavement.

Training to be a counsellor and working as a grief counsellor whilst simultaneously doing this research provided an interesting deeper layer to the questions asked of participants and the analysis of the themes.

However, the research was not without its difficulties. Covid-19 impacted the way the research was conducted as many of the interviews were conducted online or via telephone. It was not possible to visit the services and observe the work they were doing. It also became clear that this research would be significantly impacted by the quality and consistency of the data collected by the services. However, the knowledge that was gained from this has allowed us to gain further insight into this problem and importance and significance of addressing it. It is hoped that current and emerging postvention services will use this finding and the recommendations made to begin to build this into their service provision. It is also hoped that this finding will support SASP in their efforts to bring postvention services together to provide a standardised support package to everyone bereaved by suicide. This is particularly useful as this sector is unregulated and they provide sensitive and emotionally charged support to those at high risk of suicide and poor mental health outcomes. However, it is important to note that the issues faced were due to wider, external circumstances. One could argue that the use of remote means to access services and participants allowed for more honesty in the shortcomings and limitations of these services.

This research found that beneficiaries and key stakeholders perceive the support to be effective in improving well-being and preventing future suicide. It provides current and new services with considerations and recommendations that will continue to improve service delivery, in line with SASP and government recommendations. This directly contributes to both policy and practice. The research identified and evaluated specific postvention protocols that demonstrated a potential effectiveness in mitigating the psychological impact on affected individuals and communities. This has direct implications for the development of comprehensive postvention guidelines. The study highlighted the importance of community involvement in postvention efforts. By engaging local communities, postvention strategies could be tailored to the unique needs and dynamics of each community, fostering a sense of collective support.

The research generated evidence-based policy recommendations for the implementation of postvention programmes at various levels—local, regional, and national. These recommendations were designed to inform policymakers on the most effective strategies for reducing the long-term impact of suicide. The contributions of this research extend beyond the academic realm, aiming to influence policy decisions and guide the development of practical interventions. By identifying effective postvention strategies and providing actionable recommendations, the research seeks to improve the overall response to suicide, promoting resilience and facilitating the healing process for affected individuals and communities.

7.4.5 Conclusion

The present research added to our knowledge about how postvention services were created, the support that they offered and how the services impacted key stakeholders, the wider community and the beneficiaries that they support. This study also showed that suicide postvention services in the UK were perceived to be effective in improving well-being, reducing further suicide and adverse mental health consequences related to suicide bereavement. The importance of bespoke services that adapted to the needs of each individual, incorporating both practical and emotional support. Referral pathways should attempt to have a good relationship with key organisations involved in suicide deaths such as coroners, police, funeral directors and GP's. Services should have an opportunity for multiple referral points. Services should investigate means of evaluating their services which include both testimonial qualitative feedback and psychometric scores that evidence changes in well-being. This would support funding opportunities and re-commissioning. Funding should meet the changing demands of both beneficiaries and commissioners and be as responsive as possible to increases in suicide rates. The cost-effectiveness of these services should be highlighted, and further research would support this. Anyone considering creating or commissioning a postvention service should learn from the challenges and improvements of existing services to ensure that new services are delivering the best possible standard of support, as soon as possible. Postvention services were overwhelmingly beneficial and perceived to be effective. Every local authority in the UK should have a suicide postvention service to reduce further suicides in this at-risk population and improve well-being in individuals bereaved by suicide.

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Appendices

Appendix A: Ethical approval
Appendix B: PhD protocol
Appendix C: Risk assessment
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Appendix F: Gatekeeper consent form and Gatekeeper information sheet
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Appendix A

Ethics Application

LIVERPOOL
JOHN MOORES
UNIVERSITY

Date received	Initials	LJMU REC Ref

UREC Research Ethics Application Form

No research (studies on human participants or their data (including service evaluations, audit etc.)) must be started without full, unconditional ethical approval. There are a number of routes for obtaining ethical approval depending on the potential participants and type of study involved – please complete the checklists below to determine which is the most appropriate route for your research study.

1.	**Pedagogic Research (ONLY complete if you are a member of staff undertaking pedagogic research – otherwise, please leave blank)**	**YES**	**NO**
1a.	Is the proposed study being undertaken by a member of LJMU staff?		
1b.	Is the purpose of the study to evaluate the effectiveness of LJMU teaching and learning practices by identifying areas for improvement, piloting changes and improvements to current practices or helping students identify and work on areas for improvement in their own study practices?		
1c.	Will the study be explained to staff and students and their informed consent obtained?		
1d.	Will participants have the right to refuse to participate and to withdraw from the study?		
1e.	Will the findings from the study be used **solely** for internal purposes? *e.g. there is no intention to publish or disseminate the findings in journal articles or external presentations*		
If you have answered **YES to all 1a-e,** your study may be eligible for consideration under the University's Code of Practice for Pedagogic Research. You should **not** complete this application form but seek further guidance at https://www2.ljmu.ac.uk/RGSO/114123.htm or by contacting researchethics@ljmu.ac.uk.			
If you have answered **No to any of 1a-e,** please complete the checklists below			

<table>
<tr><th>2.</th><th>Requirements for NHS Research Ethics Committee & Health Research Authority Approval</th><th>YES</th><th>NO</th></tr>
<tr><td>2a.</td><td>Is the study defined as research by the HRA AND is there a regulatory or NHS policy requirement for the study to be approved by a NHS REC? (https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/
* Please note when completing the decision tool, (http://www.hra-decisiontools.org.uk/ethics/) LJMU researchers can store human tissue according to the LJMU HTA licence (https://www2.ljmu.ac.uk/RGSO/93204.htm)</td><td></td><td>X</td></tr>
<tr><td>2b.</td><td>Is the study defined as research by the HRA AND will the study involve NHS organisations in England where the NHS 215rganization has a duty of care to participants, either as patients/service users or NHS staff/volunteers (references to participants include people whose data or tissue is involved in a research project)? https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/hra-approval/</td><td></td><td>X</td></tr>
<tr><td>2c.</td><td>Is the study defined as research by the HRA AND will the study/project be led from Northern Ireland, Scotland or Wales and involves NHS/HSC sites? https://www.myresearchproject.org.uk/help/hlpnhshscr.aspx</td><td></td><td>X</td></tr>
<tr><td colspan="4">If you answered NO to 2a then your study can be ethically approved by UREC. Please complete the checklist below to determine whether your application is eligible for proportionate review (applications can be submitted at any time) or full review at UREC meetings (please refer to the deadlines for submission – https://www2.ljmu.ac.uk/RGSO/93126.htm)</td></tr>
<tr><td colspan="4">If you answered YES to 2a, please DO NOT complete this ethics application form. You must complete an IRAS form (https://www.myresearchproject.org.uk/) and seek NHS REC approval. https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/research-ethics-committee-review/</td></tr>
<tr><td colspan="4">If you answered YES to 2b, you must complete an IRAS form (https://www.myresearchproject.org.uk/) and seek HRA approval (in addition to either NHS REC or UREC approval – as determined by your answer to 2a). https://www.hra.nhs.uk/approvals-amendments/what-approvals-do-i-need/</td></tr>
<tr><td colspan="4">If you answered YES to 2c, you should apply for NHS/HSC R&D Permissions (in addition to either NHS REC or UREC approval (as determined by your answer to 2a) through the appropriate NHS/HSC permission process for that lead nation (https://www.myresearchproject.org.uk/help/hlpnhshscr.aspx)</td></tr>
</table>

If you answered **NO** to **2b** or **2c**, please seek ethical approval as determined by your answer to **2a**.

3. Full versus Proportionate Review – will the proposed study:		**YES**	**NO**
3a.	Expose participants or researchers to activities that pose a significant risk of causing physical harm or more than mild discomfort, psychological stress or anxiety or levels of risks beyond those, which the participant is likely to experience whilst participating in their everyday activities? These risks may be related to psychological or physical health, social standing or connectedness, economic well-being, legal harm or devaluation of a person's self-worth (*e.g. untrained volunteers exposed to high levels of physical exertion; participants purposefully exposed to stressful situations; exposure to pain; risk of injury or damage; research where participants are persuaded to reveal information which they would not otherwise disclose in the course of everyday life; lone working at night; interviewing in the researcher's or participant's homes, observation in potentially volatile or sensitive situations etc.)*	**X**	

3b.	Involve the discussion or disclosure of topics which participants might find sensitive or distressing? (*e.g. sexual activity; criminal/illegal activity; drug use; mental health; previous traumatic experiences; illness; bereavement; disclosure and analysis of findings based on sensitive personal information as defined by Data Protection Act e.g. racial or ethnic origin; political opinions; religious beliefs; trade union membership; physical or mental health; sexual life)*	**X**	
3c.	Involve the administration of drugs, medicines or nutritional supplements as part of the research design?		**X**
3d.	Involve the collection of venous blood samples?		**X**
3e.	Involve the collection and/or use of human tissue from healthy volunteers? *Please note, samples collected for a research purpose and subsequently processed to leave it acellular with any residual cellular material immediately discarded is **NOT** considered human tissue and is therefore not regulated by*		**X**

	the HT act or the LJMU Human Tissue License		
3f.	Include adults who may be classed as vulnerable? *E.g. drug/substance users; young offenders; prisoners/probationers; those in a dependent relationship with the researcher; those who have an impairment of, or a disturbance in, the mind or the brain. E.g. dementia, mental illness, learning disability, brain damage, intoxication, any other condition causing confusion, drowsiness or loss of consciousness (e.g. concussion, stroke, heart attack, epileptic fit, serious accident, delirium).*		**X**
3g.	Include children (below 16) NOT in an educational setting/accredited 216rganization OR where active, opt-in parental consent and child assent will not be sought?		**X**
3h.	Involve focus groups with children (below 16) with more than 8 participants in each focus group and/or the age range within the focus group is more than 3 years and/or the focus group will last more than 90 minutes in duration?		**X**
3i.	Include children (under 11) who will not be supported when undertaking the protocol?		**X**
3j.	Involve recruiting participants who have not been provided with a participant information sheet and asked to sign a consent form? *Please note that for questionnaire-based studies a consent form is generally not request as consent is implied by the completion of the questionnaire. Applicants conducting* ***questionnaire-only*** *studies should answer NO*		**X**
3k.	Involve conducting observations (including ethnography) in a non-public place?		**X**
3l.	Involve participatory/action research?		**X**
3m.	Involve deliberately misleading participants in any way?		**X**
3n.	Involve cash payments to participants for anything other than the reimbursement of reasonable expenses or reasonable incentives that are not pro-rata or are unequal between participants (including participants who withdraw)?		**X**

3o.	Be conducted outside of normal working hours or at a time and place inconvenient to participants?		**X**

3p.	Be conducted outside the EU or in one of the 3 non-EU EEA member countries?		**X**
3q.	Involve accessing and analysing existing datasets that will not be anonymous to the researcher?		**X**
3r.	Involve the sharing of directly or indirectly identifiable data with other organisations outside of LJMU or with people outside of the research team?		**X**
3s.	Involve the dissemination of directly or indirectly identifiable data/information without a participants consent (*e.g. the use of social media or the internet as a data source – unless the website or social media account is maintained by a public or commercial 217rganization*)?		**X**

If you have answered **No to all 3a-s** your study is eligible for proportionate review. Complete this application form and submit as **ONE** pdf document (the application form and all supporting documents) **at any time** to **EthicsPR@ljmu.ac.uk**. Your application will be reviewed by a UREC sub-committee, all being well, within 10 working days. Please note, the UREC sub- committee finds that your application has been wrongly submitted for proportionate review, you will be notified and your application will be consideration at the next available UREC meeting.

If you have answered **Yes to any of 3a-s** your study must be submitted for full review. Complete this application form and submit as **ONE** pdf document (the application form and all supporting documents) to **researchethics@ljmu.ac.uk** by the deadline advertise (https://www2.ljmu.ac.uk/RGSO/93126.htm). Your application will be considered at a UREC meeting. Guidance on completing the LJMU REC application form can be found at http://www2.ljmu.ac.uk/RGSO/93044.htm

https://www2.ljmu.ac.uk/RGSO/93085.htm

Research Mode:

Undergraduate – specify course

Postgraduate (Type **YES** in the boxes that apply)

	Mres
	Mphil
X	PhD
	Prof Doc e.g. EdD or DBA
	Other taught Masters programme – specify course
	Postdoctoral
	Staff project
	Other – please specify

- **Has this application previously been submitted to the University REC for review? –** Yes / No
- **If yes please state the original REC Ref Number**
- **Please confirm whether the Principle Investigator (PI) has successfully completed the LJMU Research Ethics Training and a copy of the certificate of completion emailed to the PI has been appended to this ethics application** (https://www2.ljmu.ac.uk/RGSO/131507.htm)

Please type **YES** or **NO** in the box below

YES

(Please note all students MUST have completed the LJMU Research Ethics Training BEFORE they start to complete the ethics application form. Where student Pis have not completed the training, ethics applications will be rejected).

- **Student research – please confirm that an email/letter from the supervisor has been appended to this ethics application confirming that:**

  a) the supervisor has read and reviewed this ethics application form and all supporting documents

  b) the information included in the application and all supporting documents will allow UREC to decide whether all challenges to the principles of research ethics have been identified and addressed

  Please type **YES** or **NO** in the box below

  YES

SECTION A – THE APPLICANT

A1. Title of the Research

‘A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide’

A2. Principal Investigator (PI)

(Note that the in the case of postgraduate or undergraduate research the student is designated the PI. For research undertaken by staff inclusive of postdoctoral researchers and research assistants the staff member conducting the research is designated the PI.)

Title	*Miss*	Forename	*Laura*	Surname	*Abbate*

Post: Postgraduate Student

School / Faculty: NSP

Email	L.G.Abbate@2019.ljmu.ac.uk	Telephone	07852816226

Relevant experience / Qualifications

Masters in Clinical and Health Psychology, First Class
Bachelor of Science in Psychology, First Class

A3. Co-applicants *(including student supervisors)*

Co-applicant 1 / Academic Supervisor 1 *(where the application is being submitted by a student, either undergraduate or postgraduate, details of their main dissertation supervisor must be included. The form must be submitted with a letter or email from their named supervisor indicating that they have read the application and are willing to supervisor the student undertaking the proposed study –* ***STUDENT APPLICATIONS WILL NOT BE REVIEWED UNTIL NOTIFICATION OF REVIEW BY THE NAMED SUPERVISOR IS RECEIVED***

Title *Dr* Forename *Pooja* Surname *Saini*

Post Senior Lecturer in Psychology

School / Faculty Psychology

Email P.Saini@ljmu.ac.uk Telephone 01512318121

Relevant experience / Qualifications

Fellow in Higher Education Academy
PhD in Suicide Prevention
MSc in Addictive Behaviours
BSc in Psychology Majors

Supervision of Doctoral Clinical Postgraduate Students, Medical Scholar Students, MSc Students, Interns
Leading as a Principle Investigator on 3 previous studies

Co-applicant 2 / Academic Supervisor 2

Title *Dr* Forename *Helen* Surname *Poole*

Post Subject Leader

School / Faculty School of Psychology

Email H.M.Poole@ljmu.ac.uk Telephone 01519046307

Relevant experience / Qualifications

PhD, Cpsychol, FHEA over 15 years experience as an independent researcher. Successfully supervised PhD, Cpsych, MSc students

Co-applicant 2 / Academic Supervisor 2

Title *Dr* Forename *Jennifer* Surname *Chopra*

Post Senior Lecturer

School / Faculty School of Psychology

Email	J.Chopra@ljmu.ac.uk	Telephone	01519046294

Relevant experience / Qualifications

PhD, FHEA

Where there are more than two co-applicants, please append an additional page to your application containing the relevant details

SECTION B – PROJECT DETAILS

B1. Proposed date for commencement of participant recruitment *(Please enter the date when you propose to start recruiting participants – note that no recruitment can take place without full, unconditional ethical approval)*

Start date: **December 2019**

B2. Scientific justification – please provide an overview in plain English – please avoid abbreviations and explain technical terms. State the background and why this is an important area for research *(Note this must be completed in language comprehensible to a layperson. Do not simply refer to the protocol. Maximum length – 1 side of A4)*

In England, 13 people die by suicide every day with suicide being the leading cause of death in young people and new mothers (Department of Health [DH], 2017). Pitman, Osborn, Rantell & King (2016) found that people bereaved by suicide are 65% more likely to attempt suicide than people who are bereaved by natural causes, increasing the absolute risk to 1 in 10. Research has identified the need for support immediately after suicide bereavement (Pitman et al., 2016). A lack of support can contribute to heightened grief experiences and mental health issues in those bereaved by suicide (Pitman et al., 2017; Maple et al., 2014; Houck, 2007). Bereavement by suicide increases the likelihood of experiencing long-lasting negative grief effects, post-traumatic stress disorder (PTSD) and depression (Murphy, Johnson, Wu, Fan & Lohan, 2003; Kaltman & Bonanno, 2003). Furthermore, seeing the deceased's body is a significant predictor of distress and PTSD after a suicide (Callahan, 2000). These findings suggest the need for support not just for the next of kin and immediate family members but also finder of the body, irrespective of their relation to the deceased. Additionally, services who may be exposed to suicides through their work, such as police officers, coroner's, GP's and emergency responders, may require support following a suicide.

Postvention research has focused on suicides within school and military communities (Cox et al., 2016; Streufert, 2004; Harrington-LaMorie, Jorden, Ruocco & Cerel, 2018). Few studies have focused on community postvention services. Andriessen, Dransart, Cerel & Maple (2017) suggest that postvention research should focus on increasing intercultural collaboration and theory-driven research whilst encouraging the relationships between research and practice. However, their results are based upon modest participant numbers and all participants were from Western countries, suggesting that these results may not be representative of the general population. Comans, Visser & Scuffham (2013) found a postvention service to be more cost-effective and that it increased quality-adjusted life years by 0.02 compared to usual care. Furthermore, Andriessen (2003) suggested that postvention programs must develop networks between services to improve upon the quality of support offered. However, as this was conducted in a relatively small area of Belgium, these findings may not be representative.

Adequate and timely support for those bereaved by suicide is a key objective in the NO MORE Zero Suicide Strategy (2017) for Cheshire & Merseyside. Department of Health (2012) announced that providing better information and support to those bereaved and affected by suicide is a key area for action, as is supporting research and encouraging support for those bereaved by suicide both locally and nationally. The importance of national and local suicide prevention plans was also highlighted (DH 2014). Previously, the All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2015) found that local suicide prevention plans are varying and inconsistent; however now 95% of local authorities have suicide prevention plans in place. Police, coroner and GP involvement at a local level is inconsistent and some local authorities still report not having a multi-agency suicide prevention group; thus, suggesting less collaboration between key agencies. Mental Health Taskforce to the NHS in England (2016) recommended all local authorities have a multiagency suicide prevention strategy in place by 2017.

Across England, there are service providers of postvention services following someone dying by suicide, for example in Durham, Cornwall, Devon, Somerset, Leeds, Cambridge, Peterborough, Liverpool and Nottingham. The main aim of most of these commissioned services is to 222rganiza emotional impact, promote recovery and reduce further suicides. The services offer practical support such as information surrounding the inquest, media and financial advice and emotional support and signposting to other services. Services support families, next of kin to the deceased person and finder of a body, whether they are related to the deceased or not. Some also support blue light services who are exposed to suspected suicides through their work, and communities such as schools, if there is a death within that community.

The purpose of this PhD study is to understand what services are currently available to those bereaved by suicide nationally and internationally and what research has been conducted on them to date. The main aim of this study is to assess the impact these services had on: those bereaved or affected by suicide; key wider agencies who are exposed to suicides, such as coroners, GP's, police officers; and, the suicide liaison workers themselves to develop recommendations and inform national policy guidelines.

The key objectives are as follows:
A literature review on current interventional research after suicide bereavement update (an update of McDaid et al, 2007). The literature review would include a focused search strategy to identify key evidence. Literature will be identified in the following ways: i) by contacting each of the organisations and asking for any published reports and papers; (ii) searching relevant databases and iii) by scanning publications and webpages of relevant organisations, including relevant professional bodies, charities, research institutions and government organisations (e.g. NICE). The types of evidence to be considered includes published peer-reviewed papers, policy documents, guidelines documents, research reports and evaluation reports.

Furthermore, an evaluation of a sample (n=13) of the postvention services across England and Northern Ireland, comparing suicide attempt rates in those who take up the services and those who have not. The study will also involve collection of population data pre and post intervention through 1) qualitative interviews about acceptability of those referring, those delivering and those receiving the postvention service, this qualitative data will be analysed using thematic analysis by Braun and Clarke (2006); and 2) data from all the areas will be compared and analysed using comparative analysis, to see if outcomes differed across the areas. Social network analysis (Wasserman & Faust, 1995) may also be used to measure and map the flow of relationships and relationship changes between knowledge-possessing entities such as people and organisations. The core belief of this analysis is that the patterns of these relationships can have important effects on individual and 223rganization223l behaviour, constraining or enabling access to resources, and exposure to information and behaviour. Data will then be compared to the policies outlined in the government's Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland.

B3. Give a summary of the purpose, design and methodology of the planned research. What do you propose to do and how do you propose to do it? Provide information as appropriate in plain English (comprehensible to a layperson) to help the REC understand and approve your application.

a) Participants – who are they? What will happen to them? How many times? In *what order? Where? When? How? How long will take them? Etc.*

b) *Interventions/procedures – Give details (How? When? Where? How often? For how long? Etc.) of all interventions/procedures that will be received by the participants as part of the research protocol (intervention/procedures might include seeking consent, screening questionnaires, interviews, questionnaires for data collection, exercise, measurement variables etc.)*

Sampling and Participants

Approximately 130 participants from 13 services (for example in Durham, Cornwall, Devon, Somerset, Leeds, Cambridge, Peterborough, Liverpool and Nottingham). The services included were chosen in consultation with the Public Advisory Group. Participant groups will be i). stakeholders including coroners and public health teams, ii). Those delivering the service, iii).people bereaved by suicide, iv). Commissioners, and v). commissioned service leads. The investigator conducting the interviews has previous experience and training interviewing people bereaved by suicide. Specifically, during an undergraduate degree, the researcher conducted interviews with people bereaved by suicide and during a master's degree, where the researcher conducted interviews with people bereaved by suicide, coroners, police officers, GP's and suicide liaison support workers. The investigator has attended conferences, has suicide assist training from Papyrus and is supported by a Public Advisory Group, which involves various academics with over 15 years of experience in suicide research, those with personal experience in suicide bereavement, and charities and organisations who support those bereaved by suicide. Participants will be invited to be interviewed on the effectiveness of the postvention service in that area. Interviews will take place across England and Northern Ireland over the telephone, face-to-face or via Skype. Interviews will last between half an hour and an hour and a half, depending on the participant group and will take place once ethical approval has been received. Face-to-face interviews will take place in a location convenient to the participant and as such, some travel may be required. For those bereaved by suicide and taking part via skype and telephone, the investigator will discuss with the participant the importance of privacy and advise the participants about their location when they are being interviewed. For example, participants will be advised to take part in a location such as their home to ensure confidentiality and privacy. The participants will also be advised that as the topic of discussion is sensitive, it may be preferable to not participate in a public place or in their place of employment. For coroners and other participants, it may be necessary to conduct interviews in a private room at their work place or their home. All participants will be offered to take part on Liverpool John Moores University campus, if this is convenient and they wish to meet face-to-face and they do not wish to take part in their home or place of employment.

After consultation with the Public Advisory Group, it was decided that Commissioners and Commissioned Service Leads (services who won a tender) will also be included as participants to ascertain why the services were set up, financial implications of services currently supporting people and how services are developed. This participant group may be interviewed face-to-face or via telephone and skype, with the interviewer discussing the importance of the location of the interview, as above.

Consent will be obtained prior to the interview beginning, interviews will be audio recorded and transcribed verbatim. There will be many different versions of the interview schedule for differen participant types (See Appendix for the different interview schedules). Interviews should last between one hour and one and a half hours.

The student researcher will also request service's audit data. Services must have been established for two years minimum to ensure at least one years' worth of data. A quantitative evaluation will be conducted on the audit data collected by the postvention services (n=13) across England and Northern Ireland, comparing suicide attempt rates in those who take up the service and those who have not, and

other outcomes measured by the services such as well-being that has been measured by the sWEMWBS or equivalent.

B4. State the principal research question

Are the current postvention services effective in preventing further suicides and improving well-being outcomes in those bereaved by suicide?
- What is the acceptability of the services? - What is the fidelity of the services offered?

B5a. Give details of the proposed intervention(s) or procedure(s) and the groups of people involved (*including psychological or physical interventions, interviews, observations or questionnaires)*

intervention(s) or procedure(s) *(e.g., interviews, questionnaires, Vo2max test, blood sampling, force platform, health-screening questionnaire etc.)*	**Participants** *(e.g. LJMU students, athletes, general public, children etc.)*	**Number of participants required**	**Avg. time to complete**	**Where will the intervention / procedure take place** *(LJMU classroom, LJMU laboratory, participant's homes, public places etc.)*

1. Interviews	Stakeholders, public health officials, coroners, those delivering the services, bereaved individuals supported by the services. Commissioners and commissioned service leads.	130	1 hour	Liverpool John Moores, where possible. Some interviews will take place at the participant's home or workplace. Interviews may take place over skype or telephone. All interviews will take place in a private location to adhere to confidentiality. For coroners and other professional participants, it may be necessary to conduct interviews in a private room at their work place or their home. All participants will be offered to take part on Liverpool John Moores University campus, if this is convenient and they wish to meet face-to-face and they do not wish to take part in their home or place of

				employment. Gate keeper consent will be requested where necessary.
2. Services audit data	Bereaved individuals supported by the services	All audit data currently collected		The researcher will have signed a confidentiality agreement before the research commences. The LJMU legal team and the LJMU data protection act will be asked whether they need to review the confidentiality agreement prior to research commencing. The research will not

				record any patient identifiable data from the audit data. All efforts will be made to ensure that the data used in the results will be as 226rganizati and generic as possible. Gate keeper consent will be requested where necessary.

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

B5b. Studies involving questionnaires to collect data. Please confirm that you have:

I. Appended the questionnaire as it would be presented to the participants. This might include an introduction, instructions for completing the questionnaire, instructions for returning/submitting the questionnaire and any signposting to support services where applicable.

II. Included at the start of the questionnaire, a statement of implied consent and a tick box for participants to confirm implied consent, which you can copy from the consent form template.

III. Included at the start of the questionnaire, a statement that makes it clear that participants have the option of not answering questions they do not want to answer.

IV. Requested the age of the participant at the start of the questionnaire, stated the age requirement and included instructions that those younger than the age requirement should not complete the questionnaire.

Please type **YES or NA** in the box below

NA

Have the questionnaires previously been validated?

Please type **YES**, **NO** or **NA** in the box below

NA

If YES, please include the references and state the population in which the questionnaire was validated

Interview schedules proposed in the present study were developed for a Masters study conducted by the student researcher, entitled “The impact of the Amparo service on those bereaved or affected by suicide and the local services involved (Police, Coroner, GP, AMPARO support workers)”. The interview schedules were approved by the University of Liverpool Ethics

B5c. Where interviews or focus groups (structured or semi-structured) are proposed you must append an outline of the questions you are going to ask your participants. Please confirm that you have attached an outline of your interview / focus group questions.

Please type **YES** or **NA** in the box below

YES

B6. How will the findings of the research be disseminated?*(e.g. thesis, dissertation, peer-reviewed articles, conference presentations, reports)*

The research will be disseminated in a thesis, peer-reviewed journal articles and at national and international conference presentations.

SECTION C – THE PARTICIPANTS

Please give separate details for different study groups where appropriate. *Participation in a research project must be entirely voluntary, and no one must be coerced to participate in a research project against his/her will. Researchers should avoid exerting undue influence when approaching potential participants. No sanctions should follow if the participant decides to withdraw from the research at any time.*

Gatekeepers *– A gatekeeper is any person or institution that acts as an intermediary between a researcher and potential participants (e.g., school authorities, sports club, treatment service providers, a coach, instructor etc.). The use of a gatekeeper may be necessary:*

- *To help identify participants where a researcher does not have legitimate access to personal data of potential participants (names and contact details or information related to identifying participants in relation to the inclusion/exclusion criteria of the study)*
- *Where it may also be more appropriate or good etiquette to ask a gatekeeper to make the first approach to potential participants – and in specific circumstances to take an active role in recruiting the participants*

  To 228rganiza and manage potential risks (e.g. to gain permissions to access facilities, use a gatekeeper's resources such as their facilities and their staff and to undertake the research within certain hours etc.)

C1. How will the participants been selected, approached and recruited? *(Where different groups of participants have been identified in section B5a above provide details on how each group will be selected, approached and recruited.)*

C1a. Please indicate how individuals will be IDENTIFIED as potential participants.

- If the researcher will need to access an individual's personal data, please explain why they would
  have legitimate access to the personal data (according to the data protection act).
- If using a third party, such as a gatekeeper, to identify participants, records or

samples please explain why and provide details of their relationship with the potential participants. (e.g., school authority, coach, treatment provider etc.)

Participants will be identified using third party gatekeepers from identified suicide postvention services. A Public Advisory Group will be used to identify the postvention services currently running nationally and those services will provide key stakeholder information for each of their services such as coroners, police, public health officials. Gatekeepers will make contact with

C1b. How, where and by whom will the potential participants be initially APPROACHED/CONTACTED? (e.g. *face-to-face, by email/letter, telephone, referrals (e.g. by a gatekeeper or by snowballing etc.), social media, poster, flyers, presentation to a group of individuals etc.)*

- *Consider how to approach participants without revealing private information to others (e.g. an email sent to a group of individuals who have identified themselves as dyslexic to the gatekeeper but not to each other)*
- *Time & place – Is it easy for potential participants to say yes or no?*

Gatekeepers will provide participants with information about the study via email, letter, telephone or face-to-face, depending on current contact with the postvention service. Participants will be provided with a participant information sheet and consent form. The email and letter will state that the participants can contact the researcher if they would like to ask any questions or take part in the study. The researcher will arrange a time and date for the interview once participants have been in touch to participate or if the participant consents the gatekeeper to pass on their details to the researcher for them to be interviewed. Due to postvention services in a wide range of locations across England, participants will be seen in a location which is easy

C1c. Please confirm you have appended a copy of the recruitment emails/letters/posters/adverts etc. Please type **YES** or **NA** in the box below

YES

If you wish to send a participant recruitment email/letter then in the text please state:

1. *How the person was identified as a potential participant*
2. *How you have accessed their contact details / who has provided permission for you to access their contact details / who is emailing the potential participants on behalf of the researcher.*
3. *Something like "if you are interested in participating in the study please take time to read the participant information sheet (attached) and contact me with any questions. I can be contacted….").*
4. *Inform the participant what they should do if they would like to participate*

C1d. Participant RECRUITMENT (the process of obtaining informed consent from participants). **Please explain (e.g. who, when, where, how) the process of fully informing participants, gatekeepers and parents/guardians about the purpose, methods and intended possible uses of the research, what participation in the research entails and what risks, if any, are involved.** *(Exclusively relying on simply handing out a participant information sheet should* *be avoided. Researchers should be able to verbally explain the study clearly to potential participants, provide a participant information sheet for participants to keep and be available to answer questions)*

The email and letter sent by the gatekeeper will provide an overview of the study and the information sheet provides detailed information on the study and why participants are being invited to take part, the minimal risks involved, confidentiality, details of the main researcher if they would like to email or call if they have further questions and information on having their reviews what their participation entails. Participants will only be contacted by the researcher if the participants' have given explicit consent to the gatekeepers for their information to be shared. Alternatively, the gatekeepers will send an invitation to participate in the study which

C1e. How will the participant access the information sheet after they have consented? *(e.g., will they be provided with a paper / electronic copy to keep? Online questionnaires – consider asking the participant to print/make an electronic copy of the participant information sheet)*

Participants will be provided with an email or paper copy after they have consented. Completed consent forms will not be stored with the rest of the data.

C1f. How long will the potential participants have to decide whether they would like to participate? *(Potential participants need time to consider fully the implications of taking part in research. They should be able to ask questions and reflect. Participants should not be rushed into decisions – There are no fixed guidelines for the time to be allowed to participants. It has been common practice to suggest a minimum of 24 hours, but this is not an absolute rule. Each study should be considered on its own merits. If you feel that a shorter period is reasonable in the circumstances and taking into account the nature of the study, please justify this in your answer)*

After first contact from the gatekeeper, the participants will be given one week to decide whether they would like to participate in the study and may then be sent a second email if they have not contacted the researcher. Once the researcher has been spoken to the participant about the study

C2. How was the number of participants decided? *(e.g. was a sample size calculation performed)*

Gatekeepers from each service will be identified through the Public Advisory Group and through discussion with the services themselves. Based on the previous work completed on the Amparo postvention service, it is estimated that 10 participants from each service (n=13), thus approximately 130 participants in total. This is an over-estimation, as there may be more

C3a. Will any of the participants come from any of the following groups?

- *Whether children are considered vulnerable is dependent on the child's circumstance, their susceptibility to coercion, the type of research being undertaken and how and where the research is being undertaken*
- *Please note that the Mental Capacity Act 2005 requires that all research involving participation of any adult who lacks the capacity to consent through learning difficulties, brain injury or mental health problems be reviewed by a NHS REC. For further information please see http://www2.ljmu.ac.uk/RGSO/101579.htm*

- *Vulnerable adults & participants with a dependent relationship with the researcher: This question is designed to ascertain whether your participant groups are likely to need special consideration regarding issues of informed consent and the potential for perceived pressure to participate.*

Type YES in all boxes that apply

☐ Children under 16
☐ Children under 18 considered vulnerable
☐ Adults with learning disabilities
☐ Adults with mental illness (if yes please specify type of illness below)
☐ Drug / Substance users
☐ Young offenders
☐ Those with a dependant relationship with the investigator (e.g. a coach etc.)
☐ Other vulnerable groups please specify below

Please provide details that might help the REC understand the ethical issues related to the characteristics of the participants and how they might be addressed. *(e.g. age of participants; why participants might be considered vulnerable; ethical implications with regards to mental illness, drug users, young offenders; the dependent relationship between participant and researcher etc.)*

Please justify their inclusion:

C3b. If you are proposing to undertake a research study involving interaction with children or vulnerable adults do you have current, valid clearance from the UK Disclosure and Barring Service (DBS)?

☐ **Yes** ☐ **No** ☒ **Not Applicable**

C4. What are the inclusion/exclusion criteria?

- *The answers to the questions below will help the REC understand how you will ensure the quality of the study, how you will 231rganiza any potential risks/hazards and whether there is the potential for any particular participant groups to be exploited or unfairly excluded.*
- *Participants need to be fully informed about the inclusion/exclusion criteria – please include the relevant information in any recruitment materials and information sheets*

C4a. On what basis will individuals be included or excluded (eligible/ineligible) from your study in order to address the research question/objective? *(Consider the characteristics of the target/study population)*

Key stakeholders such as coroners, public health officials, police, GP's and individuals bereaved by suicide to be currently and directly involved in the suicide prevention service. Individuals bereaved by suicide must have already had the inquest prior to taking part as it is at inquest that a death is ruled a suicide in an official capacity. All participants will also be over the age of

C4b. On what basis will individuals be included or excluded (eligible/ineligible) from your study in order to minimise/manage risk? *(e.g. those with a food allergy, injury, mental or physical health issues etc.)*

Participants bereaved under a year to be excluded to manage risk of distress. The investigator 232rganizati the risk of participant's recall of the support they have received may be impacted by this exclusion. However, about a quarter of widows and widowers will experience clinical depression and anxiety during the first year of bereavement; this risk drops to about 17% by the end of the first year and continues to decline thereafter (Jacobs, 1993). Furthermore, the first anniversary is often a time of renewed grieving and most people 232rganizat that they are recovering from their bereavement in the second year, after the first anniversary (Parkes, 1998). In a more recent study on bereaved parents after the loss of their child, parents were initially contacted 6-18 months after the child's death, however most families were 12-18 months into

C4c. How will you apply/implement each of the inclusion and exclusion criteria? *(e.g. will potential participants self-include/exclude themselves based on the information provided on the participant information sheet – or will you assess the potential participants in some way – such as with a health screening questionnaire or physiological measurements – please explain)*

Gatekeepers from each suicide postvention service to apply and implement inclusion and exclusion criteria. Researcher to ensure this has been met when in discussion with potential

C4d. If applying the inclusion / exclusion criteria requires the collection of personal information

about the participant then please detail the screening process that will ensure privacy and confidentiality. *Please consider the following:*

- *request only the minimal amount of information necessary for screening*
- *Screening should be done in private*
- *Immediate storage of data to ensure confidentiality*

NA

C4e. Please confirm that where participants are screened and excluded from participating in the study, the researcher will NOT store screening information and give the screening questionnaire back to the individual

Please type **YES** or **NA** in the box below

YES

C5. Payment, reimbursements of expenses or any other benefit or incentives for taking part in the study. *The REC will wish to be reassured that research participants are not being paid for taking risks or that payments are set at a level which would unduly influence participants and "cloud there judgement" about whether or not to participate.*

- *Research participants should not be substantially out of pocket because of taking part in a research study.*
- *Payment in cash or kind to participants must only be for costs such as travel expenses, child- care expenses, meals and demonstrable loss of earnings etc.*
- *Consideration should be given to any expense involved in returning postal questionnaires.*
- *If it is not possible to reimburse such expenses this should be explained before the research participant is recruited. A clear statement should be included in the participant information sheet setting out the position on reimbursement.*
- *Payment/compensation for time and effort is a considered a wage payment model – and will only be considered by the REC if the tax implications have been considered by the researchers and communicated to the participants.*

C5a. Will any payment or reward, such as an incentive or out of pocket expenses, be made to participants?

Please type YES or NO in the box below

NO

C5b. If YES, How much is the payment or what is the reward?

NA

C5c. Please justify the payment/reward *(consider whether this is a fair reimbursement or* *compensation or likely to coerce or apply undue pressure to participate. Is the payment/reward necessary to achieve a representative sample?)*

NA

C5d. How will the payment/reward be made? (*Vouchers are preferable as cash could have tax implications. If using a prize draw, how and when will the winners be notified of results and how and when winners will be notified and results be announced.)*

NA

C5e. Will participants be able withdraw their participation without losing a payment/reward or entered into a prize draw? Please type YES or NO in the box below.

NA

If NO, please explain why not *(consider the principle that participants should be free to withdraw their participation without being 234rganizat)*

NA

SECTION D – CONSENT

For most types of research, it is both a legal and ethical requirement to obtain informed consent from participants able to consent for themselves. The researcher is responsible for obtaining an individual's consent to participate. The participant should be fully informed about their participation (ideally verbally and in writing) and should be free to refuse to participate or withdraw their participation.

D1. Will informed consent be obtained from: (Where applicable, please type YES in the box below)

The research participants?	YES
The research participant's carers or guardians?	
Gatekeeper? *(consent for their involvement in identifying/approaching/recruiting participants and/or permissions with regards to access and use of facilities/resources for recruitment and data collection purposes)*	YES
Not applicable	

D2. Will a signed record of consent be obtained? *(Please note that where the study involves the administration of a questionnaire or survey a signed record of consent is not required for completion of the questionnaire as long as it is made clear in the information sheet that* *completion of the questionnaire is voluntary. Under these circumstances, return of the completed questionnaire is taken as implied consent. Participation in any other interventions within the same study e.g. interviews, focus groups must be supported by obtaining appropriate written consent.)*

D2a. Please type **YES**, **NO**, **implied consent** or **verbal consent** (*if written consent is not possible and implied consent is not appropriate*) in the box below.
Where the study involves the use of more than one intervention for example interviews and a questionnaire please the space below to detail the method of consent to be used for

each intervention e.g. Questionnaire – implied consent, Interview – written consent, Telephone interview – verbal consent

Face-to-face Interview – written consent
Telephone or skype interview – written and verbal consent
Verbal consent will be audio recorded and the consent audio recording will be stored separately from the interview recording

If implied consent is to be assumed by return of questionnaires, the following statement (or similar) must be included on the questionnaire:
"I have read the information sheet provided and I am happy to participate. I understand that by completing and returning this questionnaire I am consenting to be part of this research study and for my data to be used as described in the information sheet provided" – please include a tick box so that the participant can confirm hey have read the statement.

D2b. If you propose NOT to obtain consent in writing (other than for questionnaires), please explain why not. *(Where a participant is unable to sign or mark a document to indicate their consent, arrangements should be made for their consent to be witnessed and this should be documented)*

NA

PLEASE APPEND COPIES OF ANY PROPOSED CONSENT FORMS TO THIS APPLICATION

D3. All participants must be provided with written information detailing the purpose, procedures, risks and benefits of participating. An approved template for the participant information sheet can be found at. Please check the box below to confirm that a participant information sheet has been appended to this application.

X

APPLICATIONS SUBMITTED WITHOUT A PARTICIPANT INFORMATION SHEET WILL NOT BE REVIEWED.

D4. Will participants be able to withhold consent (refuse to take part)?

D4a. Will participants be able to freely withhold consent (refuse to take part)?
Please type **YES** or **NO** in the box below

YES

If **NO** please explain why not

D4b. Will participants be able to freely withdraw from the study whilst it is ongoing?

Please type **YES** or **NO** in the box below

YES

If **NO** please explain why not

D4c. Will participants be able to freely withdraw their identifiable data from the study after data collection has ended? *(if there are practical issues related to withdrawing a participants data once it has been amalgamated please explain below)*

Please type **YES**, **NO** or **NA** in the box below

NO

If **NO** please explain why not

The data will be 236rganizati and as such, their data will not be identifiable.

THE ABILITY OF PARTICIPANTS TO REFUSE TO TAKE PART OR TO WITHDRAW FROM A STUDY MUST BE MADE CLEAR IN THE WRITTEN INFORMATION PROVIDED TO PARTICIPANTS

SECTION E – RISKS AND BENEFITS

Risks *– the potential physical or psychological harm, adverse effects, discomfort, distress, intrusion, inconvenience or changes to lifestyle*
Benefits *– as defined and perceived by the participant rather than the researcher. Benefits are sometimes "hoped-for"*

E1. Outline all potential risks to participants which are anticipated to be beyond those experienced in their everyday/normal life, how the risks will be 236rganizat and managed

- *Could be physical, psychological, social, economic, legal harm or damage to a person's self-worth. E.g. side effects, incorrect dosage, injury, dangerous intervention/procedure, untrained volunteers exposed to high levels of physical exertion, participants purposefully exposed to stressful situations, research where participants are persuaded to reveal information which they would not otherwise disclose in the course of everyday life, individual or group interviews/questionnaires discuss any topics or issues that might be sensitive, embarrassing or upsetting, breach of confidentiality, possible misunderstanding etc.*
- *Whether the risk will involve an increased likelihood or significantly higher risk of*

such negative events occurring than would be encountered in the participant's everyday life, will depend on the context and a judgement as to the nature of the specific participant(s) and what constitutes their everyday lives.

	Anticipated risks	**How 236rganizat** *(e.g. consider contraindications, checks, training, information to participants, procedures, equipment etc.)*	**How managed both during and after participation** *(what if something does happen during and after the study – what will/might you do) (e.g. stop, treatment, equipment availability, training, re-assess, refer, reschedule, carry-on, signpost to support services to help after-participation care of the participants etc.)*
1.	Distress	Participants to have an understanding that they can take breaks, stop interviews and have their data withdrawn. Interviews to take place in a location that is comfortable for the participants and appropriate in regards to privacy. Participants taking part in the workplace will be advised to find a private room. Participants taking part via skype and telephone will be advised to take part in a private location. The student researcher has two years' experience interviewing people bereaved by suicide, as	The level of risk shall be no more than what the participant would endure on a day-to-day basis as a result of their bereavement. Interviews will not include specific questions relating to the death. The questions focus on the bereaved individual's experience of the postvention services. All the remaining professional participants (stakeholders, coroners, public health officials, individuals delivering the services) will already be discussing such suicides in their daily professional roles and as such there will be no added distress. Information sheets will prepare participants and give an understanding of what participation entails. If a participant does become distressed,

		part of their undergraduate and master's degrees. For commissioners and commission service leads, the motivations of why they tendered/set up the service will be asked, with an interest in finding if they have a personal experience which has led them to commission or set up a suicide bereavement postvention service. However this participant group will be reassured that they do not have to expand on this and will not be asked for any details about their personal experience.	they will be provided with the contact details for Samaritans, Listening Ear or other local services. Participants will be asked if they would like the researcher to wait with them whilst they contact a GP and/or family member. No participant to be left with in a distressed state. All participants will be signposted to relevant national and local services in the information sheet and debrief sheet, should they become distressed after the researcher has left.

		All participants will be signposted in the Participant Information Sheet and debrief to appropriate sources of help and support, should they need it	

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

E2. Reporting findings to participants

E2a. Is there the potential for the research to reveal findings that might be considered abnormal or significant with regards to the participant's health?

Please type **YES** or **NO** in the box below

NO

If YES, please confirm that the participant will be informed on the participant information sheet that they will be given the option on the consent form to agree, or not agree, for abnormal results to be reported to them.

Please type **YES** in the box below

NA

E2b. What advice/information will be provided to participants when passing findings onto participants- and who will provide the advice/information?

Consider the whether the methods are a proper diagnostic tool, the researcher's qualifications to diagnose and disclose, whether the participant should consult with an appropriate authority such as their GP etc.

NA

E3. Explain any potential or hoped for benefits of the study.

- *PLEASE BE REALISTIC and do not over-emphasise the potential direct benefits to individual participants. Where there are no direct benefits to individual participants, provide brief details of the potential or hoped for broader benefits of the study for example to society or to future service users.*
- *Participation might be a positive experience but it is probably best to refrain from claiming any therapeutic benefit simply from participation)*

It is hoped that the results will inform the creation of new national suicide postvention services and give a better understanding of the services currently supporting people bereaved by suicide,

E4. What are the potential risks for the researchers themselves? (if any)

Consider issues related to working outside of normal hours, off university premises (including a participant's home), loan working, interacting with participants and members of the public who might pose a threat and potentially dangerous environments.

	Anticipated risks	How minimised	How the risks will be managed should an event occur

1.	Distress	There will be no more than two nterviews conducted in any single day and no more than five nterviews in any single week. The Standard Operating Procedures includes a lone- worker policy and provides guidelines to ensure researcher safety for data collection on- campus and further away. The nterviewer will also have a mobile phone with them. Regular contact will be maintained between the research supervisor and student researcher and there will be a debriefing opportunity at the end of each interview. The student researcher has two years previous experience with this work and has had previous raining in data collection and how to manage discussion of sensitive topics, specifically in relation to suicide research.	Debriefing opportunities at the end of each interview.
2.			

To include additional interventions place your mouse cursor in the last cell of the final column and press the tab button on your keyboard. A new row will be created for the above table.

E5. For studies that involve transporting participants, will the transport be hired through LJMU Insurance officer?

NA

Please type **YES** or **NO** in the box below

If NO, please confirm that the LJMU insurance officer has authorised the use of transport that is not hired through LJMU

NA

Please type YES in the box below

SECTION F – DATA ACCESS AND STORAGE

- ***Privacy*** *– an individual's control over the extent, timing, and circumstances of sharing oneself (physically, behaviourally, or intellectually) with others.*
- ***Confidentiality*** *– the treatment of information that an individual has disclosed in a relationship of trust and with the expectation that it will not be divulged to others without permission in ways that are inconsistent with the understanding of the original disclosure.*
- ***Anonymity*** *– where individuals cannot be directly and indirectly identified – this could be related to participation (no way of anyone, including the researcher, knowing that an individual has participated), data/information (no way for anyone, including the researcher, to identify the individual from the data/information collected) and publication (no way for an individual to be identified from data/information that is published).*
- ***Link-codes*** *– used to help maintain confidentiality – data is coded so that that the data is unidentifiable simply by viewing the coded data but is identifiable when using the record that links the code to the identity of an individual. Data coded in this way is NOT 240rganizati, is still regarded as personal identifiable data and must be used/stored in accordance with the data protection act.*

- ***Personal identifiable Data/information*** *– Data/information that can be identified with a participant through identifiers such as names, link-codes, postal/email addresses, telephone numbers, date of birth, full postcode, medical records, academic records, audio/video recordings of individuals, images, voices etc.. The use of identifiable personal information in research should be reduced so far as possible consistent with achievement of the research aims. The "Caldecott Principles" set out an ethical framework for use of identifiable data:*
  1) *Justify the purpose(s) for obtaining the information.*
  2) *Do not use person-identifiable information unless it is absolutely necessary.*
  3) *Use the minimum necessary person-identifiable information.*
  4) *Access to person-identifiable information should be on a strict need-to-know basis.*
  5) *Everyone with access to person-identifiable information should be aware of his or her responsibilities.*
  6) *Understand and comply with the law.*

F1. Personal Data Management.

F1a. Please provide details of any personal, identifiable or sensitive information will be collected and stored *(e.g. names, postal/email addresses, telephone numbers, date of birth, full postcode, medical records, academic records, audio/video recordings of individuals, images, voices etc.)*

The only data that will be kept is the participants name and contact details if they agree to be contacted for the research study and the audio recordings. Interviews will be audio recorded on a password protected audio recording device and as soon as possible, the recording will be transferred to secure storage and deleted from the recording device. All data will be kept on a

F1b. How will personal identifiable data/information be COLLECTED/RECORDED to ensure privacy and confidentiality?

- *Will data/information be anonymous? Will you use linked-codes/pseudonyms? Will you require codes/pseudonyms to be linked to the identity of the participant?*
- *How will you ensure that individuals are not identifiable from the codes/pseudonyms?*
- *Will recording devices be password protected and only accessible to the researchers? Will the data/information be deleted from a recording device once transferred to storage?*
- *For questionnaires (used for collecting data and screening participants), please explain how the method of submitting/delivering the completed questionnaire to the researcher will*

ensure confidentiality.

Audio recordings will be collected on a password protected recording device and transferred to LJMU servers at the earliest convenience before being deleted from the Dictaphone. The interviews will then be transcribed by the researcher and all identifiable data will be removed and pseudonyms will be used. All 241rganizati transcripts will be only used for data analysis.

If required, data sharing agreements will be put in place with participating services, in consultation with Liverpool John Moores University's contracts team. Audit data will be redacted to ensure confidentiality. Information from the audit data such as sWEMWBS questionnaires or other measures will also be 242rganizati. Interviews will either be transcribed

F1c. How will personal identifiable data/information be securely STORED to ensure privacy and confidentiality? *(e.g. a locked filing cabinet in an LJMU office, managed client LJMU computers/laptops that require an LJMU username and password to use, an LJMU portal such as the M:drive).*

Please note, personal identifiable data/information must not be stored on home or personal computer/laptop or a portable storage device (such as a USB drive)

Data will only be stored on a password protected LJMU portal such as the M:drive. Completed consent forms will be stored in a locked cabinet, with the student researcher possessing the only key.

F1d. How will study findings be DISSEMINATED in order to ensure privacy and confidentiality? *(e.g. participants will not be directly attributed to data/information that is disseminated – or will be attributed but only with explicit consent from the participant, use of pseudonyms etc.)*

Pseudonyms will be used in thesis, peer-reviewed articles and conferences. Any identifying information will be 242rganizati to 242rganiza indirect identification.

F1e. Following attempts to ensure privacy and confidentiality, if there is the possibility that individuals could be indirectly identified once the study has been DISSEMINATED please explain what you will do (including involving the participant in the decision making process) to 242rganiza the potential for indirect identification, and how you will manage the potential for indirect identification?

- *participants with specific characteristics/certain profile or who belong to a specific group might be indirectly identifiable from the things they have said/done that are disseminated by the researcher).*
- *Care should be taken that the combination of incidental details e.g. details*

about occupation, location, age and ethnicity, do not lead to individuals being identifiable

- *You might want to consult with the participant about how information will be disseminated and what information should not be disseminated.*

There is a risk of indirect identification in this study given the different service locations. We will use quotes that 242rganiza the risk of identification of participants.

F2. Will you share personal, identifiable data with other organisations outside of LJMU or with people outside of your research team? *(e.g. supervisor, co-applicants)*

- *Unless there is a good reason, only 243rganizati data should be shared. Where data has been effectively pseudo-anonymised (can be identified via a linked code) it should only be shared on the basis that the recipient cannot disclose pseudo-anonymised data to third parties and is not permitted to link the data with other data which might render the information more identifiable.*

Please type YES or NO in the box below

NO

If YES, please provide further information

Please confirm that personal identifiable data/information will not be transferred out of the EEA without the explicit consent of participants *(include this information on information sheets and consent forms).*

- *In general, personal identifiable data should not be transferred outside of the European Economic Area (EEA). This is because other countries do not have the same legal framework or protections for patient data. Even where this is the case, it is difficult to manage and monitor the use of data to ensure it is safeguarded appropriately and is not misused.*
- *Such information should be handled with great care and only used in the way described in the way described in the participant information sheet.*

Please type YES or NA in the box below

YES

F3. For how long will any personal, identifiable data collected during the study be stored?

Five years to abide by LJMU policy

F4. Limits of confidentiality

F4a. Is it possible that criminal or other disclosures requiring action could take place during the study? *(e.g. during an interview)*

- *A range of situations – across disciplinary domains – might prompt consideration of the need to breach confidentiality.*

- *Although it is generally the case that information resulting from research with human participants should remain confidential between the researcher and participant, there are limits to confidentiality and situations where research brings to light information that may mean that this confidentiality will need to be broken. In such cases, a third party (such as an appropriate/relevant authority or 243rganization) might need to be informed of the information in question.*

Please type **YES**, **NO** or **NA** in the box below

YES

If YES, please state under which circumstances confidentiality might be breached for ethically or legally justifiable reasons. *For example*

- *When the researcher knows or suspects that there is serious, immediate or future harm to others with regards money-laundering, crimes covered by the prevention of terrorism legislation or child protection offenses/abuse of vulnerable adults.*
- *When the researcher knows or suspects that an individual is harming themselves or others or might harm themselves or others in the future.*

In certain exceptional circumstances, where the participant or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority.

F4b. If YES, what might you do if you are confronted with the need to breach confidentiality? *(e.g., stop the research and consult with relevant individuals/organisations). Please consider that breaching confidentiality will have legal implications.*

F4c. Please confirm that it will be clear to the participants (i.e. on the participant information sheet) as to the circumstances and process in which confidentiality may be breached.

Please type **YES** or **NA** in the box below

NA

DECLARATION OF THE PRINCIPAL INVESTIGATOR

- The information in this form is accurate to the best of my knowledge and belief and I take full responsibility for it.
- I undertake to abide by the ethical principles underlying the Declaration of Helsinki and LJMU's REC regulations and guidelines together with the codes of practice laid down by any relevant professional or learned society.
- If the research is approved, I undertake to adhere to the approved study procedures and any conditions set out by the REC in giving its favourable opinion.
- I undertake to seek an ethical opinion from LJMU REC before implementing substantial amendments to the approved study plan. https://www2.ljmu.ac.uk/RGSO/93205.htm
- If, in the course of the administering any approved intervention, there are any serious adverse events, I understand that I am responsible for immediately stopping the

intervention and alerting LJMU REC. https://www2.ljmu.ac.uk/RGSO/93130.htm

- I am aware of my responsibility to comply with the requirements of the law and relevant guidelines relating to security and confidentiality of personal data.
- I understand that any records/data may be subject to inspection for audit purposes if required in the future.

- I understand that personal data about me as a researcher will be held by the University and this will be managed according to the principals of the Data Protection Act.
- I understand that the information contained in this application, any supporting documentation and all correspondence with LJMU REC relating to the application will be subject to the provisions of the Freedom of Information Act. The information may be disclosed in response to requests made under the Act except where statutory exemptions apply.
- I understand that all conditions apply to my co-applicants and other researchers involved in the study and that it is my responsibility that they abide by them.

YES	**Type YES to CONFIRM THAT YOU HAVE READ AND AGREE TO THE DECLARATION ABOVE**

SUBMITTING YOUR APPLICATION FOR REVIEW

Once you have completed the ethics application form appended all of the supporting documents and saved as **ONE** pdf document, please submit it electronically to **either** EthicsPR@ljmu.ac.uk (no submission deadline) for proportionate review or to researchethics@ljmu.ac.uk for full review (by the advertised submission deadline). https://www2.ljmu.ac.uk/RGSO/93085.htm

APPLICATIONS MUST BE SUBMITTED VIA AN LJMU EMAIL ACCOUNT AND FOR STUDENT APPLICATIONS SUPPORTED BY AN EMAIL / LETTER FROM THE MAIN SUPERVISOR CONFIRMING THAT THEY HAVE READ AND APPROVED THE STUDY / APPLICATION.

CHECKLIST OF DOCUMENTS SUBMITTED ELECTRONICALLY

(Please note that applications submitted without the required supporting documents will not be reviewed).

X	LJMU REC training certificate of completion (Mandatory for students) https://www2.ljmu.ac.uk/RGSO/131507.htm
X	Ethics Application Form (MANDATORY)
X	Protocol (MANDATORY) see note below
	Email / letter from supervisor confirming that a) the supervisor has read and reviewed this ethics application form and all supporting documents and b) the information included in the application and all supporting documents will allow UREC to decide whether all challenges to the principles of research ethics have

☐ been identified and addressed

☒ Copies of any recruitment/advertisement material e.g. letters, emails, posters etc.
☒ Participant Information Sheet https ://www2.ljmu.ac.uk/RGSO/93044.htm
☐ Carer Information Sheet https://www2.ljmu.ac.uk/RGSO/93044.htm
☒ Gatekeeper Information Sheet https://www2.ljmu.ac.uk/RGSO/93044.htm
☒ Participant Consent Form https ://www2.ljmu.ac.uk/RGSO/93044.htm
☐ Carer Consent Form https://www2.ljmu.ac.uk/RGSO/93044.htm

☒ Gatekeeper Consent Form https://www2.ljmu.ac.uk/RGSO/93044.htm
☐ Non-validated questionnaires
☒ List of interview questions
☒ Risk Assessment Form https://www2.ljmu.ac.uk/RGSO/93044.htm
☐ Other please specify

Note

A research protocol is *a document describing in detail how a research study is to be conducted in practice, including a brief introduction or background to the study, the proposed methodology and a plan for analysing the results. For the purposes of your application for ethical approval, it is something that can be presented in a variety of formats dependent on its origin for example:*

- *for postgraduate research students it may be the programme of work embedded within their programme registration form (RD9R)*
- *for studies which have obtained external funding it is often the description of what they propose doing which they submitted to the funder*
- *for other students it is the study proposal they have written and had assessed/approved by their supervisor.*

This is an automatically generated email to certify completion of the LJMU Research Ethics Training. You are receiving this because the LJMU REC has specified your email address for sending the certificate of completion.

Name	Abbate, Laura
LJMU Email address	l.g.abbate@2019.ljmu.ac.uk
ID number	486421
Date/Time	**2 June 2019 16:00**
Answered:	**3 / 3**
Your Score	**3 / 3 (100%)**
Passing Score	**3 (100%)**
Time Spent:	**38 sec**
Result	**Passed**

Question 1 **Correct**
Points: 1/1 | Attempts: 1/3
Research Ethics Committees:

Select one or more correct answers from the choices below

Inswer	Correct Answer
✓ Protect the safety, dignity and rights of participants in research	Protect the safety, dignity and rights of participants in research
✓ Provide assurances of good quality research being conducted within an evidence base and for the benefit of society	Provide assurances of good quality research being conducted within an evidence base and for the benefit of society
✓ Protect all stakeholders	Protect all stakeholders

Feedback: That's right! You answered correctly.

Question 2 Correct
Points: 1/1 | Attempts: 1/3
Research ethics is the set of principles and guidelines that help us to uphold the things we value

Choose whether the statement is true or false

Your Answer	Correct Answer
✓ True	True

Feedback: That's right! You answered correctly.

Question 3 Correct
Points: 1/1 | Attempts: 1/3
Ethical approval must be in place BEFORE starting participant recruitment

Choose whether the statement is true or false

Inswer	Correct Answer
✓ True	True

Feedback: That's right! You answered correctly.

Appendix B

PhD Protocol

Title: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Background

In England, 13 people die by suicide every day with suicide being the leading cause of death in young people and new mothers (Department of Health [DH], 2017). Pitman, Osborn, Rantell & King (2016) found that people bereaved by suicide are 65% more likely to attempt suicide than people who are bereaved by natural causes, increasing the absolute risk to 1 in 10. Research has identified the need for support immediately after suicide bereavement (Pitman et al., 2016). A lack of support can contribute to heightened grief experiences and mental health issues in those bereaved by suicide (Pitman et al., 2017; Maple et al., 2014; Houck, 2007). Bereavement by suicide increases the likelihood of experiencing long-lasting negative grief effects, post-traumatic stress disorder (PTSD) and depression (Murphy, Johnson, Wu, Fan & Lohan, 2003; Kaltman & Bonanno, 2003). Furthermore, seeing the deceased's body is a significant predictor of distress and PTSD after a suicide (Callahan, 2000). These findings suggest the need for support not just for the next of kin and immediate family members but also finder of the body, irrespective of their relation to the deceased. Additionally, services who may be exposed to suicides through their work, such as police officers, coroner's, GP's and emergency responders, may require support following a suicide.

Postvention research has focused on suicides within school and military communities (Cox et al., 2016; Streufert, 2004; Harrington-LaMorie, Jorden, Ruocco & Cerel, 2018). Few studies have focused on community postvention services. Andriessen, Dransart, Cerel & Maple (2017) suggest that postvention research should focus on increasing intercultural collaboration and theory-driven research whilst encouraging the relationships between research and practice. However, their results are based upon modest participant numbers and all participants were from Western countries, suggesting that these results may not be representative. Comans, Visser & Scuffham (2013) found a postvention service to be more cost-effective and increased quality-adjusted life years by 0.02 compared to usual care. Furthermore, Andriessen (2003) suggested that postvention programs must develop networks between services to improve upon the quality of support offered. However, as this was conducted in a relatively small area of Belgium, these findings may not be representative.

Adequate and timely support for those bereaved by suicide is a key objective in the NO MORE Zero Suicide Strategy (2017) for Cheshire & Merseyside. Department of Health (2012) announced that providing better information and support to those bereaved and affected by suicide is a key area for action, as is supporting research and encouraging support for those bereaved by suicide both locally and nationally. The importance of national and local suicide prevention plans was also highlighted (DH 2014). Previously, the All-Party Parliamentary Group on Suicide and Self-Harm Prevention (2015) found that local suicide prevention plans are varying and inconsistent; however now 95% of local authorities have suicide prevention plans in place. Police, coroner and GP involvement at a local level is inconsistent and some local authorities still report not having a multi-agency suicide prevention group; thus, suggesting less collaboration between key agencies. Mental Health Taskforce to the NHS in England (2016) recommended all local authorities have a multiagency suicide prevention strategy in place by 2017.

Across England, there are service providers of postvention services following someone dying by suicide, for example in Durham, Cornwall, Devon, Somerset, Leeds, Cambridge, Peterborough, Liverpool and Nottingham. The main aim of most of these commissioned services is to 249rganiza emotional impact, promote recovery and reduce further suicides. The services offers practical support such as information surrounding the inquest, media and financial advice and emotional support and signposting to other services. Services support families, next of kin to the deceased person and finder of a body, whether they are related to the deceased or not. Some also support blue light services who are exposed to suspected suicides through their work, and communities such as schools, if there is a death within that community.

The PhD would include:

1) A literature review on current interventional research after suicide bereavement (an update of the McDaid et al 2007)
2) An evaluation of a sample (n=13) of the postvention services across England and Northern Ireland.

The literature review would include a focused search strategy to identify key evidence. Literature will be identified in the following ways: i) by contacting each of the organisations and asking for any published reports and papers; (ii) searching relevant databases and iii) by scanning publications and webpages of relevant organizations, including relevant professional bodies, charities, research institutions and government organizations (e.g., NICE). The types of evidence to be considered includes published peer-reviewed papers, policy documents, guidelines documents, research reports and evaluation reports.

The study will also involve collection of population data pre and post intervention through 1) a comparative analysis of each areas outcomes and 2) qualitative interview data which will collate information on acceptability to those referring, those delivering and those receiving the postvention service. Data from all the areas will be compared and analysed to see if outcomes differed across the areas. This will then be compared to the policies outlined in the government's Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland. The student will be involved in all aspects of the project including study design and data collection. The steps will be as follows:

1) Ethics application to be written and submitted to Liverpool John Moores University for the study.
2) Pre and post data collection for suicide rates in areas with commissioned postvention services for the one year prior, one year during and one year after implementation.
3) Design of Interview tools for the one-to-one interviews with stakeholders who have implemented or used the postvention services. These will be written using the information retrieved from the literature review and based on previous tools used across

England. The wider research group will review and/or edit documents before interviews take place.

4) PhD student to organise and conduct the interviews across England over the telephone, face-to-face or via Skype (n=130) with Stakeholders including coroners, police officers, public health teams, people delivering the services and people bereaved by suicide who are being supported by the services. All interviews will be recorded with consent. Interviews to be uploaded and transcribed by the student or a transcription service, UK Transcription Limited. PhD student to ensure all transcripts are anonymised before circulation to other research team members. The student researcher will also request service's audit data. Services must have been established for two years minimum to ensure at least one years' worth of data. A quantitative evaluation will be conducted on the audit data collected by the postvention services (n=13) across England and Northern Ireland, comparing suicide attempt rates in those who take up the service and those who have not, and other outcomes measured by the services such as well-being that has been measured by the sWEMWBS or equivalent.
5) PhD student and Supervisors to analyse the qualitative data using thematic analysis by Braun and Clarke (2006).
6) Comparison of the data from all included postvention services for quantitative data and qualitative data, using comparative analysis. Social network analysis (Wasserman & Faust, 1995) may also be used to measure and map the flow of relationships and relationship changes between knowledge-possessing entities such as people and organisations. The core belief of this analysis is that the patterns of these relationships can have important effects on individual and organisational behaviour, constraining or enabling access to resources, and exposure to information and behaviour.
7) Dissertation report to be written up, submission of peer-reviewed papers in journals, presentation of the study findings at national and international conferences.

Suitability of the Research Team

The project will be supervised by the Dr Pooja Saini, Senior Lecturer at Liverpool John

Moores University who has fifteen years' experience of working within suicide and self-harm research using mixed methods. Dr Saini has supervised multiple staff and students within collaborative research projects throughout her previous posts at NIHR Collaboration for Leadership in Applied Health Research and Care North West Coast (CLAHRC NWC) and suicide research projects in Higher Education Institutions. All research has been disseminated to different audiences, published in high impact peer reviewed journals and presented as posters or oral PowerPoint presentations at national and international conferences.

Supervision will also be provided by Dr Helen Poole, Reader and Health Psychologist at Liverpool John Moores University who has over 20 years of experience in PhD supervision, and Dr Jennifer Chopra who is a Lecturer in School of Psychology.

The PhD student, Laura Abbate was recently awarded a first class for her Master level degree at University of Liverpool, which Dr Saini supervised. Laura (Abbate et al, 2018) co-designed interview tools and conducted all of the stakeholder interviews for the AMPARO Suicide Liaison Service based in Liverpool and therefore has experience in this research area. She also interviewed people bereaved by suicide for the research she undertook for her third year dissertation within her undergraduate degree.

Project Advisory Board

- *Richard Brown, CEO Listening Ear* – led on the commissioned AMPARO Suicide Liaison Service that was implemented in Cheshire and Merseyside and Suffolk.
- *Pat Nicholls, Strategic Lead for Mental Wellbeing & Suicide Prevention* – Led the development of the NO MORE Suicide Strategy and supported the multi-partnership Board and operational groups across 9 local authorities.
- *Dr Alexandra Pitman, Senior Clinical Lecturer* in the UCL Division of Psychiatry and an Honorary Consultant Psychiatrist at Camden & Islington NHS Foundation Trust. Her clinical and research interests are the care of people who feel suicidal, the prevention of suicide attempt and people bereaved by suicide.
- *Prof Ann John, Professor* at Swansea University Medical School. Her main areas of interest are the epidemiology and prevention of common mental health disorders, suicide and self-harm. She is the Chair of the National Advisory Group to Welsh Government on Suicide and Self-harm prevention.
- *Katherine McGleenan,* Suicide Prevention Lead – North East and North Cumbria ICS
- *Angela Samata, Expert-by-Experience*
- *Hamish Elvidge, Founder of Matthew Elvidge Trust*, Expert-by-Experience
- *Clare Milford-Haven, Founder of James Place*, Expert-by-Experience
- *Steve Mallen, Chair of The MindEd Trust*, Expert-by-Experience
- *Amy Meadows, Trustee of Judi Meadows Memorial Trust*, Expert-by-Experience
- *Doug McQueen, Founder of the Mark McQueen Foundation*, Expert-by-Experience
- *Dr Pooja Saini, Senior Lecturer* at Liverpool John Moores University

Indicative costs for the project: £60,000,

Liverpool John Moores University will provide £30,000 towards the total projected cost of £60,000.

Matched funding would be needed of £30,000. Potential funder would be Hamish Elvidge, Founder of Matthew Elvidge Trust or Hamish Elvidge, National Suicide

Prevention Alliance.

Timelines

Year One: Ethics application, systematic literature review, stakeholder engagement for pre and post suicide rates data, design of interview study tools

Year Two: Publish systematic review, conduct all interviews with stakeholders and complete both quantitative and qualitative data analysis

Year Three: Continue with remaining data analysis and writing of thesis for PhD.

Publish papers in peer-reviewed journals (this may continue after the PhD is completed.

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Appendix C

Risk Assessment

Health and Safety Unit

Risk Assessment			
Building		Date of Risk Assessment	23/08/2019
School/Service Department		Assessment carried out by	Laura Abbate
Location	Participant's homes	Signed	
Activity	Conducting research	Persons consulted during the Risk Assessment	Dr Pooja Saini, Dr Helen Poole, Dr Jennifer Chopra
STEP 1 What are the Hazards? *Spot hazards by* • *Walking around the workplace* • *Speaking to employees* • *Checking manufacturers instructions*	• Walking to and from participant's homes • Walking around participant's homes • Fire in unfamiliar places • Risk of physical harm to researcher, by unknown persons or participant • Falls or trips		

STEP 2 Who might be harmed and how? *Identify groups of people. Staff and students are obvious, but please remember* • *Some staff/students have particular needs* • *People who may not be present all the time* • *Members of the public* • *How your work affects others if you share a workplace*	• Student – physical and psychological harm • Participants – Psychological harm • Others in the home – Psychological harm

STEP 3 (a) What are you already doing? *What is already in place to reduce the likelihood of harm, or to make any harm less serious*	• Abiding by lone working policy, ensuring someone is aware of my location, what time I will be finished. If I student do not make contact one hour after the allotted time, person aware of my location to make contact with me and if necessary, police. • Always carry a mobile phone • Avoid any activities that may be a risk of injury, such as running for the train or lifting heavy objects • Make sure I am aware of exits or fire exits in case of fire or risk of physical harm • If I am uncomfortable or at risk of harm, leave the setting quickly and safely and inform the police if necessary • Ensure participants and those in the home with them are aware the interview can be paused to take a break or terminated • Provide contact details of Survivors of Bereavement by Suicide, Samaritans or encourage participants or those in the home with them to contact their GP if necessary • Use debriefing opportunities and practice self-care to alleviate mental distress • There will be no more than two interviews conducted in any single day and no more than five interviews in any single week. • The Standard Operating Procedures includes a lone-worker policy and provides guidelines to ensure researcher safety for data collection on-campus and further away.
STEP 3 (b) What further action is needed? *Compare what you are already doing with good practice. If there is a gap, please list what needs to be done.*	

STEP 4 How will you put the assessment into action? *Please remember to prioritise. Deal with the hazards that are high risk and have serious consequences first*	- Be aware of surroundings and risks when in people's homes. - Do not put myself in any situations that may be a risk. - Remain contactable. - Be aware of any distress or psychological harm to myself or others.

Appendix D

Steering Group Terms of Reference

Suicide Postvention Service PhD, Steering Group Terms of Reference

1. Purpose / role of the group:

The aim of the Steering Group is to provide expertise, guidance and leadership to the running Suicide Postvention Services PhD.

The Objectives of the Steering Group are to:
- Advise on the set-up and management of the study
- Ensure that the protocol is followed
- Identify services and individuals who could be approached to be involved in the study
- Identify effective ways of engaging with suicide postvention services.
- Explore perceived barriers to the research.

2. Membership:

The Group will consist of representatives as follows:
- Laura Abbate, PhD student
- Dr Pooja Saini (PhD Supervisor, Liverpool John Moores University)
- Dr Jennifer Chopra (PhD Supervisor, Liverpool John Moores University)
- Dr Helen Poole (PhD Supervisor, Liverpool John Moores University)
- Hamish Elvidge (Support after Suicide Partnership, Chair of the Matthew Elvidge Trust)
- Prof Ann John (Professor in Public Health and Psychiatry, Swansea University Medical School)
- Dr Alexandra Pitman (Associate Professor in General Adult Psychiatry, University College London)
- Angela Samata (Ambassador of Survivors of Bereavement by Suicide - SOBS)
- Richard Brown (CEO of Listening Ear)
- Pat Nicholl (CHAMPS Public Health Collaborative, Mental Wellbeing Lead)
- Katherine McGleenan (North East and North Cumbria Suicide Prevention Lead)
- Doug McQueen (Mark McQueen Foundation)
- Steve Mallen (The Mind Ed Trust)
- Jennifer Hicken (Network Delivery Lead, NENC Suicide Prevention Network)
- Clare Milford Haven (Founder & Trustee of James' Place)

The period of membership will be for three years and will then be reviewed.

*Amended group membership (2022)
The Group will consist of representatives as follows:
- Laura Abbate, PhD student
- Dr Pooja Saini (PhD Supervisor, Liverpool John Moores University)
- Dr Jennifer Chopra (PhD Supervisor, Liverpool John Moores University)
- Dr Helen Poole (PhD Supervisor, Liverpool John Moores University)

- Sue Christie (Support after Suicide Partnership)
- Prof Ann John (Professor in Public Health and Psychiatry, Swansea University Medical School)
- Dr Alexandra Pitman (Associate Professor in General Adult Psychiatry, University College London)
- Angela Samata (Ambassador of Survivors of Bereavement by Suicide - SOBS)
- Richard Brown (CEO of Listening Ear)
- Neil Boardman (CHAMPS Public Health Collaborative, Mental Wellbeing Lead)
- Katherine McGleenan (North East and North Cumbria Suicide Prevention Lead)
- Doug McQueen (Mark McQueen Foundation)
- Steve Mallen (The Mind Ed Trust)
- Clare Milford Haven (Founder & Trustee of James' Place)

3. Accountability: The group will report back to the Suicide Postvention Services PhD Steering group

4. Review: The terms of reference will be reviewed on an annual basis.

5. Working methods / ways of working: The Steering Group will meet virtually using Zoom (or other video conferencing method) with a view to meeting face to face in the future.

6. Meetings

Meetings will be held on a tri-annual basis in the first instance. The regularity will be reviewed on an ongoing basis. Laura Abbate and Dr Pooja Saini will Chair the meetings which will be minuted by Laura Abbate. Minutes will be circulated within 2 a week of the meeting. Papers for the meetings will be circulated via email at least 3 days before the meeting. Topics for the agenda will be agreed in advance by the Chair. Items to be considered for the agenda should be agreed upon at least 5 days in advance of the meeting. Up to two additional non-members may attend the meeting upon invitation from Steering Group members and agreement by the chair only. It is required that members attend two out of four of the meetings per year.

7. Sharing of information and resources
   Information and documents will be shared by email. It is not anticipated that the group will access confidential information.

Appendix E

Interview Schedules

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: **Laura Abbate, Dr Pooja Saini**

Questionnaire for Service users

Thank you for agreeing to talk about your experience of a suicide postvention service**.** I am interested in your own personal experience which may be different from other people, and would like hear how it has been for you. The interview will probably last approximately between 30 minutes and one hour. I would like to audio record the conversation with your permission, and then I will transcribe the tape to provide a typed record of our discussion. The tape will then be destroyed, and all identifiers will be removed from the saved typewritten file. You will not be identifiable from any report we write up from this project. We will be able to arrange an opportunity for you to hear the recording or to read the transcript if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive, I can assure you that the information you provide will remain confidential unless I have concerns about imminent risk to yourself.

1) How did you hear about the service? How were you referred?
2) Were you given any information about what to expect from the service? If so, was it useful? What other information could you have been given?
3) Can you describe your expectations of the service?
4) How has this service supported or helped you? Have there been any negative impacts? Prompts: add positive and negative aspects eg inquire about stigma
5) Were your expectations met or do you feel that improvements could be made? If so, what might they be?
6) What impact has this service had on you?

a. Immediately after the bereavement (within the first month)
b. Longer term – on your own health, work, family life, social life, relationships
c. With the police or other services
d. Dealing with media
e. Collecting personal belongings
f. At/after the inquest
g. Referral to other services
h. Other eg finances, family dynamics, breaking bad news to children

7) Could the referral process be improved for how you were referred in or out of the service? If so, how?
8) Anything else you’d like to add?

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: Laura Abbate, Dr Pooja Saini

Questionnaire for Commissioned Service Leads

Thank you for agreeing to talk about your experience of a suicide postvention service**.** I am interested in your own personal experience which may be different from other people, and would like hear how it has been for you. The interview will probably last approximately between 30 minutes and one hour. I would like to audio record the conversation with your permission, and then I will transcribe the tape to provide a typed record of our discussion. The tape will then be destroyed, and all identifiers will be removed from the saved typewritten file. You will not be identifiable from any report we write up from this project. We will be able to arrange an opportunity for you to hear the recording or to read the transcript if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive I can assure you that the information you provide will remain confidential unless I have concerns about imminent risk to yourself.

1) Why did you apply for a suicide bereavement support service tender? Prompt: counselling/other training? Personal experience?
2) Could you tell me about your service and why did your service think it was important to apply for/win this tender?
   Prompt: does your service have any links or affiliations to other services?
3) What was the scope of the tender?
4) What features of your bid do you think helped you win the tender? Is this your own view or was it represented in feedback?
5) Do you think the finances attached to the tender were sufficient?
6) How has the service developed since it was launched?
7) Do you think this service needs future investment? Why/why not?
8) What do you wish you had done differently if you could set up the service

again? What service model would you operate if you could revise it from scratch? How do you find the reality of setting up and delivering the service?

9) Is there anything you would like to feedback to commissioners from your experience?

10) Any other questions?

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: Laura Abbate, Dr Pooja Saini

Questionnaire for Commissioners

Thank you for agreeing to talk about your experience of a suicide postvention service**.** I am interested in your own personal experience which may be different from other people, and would like hear how it has been for you. The interview will probably last approximately between 30 minutes and one hour. I would like to audio record the conversation with your permission, and then I will transcribe the tape to provide a typed record of our discussion. The tape will then be destroyed, and all identifiers will be removed from the saved typewritten file. You will not be identifiable from any report we write up from this project. We will be able to arrange an opportunity for you to hear the recording or to read the transcript if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive I can assure you that the information you provide will remain confidential unless I have concerns about imminent risk to yourself.

1. Do you think it is necessary to commission a suicide bereavement support service? If not, why? If so, what are your reasons?
   Prompt: Research literature describing impact of suicide loss; awareness of unique aspects of suicide bereavement eg stigma as a barrier to support; Personal experience?
2. Prior to hearing about Amparo, which other suicide bereavement support services were you aware of?
3. What did you envisage the scope of the service to be?
4. How did you develop the finances associated for the service? Prompts: Did you have a business plan
5. Context: Some services are based on different models such as IAPT services or charities. Some services are based on other pre-existing services and some are brand new. How did you decide which service to commission? Did you scope any other services? Prompt: name some local services.
   Prompt: What is specific to your area?
   Prompt: Scoring system?
   Prompt: Did you have any good examples you wanted to follow?

6. In what ways has the service met or not met your expectations?
7. What have you found most valuable about the service? Any negative effects of the service? Prompt: creating demand for other services that cannot be met. Any unexpected benefits?
8. Do you think this area needs future investment? Why?/Why not?

9. What have you observed about the commissioning of suicide bereavement support services in other parts of the UK/ internationally?
10. Anything else you’d like to add?

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: Laura Abbate, Dr Pooja Saini

Questionnaire for Postvention Service Support Workers/Employees

Thank you for agreeing to talk about your experience of a suicide postvention service**.** I am interested in your own personal experience which may be different from other people, and would like hear how it has been for you. The interview will probably last approximately between 30 minutes and one hour. I would like to audio record the conversation with your permission, and then I will transcribe the tape to provide a typed record of our discussion. The tape will then be destroyed, and all identifiers will be removed from the saved typewritten file. You will not be identifiable from any report we write up from this project. We will be able to arrange an opportunity for you to hear the recording or to read the transcript if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive I can assure you that the information you provide will remain confidential unless I have concerns about imminent risk to yourself.

1) How long have you been working with the suicide postvention support service? What attracted you to this role?
2) Over the years, how many clients have you supported?
3) Can you describe the nature of the suicide postvention support you provide your clients?

   Prompts: Signposting, Emotional needs, Practical needs (collecting personal items, inquest)

4) Do you think that your clients benefited from the service being available to them? If so, in what ways?
5) How do you feel that this service has impacted on your clients?

   Prompts: emotionally, practically, support, helpful, any negative impacts (eg intrusion, stigma)

6) Do you feel that improvements could be made to the service? If so, what might they be?
7) Could the referral process be improved for individuals being referred into the service and/or out of the service? If so, in what ways?

   Prompt: Knowledge/availability of other available services.

8) Due to the nature of your role at the suicide postvention support service, is there any support available to you within your organisation?
9) If you were to write a job description for this role, what would it include? Prompt: Do you need to be bereaved?
10) Do you use any measures to assess your beneficiaries well-being? Prompt: Core, SWEMWBs
11) Anything else you'd like to add?

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: Laura Abbate, Dr Pooja Saini

Questionnaire for Stakeholders, including Coroners, Police, GP's, Public Health Officials

Thank you for agreeing to talk about your experience of a suicide postvention service**.** I am interested in your own personal experience which may be different from other people, and would like hear how it has been for you. The interview will probably last approximately between 30 minutes and one hour. I would like to audio record the conversation with your permission, and then I will transcribe the tape to provide a typed record of our discussion. The tape will then be destroyed, and all identifiers will be removed from the saved typewritten file. You will not be identifiable from any report we write up from this project. We will be able to arrange an opportunity for you to hear the recording or to read the transcript if you would like. Should you wish to stop the interview at any time, or take a break, please tell me. Because the topic of our discussions is sensitive I can assure you that the information you provide will remain confidential unless I have concerns about imminent risk to yourself.

9) How did you/your organisation hear about the suicide postvention support service?
10) How were you introduced to this service?
11) Were you given any information and was it useful?
12) Can you describe what you/your organisation hoped to gain by using the service?
13) From your perspective, how has the suicide postvention support worker been involved in the process leading up to the inquest?
14) From your perspective, how has the suicide postvention support worker been involved with the inquest?
15) Were your expectations met or do you feel that improvements could be made? If so, what might they be?
16) Can you describe what impact the suicide postvention support has service had on you or your organisation?
17) How did you find the referral process?
18) How could the referral process be improved?
19) Anything else you'd like to add?

Appendix F

Gatekeeper Consent & Information Sheet

LIVERPOOL JOHN MOORES UNIVERSITY

GATEKEEPER CONSENT FORM

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researchers: Laura Abbate

Please tick to confirm your understanding of the study and that you are happy for your organisation to take part and your facilities to be used to host parts of the project.

Your participation will include identifying potential participants, contacting them on behalf of the researcher/providing contact details and sharing audit data/reports.

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I confirm that this service is the custodian of the data being shared ☐
3. I understand that participation of our organisation and students/members in the research is voluntary and that they are free to withdraw at any time, without giving a reason and that this will not affect legal rights. ☐
4. I understand that any personal information collected during the study will be anonymised and remain confidential. ☐
5. I agree for our organisation and members to take part in the above study. ☐
6. I agree to conform to the data protection act ☐

Name of Gatekeeper: Date: Signature:

Name of Researcher: Date: Signature:

Name of Person taking consent: Date: Signature:
(if different from researcher)

LIVERPOOL JOHN MOORES UNIVERSITY GATEKEEPER INFORMATIO

Title of Project: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Name of Researcher and School/Faculty: Laura Abbate, School of Psychology

The following questions can be headings in your information sheet and beneath each you should add text that is relevant to your study:

1. What is the reason for this letter?

You are being invited to take part in a study. Your service has been identified as one of the suicide postvention services in England and Northern Ireland. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

2. What is the purpose of the study/rationale for the project?

The aim of this study is to evaluate the impact of suicide postvention services across England and Northern Ireland on the local services involved in suicide (Police, Coroner, GP, individuals delivering the services and public health officials) and individuals bereaved or affected by a suicide. In order to do this, we will be undertaking qualitative interviews with individuals who have direct experience of the services. The findings from the study will help us to evaluate the programme, identifying both the successful aspects and/or areas for improvement, from the perspective of those taking part. This may then contribute to improving the service for future recipients. The data collected will be compared and analysed to see how the experiences of the services differed across the England and Northern Ireland. This will then be compared to the policies outlined in the government’s Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland.

3. What we are asking you to do?

We are asking for your service's involvement in the study and participant identification. We are also asking for audit data to gain more information about individuals you support. This information may vary from service to service, but may include any demographic information about the people you support, any pre- and post- support questionnaires such as sWEMWBS or equivalent. This information must be confidential. If you have any questions surrounding this, please do not hesitate to contact me.

4. Why do we need access to your facilities?

Only the services themselves can inform and share information on those who have direct involvement in the service, such as who refers to your service and individuals you support.

5. If you are willing to assist in the study what happens next?

We will arrange a convenient time for you to meet the researcher and discuss the study in further detail. We will then give you information to share with potential participants who have had direct experience with the service. They will then contact the researcher directly. You may give contact details of those who refer into your service or other organisations you have direct contact with such as coroners, police, GP's, public health officials.

6. How we will use the information/questionnaire?

You will be asked to email, telephone or send letters to potential participants you identify. If the participant is a bereaved individual you have supported, they must have been bereaved for over one year. All participants must be over the age of 18. The student researcher will then conduct interviews with those who have consented to participating.

7. Will the name of my organisation taking part in the study be kept confidential?

No, this will not be necessary as you will be contacting potential participants. However, any information that those delivering the service give in their interviews will be kept confidential, including their identities.

8. What will taking part involve? What should I do now?

Taking part will involve contacting potential participants with an information sheet provided by the researcher. Potential participants will then contact the researcher directly. Any audit data or reports you write which include audit data can be sent directly to the researcher.
Please sign and return the **Gatekeeper Consent Form** provided.

Should you have any comments or questions regarding this research, you may contact the researchers: Laura Abbate, 07852816226, L.G.Abbate@2019.ljmu.ac.uk

This study has received ethical approval from LJMU's Research Ethics Committee *(reference 19/NSP/064)*

Contact Details of Researcher

Laura Abbate, 07852816226, L.G.Abbate@2019.ljmu.ac.uk

Contact Details of Academic Supervisor

Dr Pooja Saini, 01512318121, P.Saini@ljmu.ac.uk

If you have any concerns regarding your involvement in this research, please discuss these with the researcher in the first instance. If you wish to make a complaint, please contact researchethics@ljmu.ac.uk and your communication will be re-directed to an independent person as appropriate.

Appendix G

Invitation Letter/Email – Individuals bereaved by suicide

Laura Abbate
Room 317
Tom Reilly Building

Byrom Street

Liverpool, L3 3AF

07852816226

L.G.Abbate@2019.ljmu.ac.uk

[Date]

Dear [Name],

We are undertaking a study with any individuals involved in delivering the [Service Name] and any bereaved individuals who received a referral to the [Service Name].

We are interested to learn what impact this service has had on local services and individuals bereaved or affected by suicide. We are also interested in how effective the service was in the days and weeks following people being bereaved by suicide. We hope that our findings will help us to understand how the service can best help individuals going forwards.

You have been invited to take part in the study because we understand that you have had experiences of this service.

Please read the information sheet enclosed with this letter. We would like to stress that: the study has full ethical approval from the Liverpool John Moores University's Ethical Committee (reference 19/NSP/064), any information that you provide is strictly confidential and accessible only to the lead researcher carrying out the study.

If you are interested in the study but would like to find out more about this study and what it might involve please do not hesitate to contact me on the details above at any time to discuss this further.

Please do not feel that there is any pressure to take part in this study and thank you for taking the time to read this letter.

Yours sincerely,

Ms Laura Abbate

Invitation Letter/Email – Commissioners

Laura Abbate
Room 317
Tom Reilly Building
Byrom Street
Liverpool, L3 3AF
07852816226
L.G.Abbate@2019.ljmu.ac.uk

Dear [Name], [Date]

We are undertaking a study with any individuals involved in delivering the [Service Name] and any bereaved individuals who received a referral to the [Service Name].

We are interested to learn what impact this service has had on local services and individuals bereaved or affected by suicide. We are also interested in how effective the service was in the days and weeks following people being bereaved by suicide. We hope that our findings will help us to understand how the service can best help individuals going forwards.

You have been asked to take part in the study because we understand that you have commissioned this service.

Please read the information sheet enclosed with this letter. We would like to stress that: the study has full ethical approval from the Liverpool John Moores University's Ethical Committee (reference 19/NSP/064), any information that you provide is strictly confidential and accessible only to the lead researcher carrying out the study.

If you are interested in the study but would like to find out more about this study and what it might involve please do not hesitate to contact me on the details above at any time to discuss this further.

Please do not feel that there is any pressure to take part in this study and thank you for taking the time to read this letter.

Yours sincerely,

Ms Laura Abbate

Invitation Letter/Email – Commissioned Service Leads

Laura Abbate
Room 317
Tom Reilly Building
Byrom Street
Liverpool, L3 3AF
07852816226
L.G.Abbate@2019.ljmu.ac.uk

[Date]

Dear [Name]

We are undertaking a study with any individuals involved in delivering the [Service Name] and any bereaved individuals who received a referral to the [Service Name].

We are interested to learn what impact this service has had on local services and individuals bereaved or affected by suicide. We are also interested in how effective the service was in the days and weeks following people being bereaved by suicide. We hope that our findings will help us to understand how the service can best help individuals going forwards.

You have been asked to take part in the study because we understand that you have been involved in setting up and running this service.

Please read the information sheet enclosed with this letter. We would like to stress that: the study has full ethical approval from the Liverpool John Moores University's Ethical Committee (reference 19/NSP/064), any information that you provide is strictly confidential and accessible only to the lead researcher carrying out the study.

If you are interested in the study but would like to find out more about this study and what it might involve please do not hesitate to contact me on the details above at any time to discuss this further.

Please do not feel that there is any pressure to take part in this study and thank you for taking the time to read this letter.

Yours sincerely,

Ms Laura Abbate

Invitation Letter/Email – Suicide postvention service employees/support workers

Laura Abbate
Room 317
Tom Reilly Building

Byrom Street

Liverpool, L3 3AF

07852816226

L.G.Abbate@2019.ljmu.ac.uk

[Date]

Dear [Name],

We are undertaking a study with any individuals involved in delivering the [Service Name] and any bereaved individuals who received a referral to the [Service Name].

We are interested to learn more about the service and what impact this service has had on local services and individuals bereaved or affected by suicide. We are also interested in how effective the service was in the days and weeks following people being bereaved by suicide. We hope that our findings will help us to understand how the service can best help individuals going forwards.

You have been invited to take part in the study because we understand that you support people bereaved by suicide as an employee of the service.

Please read the information sheet enclosed with this letter. We would like to stress that: the study has full ethical approval from the Liverpool John Moores University’s Ethical Committee (reference 19/NSP/064), any information that you provide is strictly confidential and accessible only to the lead researcher carrying out the study.

If you are interested in the study but would like to find out more about this study and what it might involve please do not hesitate to contact me on the details above at any time to discuss this further.

Please do not feel that there is any pressure to take part in this study and thank you for taking the time to read this letter.

Yours sincerely,

Ms Laura Abbate

Invitation Letter/Email – Key wider agencies (Coroners, Police Officers, GP's)

Laura Abbate
Room 317
Tom Reilly Building
Byrom Street
Liverpool, L3 3AF
07852816226
L.G.Abbate@2019.ljmu.ac.uk

[Date]

Dear [Name],

We are undertaking a study with any individuals involved in delivering the [Service Name] and any bereaved individuals who received a referral to the [Service Name].

We are interested to learn what impact this service has had on local services and individuals bereaved or affected by suicide. We are also interested in how effective the service was in the days and weeks following people being bereaved by suicide. We hope that our findings will help us to understand how the service can best help individuals going forwards.

You have been invited to take part in the study because we understand that you have had experience of this service.

Please read the information sheet enclosed with this letter. We would like to stress that: the study has full ethical approval from the Liverpool John Moores University's Ethical Committee (reference 19/NSP/064), any information that you provide is strictly confidential and accessible only to the lead researcher carrying out the study.

If you are interested in the study but would like to find out more about this study and what it might involve please do not hesitate to contact me on the details below at any time to discuss this further.

Please do not feel that there is any pressure to take part in this study and thank you for taking the time to read this letter.

Yours sincerely,

Ms Laura Abbate

Appendix H

Participant Information Sheet

Individuals bereaved by suicide

LJMU's Research Ethics Committee Approval Reference: 19/NSP/064
YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

You are being invited to take part in a study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

1. Who will conduct the study?

Study Team
Principal Investigator: Laura Abbate, PhD student
Supervisors: Dr Pooja Saini, Dr Helen Poole, Dr Jennifer Chopra
School/Faculty within LJMU: School of Psychology

2. What is the purpose of the study?

The aim of this study is to evaluate the impact of suicide postvention services across England and Northern Ireland on the local services involved in suicide (Police, Coroner, GP, individuals delivering the services and public health officials) and individuals bereaved or affected by a suicide. In order to do this, we will be undertaking qualitative interviews with individuals who have direct experience of the services. The findings from the study will help us to evaluate the programme, identifying both the successful aspects and/or areas for improvement, from the perspective of those taking part. This may then contribute to improving the service for future recipients. The data collected will be compared and analysed to see how the experiences of the services differed across the England and Northern Ireland. This will then be compared to the policies outlined in the government's Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland.

This study hopes to answer the following question:

Are the current postvention services effective in preventing further suicides and improving well-being outcomes in those bereaved by suicide?

3. Why have I been invited to participate?

You have been invited to take part because we understand that you have had experiences of a suicide postvention service. It may be that you were contacted by the service itself and asked to contact the researcher if you would like to take part.

The exclusion / inclusion criteria are you must have had direct experience of a suicide postvention service in England and Northern Ireland. If you have been supported by the service, you must have been bereaved for over one year and the inquest must have already taken place. In addition, you must be over 18 years old to take part.

4. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

5. What will happen to me if I take part?

We will talk you through the study procedures and give you the chance to ask any questions. The researcher, Laura Abbate, will contact you to arrange a convenient time to conduct a face-to- face interview, then a suitable venue can be arranged at Liverpool John Moores University or in your home. If face-to-face interviews are not possible, interviews can be conducted via skype or telephone at a convenient time for you. When interviews are conducted via telephone or skype, it would be preferable to do this from your home to ensure your privacy. You will be asked to attend one interview, lasting between one hour to an hour and a half. You can also bring someone to accompany you to the interview if you would like.

6. Will I be recorded and how will the recorded media be used?

Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device. You are free to stop the recording at any time, take a break or terminate the interview.

7. What should I consider?

a. Questions will focus on your experience of the suicide postvention service and will not focus on your bereavement itself;
b. You need to have been bereaved over one year to take part to manage the risk of distress and to ensure the inquest has already taken place.
c. You can stop the interview at any time, take a break or terminate the interview;
d. The researcher will be contactable before and after the interview, should you have any questions about the study

8. Are there any possible disadvantages or risks from taking part?

There are no potential disadvantages to taking part in this study. You will however be required to give up some of your time for the interview to be conducted; this will be approximately one hour. Although the subject of our discussion is sensitive, this study is an evaluation of the service. The questions themselves will not focus on your bereavement but on your experience of the support you received. However, you may be talking about sensitive topics surrounding your bereavement that could be distressing, e.g. the inquest. You are free to decline answering any questions you do not wish to answer. The interview will be conducted through a face-to-face, skype or telephone interview and you are free to end the interview at any time without giving a reason. If you feel distressed, and require support following the interview, then please contact your GP to discuss further support, SOBS (Survivors of Bereavement by Suicide – 0330 111 5065) or Samaritans (116 123).

9. What are the possible benefits of taking part?

Whilst will be no direct benefits to you for taking part in the study, but it is hoped that this work will help us to develop a better understanding of the postvention services across England and Northern

Ireland, how they work and the impact they are having. This may help inform the development of new services in other areas that do not currently have a suicide postvention service and give government bodies a better understanding of the impact these services have on those bereaved by suicide.

10. What will happen to the data provided and how will my taking part in this project be kept confidential?

The information you provide as part of the study is the **study data**. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as **personal data**. This includes more sensitive categories of personal data (**sensitive data**) such as your race; ethnic origin; politics; religion; trade union membership; genetics; biometrics (where used for ID purposes); health; sex life; or sexual orientation.

The voice recording from the interview will be listened to by the researcher and typed (transcribed) into a written version in order to conduct the qualitative analysis. At the time of transcribing, any identifiable personal or professional information provided by you in the interview will be removed. Anonymised interview transcripts will be kept on a secure, password protected computer, only accessible by the researcher. Your comments and any direct quotes will be combined with the responses from other participants to create a final report which will include the qualitative data. Your identity will remain anonymous in any study reports and the researcher's thesis. Your identity will similarly remain anonymous should the study lead to any future publications in any peer reviewed journals.

In addition, responsible members of Liverpool John Moores University may be given access to personal data for monitoring and/or audit of the study to ensure that the study is complying with applicable regulations.

When we do not need to use personal data, it will be deleted or identifiers will be removed. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). However, your consent form, contact details, audio recordings etc. will be retained for 5 years.

11. Limits to confidentiality

Please note that confidentiality may not be guaranteed; for example, due to the limited size of the participant sample, the position of the participant or information included in reports, participants might be indirectly identifiable in transcripts and reports. The investigator will work with the participant in an attempt to minimise and manage the potential for indirect identification of participants.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The investigator believes you are at serious risk of harm, either from yourself or others
- The investigator suspects a child or vulnerable adult may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism or money laundering

12. What will happen to the results of the study?

The investigator intends to publish the results in a PhD thesis, journal article and talk at academic conferences.

13. Who is organising and funding/commissioning the study?

This study is organised by Liverpool John Moores University and funded/commissioned by Liverpool John Moores University and Community Foundations for Lancashire and Merseyside and has no conflicts of interest.

14. Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19/NSP/064).

15. What if something goes wrong?

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The investigator should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

16. Data Protection Notice

Liverpool John Moores University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Liverpool John Moores University will process your personal data for the purpose of research. Research is a task that we perform in the public interest. Liverpool John Moores University will keep identifiable information about you for 5 years.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the study to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting ~~secretariat@ljmu.ac.uk~~.

If you are concerned about how your personal data is being processed, please contact LJMU in the first instance at ~~secretariat@ljmu.ac.uk. If you remain unsatisfied,~~ you may wish to contact the Information Commissioner's Office (ICO). Contact details, and details of data subject rights, are available on the ICO website at: https://ico.org.uk/for-organisations/data-protection-reform/overview-of-the-gdpr/individuals-rights/

17. Contact for further information

Laura Abbate

Tom Reilly Building
Byrom Street
Liverpool, L3 3AF
07852816226
L.G.Abbate@2019.ljmu.ac.uk

Thank you for reading this information sheet and for considering to take part in this study.

Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form

.**--**

PARTICIPANT INFORMATION SHEET

Commissioners & Commissioned Service Leads

LJMU's Research Ethics Committee Approval Reference: 19/NSP/064
YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

You are being invited to take part in a study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

1. Who will conduct the study?

<u>**Study Team**</u>
Principal Investigator: Laura Abbate, PhD student
Supervisors: Dr Pooja Saini, Dr Helen Poole, Dr Jennifer Chopra
School/Faculty within LJMU: School of Psychology

2. What is the purpose of the study?

The aim of this study is to evaluate the impact of suicide postvention services across England and Northern Ireland on the local services involved in suicide (Police, Coroner, GP, individuals delivering the services and public health officials) and individuals bereaved or affected by a suicide. In order to do this, we will be undertaking qualitative interviews with individuals who have direct experience of the services. The findings from the study will help us to evaluate the programme, identifying both the successful aspects and/or areas for improvement, from the perspective of those taking part. This may then contribute to improving the service for future recipients. The data collected will be compared and analysed to see how the experiences of the services differed across the England and Northern Ireland. This will then be compared to the policies outlined in the government's Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland.

This study hopes to answer the following question:

Are the current postvention services effective in preventing further suicides and improving well-being outcomes in those bereaved by suicide?

3. Why have I been invited to participate?

You have been invited to take part because we understand that you have had experiences of a suicide postvention service. It may be that you were contacted by the service itself and asked to contact the researcher if you would like to take part or you were contacted directly by the researcher.

The exclusion / inclusion criteria are you must have had direct experience of a suicide postvention service in England and Northern Ireland. In addition, you must be over 18 years old to take part.

4. Do I have to take part?

No. It is up to you to decide whether or not to take part. If you do decide to take part you will be given this information sheet to keep and be asked to sign a consent form.

5. What will happen to me if I take part?

We will talk you through the study procedures and give you the chance to ask any questions. The researcher, Laura Abbate, will contact you to arrange a convenient time to conduct a face-to- face interview, then a suitable venue can be arranged at Liverpool John Moores University or in your home. If face-to-face interviews are not possible, interviews can be conducted via skype or telephone at a convenient time for you. When interviews are conducted via telephone or skype, it would be preferable to do this in your home to ensure your privacy. You will be asked to attend one interview, lasting between one hour to an hour and a half. You can also bring someone to accompany you to the interview if you would like.

6. Will I be recorded and how will the recorded media be used?

Interviews will be audio recorded on a password protected audio recording device and as soon as possible the recording will be transferred to secure storage and deleted from the recording device. You are free to stop the recording at any time, take a break or terminate the interview.

7. What should I consider?

- Questions will focus on your experience of the suicide postvention service and how the service was commissioned, set up and is delivered to those bereaved by suicide ;
- You can stop the interview at any time, take a break or terminate the interview;
- The researcher will be contactable before and after the interview, should you have any questions about the study;
- The questions will ask your motivation for commissioning and setting up the service and if that is due to personal experiences, the researcher will not ask you to expand on this or answer this in any detail;
- Questions surrounding funding are included to ascertain how services are set up and delivered

8. Are there any possible disadvantages or risks from taking part?

There are no potential disadvantages to taking part in this study. You will however be required to give up some of your time for the interview to be conducted; this will be approximately one hour. Although the subject of our discussion is sensitive, this study is an evaluation of the service. The questions themselves will not focus on a bereavement but on your experience of commissioning and setting up a suicide bereavement service. You are free to decline answering any questions you do not wish to answer. The interview will be conducted through a face-to-face, skype or telephone interview and you are free to end the interview at any time without giving a reason. If you feel distressed, and require support following the interview, then please contact your GP to discuss further support, SOBS (Survivors of Bereavement by Suicide – 0330 111 5065) or Samaritans (116 123).

9. What are the possible benefits of taking part?

Whilst will be no direct benefits to you for taking part in the study, but it is hoped that this work will help us to develop a better understanding of the postvention services across England and Northern Ireland, how they work and the impact they are having. This may help inform the development of new services in other areas that do not currently have a suicide postvention service and give government bodies a better understanding of the impact these services have on those bereaved by suicide.

10. What will happen to the data provided and how will my taking part in this project be kept confidential?

The information you provide as part of the study is the **study data**. Any study data from which you can be identified (e.g. from identifiers such as your name, date of birth, audio recording etc.), is known as **personal data**. This includes more sensitive categories of personal data (**sensitive data**) such as your race; ethnic origin; politics; religion; trade union membership; genetics; biometrics (where used for ID purposes); health; sex life; or sexual orientation.

The voice recording from the interview will be listened to by the researcher and typed (transcribed) into a written version in order to conduct the qualitative analysis. At the time of transcribing, any identifiable personal or professional information provided by you in the interview will be removed. Anonymised interview transcripts will be kept on a secure, password protected computer, only accessible by the researcher. Your comments and any direct quotes will be combined with the responses from other participants to create a final report which will include the qualitative data. Your identity will remain anonymous in any study reports and the researcher's thesis. Your identity will similarly remain anonymous should the study lead to any future publications in any peer reviewed journals.

In addition, responsible members of Liverpool John Moores University may be given access to personal data for monitoring and/or audit of the study to ensure that the study is complying with applicable regulations.

When we do not need to use personal data, it will be deleted or identifiers will be removed. Personal data does not include data that cannot be identified to an individual (e.g. data collected anonymously or where identifiers have been removed). However, your consent form, contact details, audio recordings etc. will be retained for 5 years.

11. Limits to confidentiality

Please note that confidentiality may not be guaranteed; for example, due to the limited size of the participant sample, the position of the participant or information included in reports, participants might be indirectly identifiable in transcripts and reports. The investigator will work with the participant in an attempt to minimise and manage the potential for indirect identification of participants.

In certain exceptional circumstances where you or others may be at significant risk of harm, the investigator may need to report this to an appropriate authority. This would usually be discussed with you first. Examples of those exceptional circumstances when confidential information may have to be disclosed are:

- The investigator believes you are at serious risk of harm, either from yourself or others
- The investigator suspects a child or vulnerable adult may be at risk of harm
- You pose a serious risk of harm to, or threaten or abuse others
- Under a court order requiring the University to divulge information
- We are passed information relating to an act of terrorism or money laundering

12. What will happen to the results of the study?

The investigator intends to publish the results in a PhD thesis, journal article and talk at academic conferences.

13. Who is organising and funding/commissioning the study?

This study is organised by Liverpool John Moores University and funded/commissioned by Liverpool John Moores University and Community Foundations for Lancashire and Merseyside and has no conflicts of interest.

14. Who has reviewed this study?

This study has been reviewed by, and received ethics clearance through, the Liverpool John Moores University Research Ethics Committee (Reference number: 19/NSP/064)

15. What if something goes wrong?

If you have a concern about any aspect of this study, please contact the relevant investigator who will do their best to answer your query. The investigator should acknowledge your concern within 10 working days and give you an indication of how they intend to deal with it. If you wish to make a complaint, please contact the chair of the Liverpool John Moores University Research Ethics Committee (researchethics@ljmu.ac.uk) and your communication will be re-directed to an independent person as appropriate.

16. Data Protection Notice

Liverpool John Moores University is the sponsor for this study based in the United Kingdom. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. Liverpool John Moores University will process your personal data for the purpose of research. Research is a task that we perform in the public interest. Liverpool John Moores University will keep identifiable information about you for 5 years.

Your rights to access, change or move your information are limited, as we need to manage your information in specific ways in order for the study to be reliable and accurate. If you withdraw from the study, we will keep the information about you that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use your information by contacting ~~secretariat@ljmu.ac.uk~~.

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17. Contact for further information

Laura Abbate

Tom Reilly Building
Byrom Street
Liverpool, L3 3AF
07852816226
L.G.Abbate@2019.ljmu.ac.uk

Thank you for reading this information sheet and for considering to take part in this study.
Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form

PARTICIPANT INFORMATION SHEET

Key wider agencies & support workers

LJMU's Research Ethics Committee Approval Reference: 19/NSP/064

YOU WILL BE GIVEN A COPY OF THIS INFORMATION SHEET

Title of Study: A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

You are being invited to take part in a study. Before you decide it is important for you to understand why the study is being done and what participation will involve. Please take time to read the following information carefully and discuss it with others if you wish. Ask us if there is anything that is not clear or if you would like more information. Take time to decide whether or not you wish to take part. Thank you for taking the time to read this.

1. Who will conduct the study?

Study Team

Principal Investigator: Laura Abbate, PhD student

Supervisors: Dr Pooja Saini, Dr Helen Poole, Dr Jennifer Chopra

School/Faculty within LJMU: School of Psychology

2. What is the purpose of the study?

The aim of this study is to evaluate the impact of suicide postvention services across England and Northern Ireland on the local services involved in suicide (Police, Coroner, GP, individuals delivering the services and public health officials) and individuals bereaved or affected by a suicide. In order to do this, we will be undertaking qualitative interviews with individuals who have direct experience of the services. The findings from the study will help us to evaluate the programme, identifying both the successful aspects and/or areas for improvement, from the perspective of those taking part. This may then contribute to improving the service for future recipients. The data collected will be compared and analysed to see how the experiences of the services differed across the England and Northern Ireland. This will then be compared to the policies outlined in the government's Zero Suicide Policy to assess the overall service provision levels in England and Northern Ireland.

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8. Are there any possible disadvantages or risks from taking part?

There are no potential disadvantages to taking part in this study. You will however be required to give up some of your time for the interview to be conducted; this will be approximately one hour. You are free to decline answering any questions you do not wish to answer. The interview will be conducted through a face-to-face, skype or telephone interview and you are free to end the interview at any time without giving a reason. If you feel distressed, and require support following the interview, then please contact your GP for further support, SOBS (Survivors of Bereavement by Suicide – 0330 111 5065) or Samaritans (116 123). It may be appropriate to talk to your line manager or supervisor if any distress you are experiencing is related to your occupation.

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Laura Abbate

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Note: A copy of the participant information sheet should be retained by the participant with a copy of the signed consent form

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Appendix I

Participant Consent Form

LIVERPOOL JOHN MOORES UNIVERSITY CONSENT FORM

A feasibility study of the effectiveness and acceptability of postvention liaison services for individuals bereaved by suicide

Lead Researcher: Laura Abbate, School of Psychology

1. I confirm that I have read and understand the information provided for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and that this will not affect my legal rights. ☐
3. I understand that any personal information collected during the study will be anonymised and remain confidential ☐
4. I agree to take part in the above study, involving one interview ☐
5. I understand that the interview will be audio recorded and I am happy to proceed ☐
6. I understand that parts of our conversation may be used verbatim in future publications or presentations but that such quotes will be anonymised. ☐

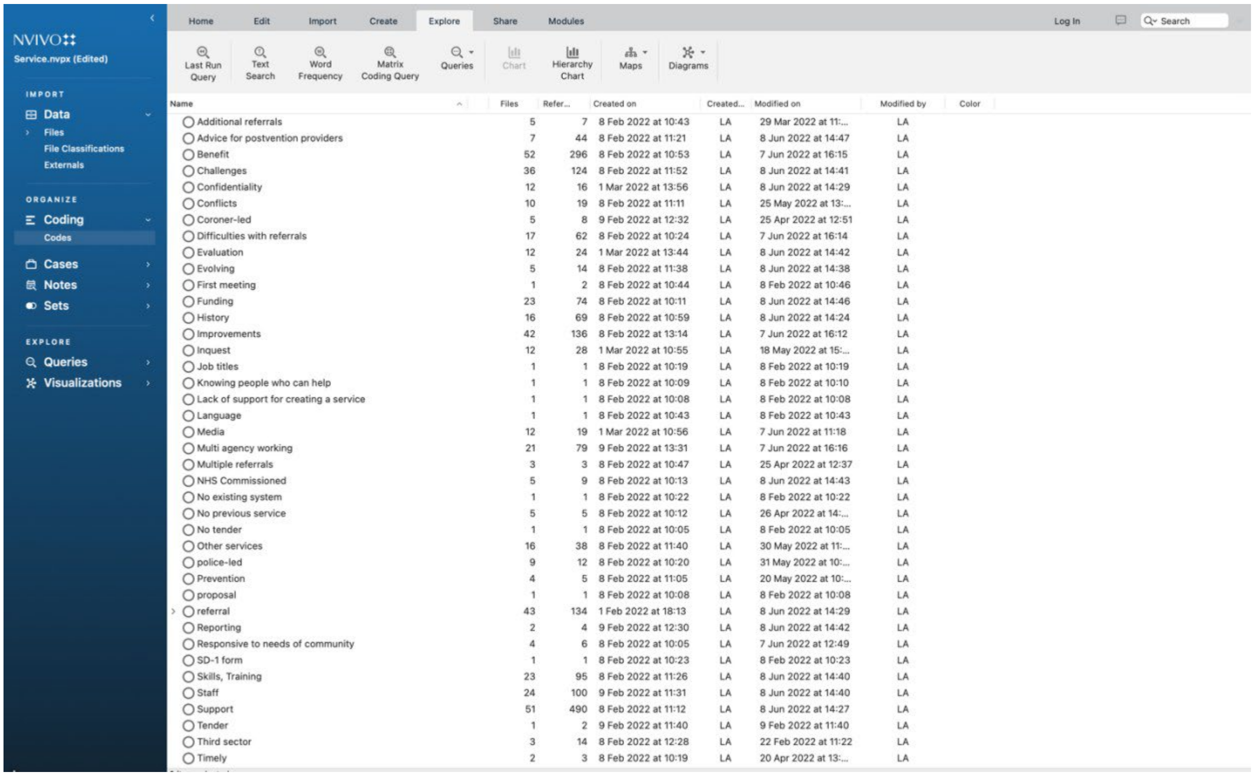
Name of Participant	Date	Signature
Name of Researcher	Date	Signature

Name of Person taking consent Date Signature

(if different from researcher)
Note: When completed 1 copy for participant and 1 copy for researcher

Appendix J

Analysis x Service



Name	Files	Refer...	Created on	Created...	Modified on	Modified by	Color
○ Additional referrals	5	7	8 Feb 2022 at 10:43	LA	29 Mar 2022 at 11:...	LA	
○ Advice for postvention providers	7	44	8 Feb 2022 at 11:21	LA	8 Jun 2022 at 14:47	LA	
○ Benefit	52	296	8 Feb 2022 at 10:53	LA	7 Jun 2022 at 16:15	LA	
○ Challenges	36	124	8 Feb 2022 at 11:52	LA	8 Jun 2022 at 14:41	LA	
○ Confidentiality	12	16	1 Mar 2022 at 13:56	LA	8 Jun 2022 at 14:29	LA	
○ Conflicts	10	19	8 Feb 2022 at 11:11	LA	25 May 2022 at 13:...	LA	
○ Coroner-led	5	8	9 Feb 2022 at 12:32	LA	25 Apr 2022 at 12:51	LA	
○ Difficulties with referrals	17	62	8 Feb 2022 at 10:24	LA	7 Jun 2022 at 16:14	LA	
○ Evaluation	12	24	1 Mar 2022 at 13:44	LA	8 Jun 2022 at 14:42	LA	
○ Evolving	5	14	8 Feb 2022 at 11:38	LA	8 Jun 2022 at 14:38	LA	
○ First meeting	1	2	8 Feb 2022 at 10:44	LA	8 Feb 2022 at 10:46	LA	
○ Funding	23	74	8 Feb 2022 at 10:11	LA	8 Jun 2022 at 14:46	LA	
○ History	16	69	8 Feb 2022 at 10:59	LA	8 Jun 2022 at 14:24	LA	
○ Improvements	42	136	8 Feb 2022 at 13:14	LA	7 Jun 2022 at 16:12	LA	
○ Inquest	12	28	1 Mar 2022 at 10:55	LA	18 May 2022 at 15:...	LA	
○ Job titles	1	1	8 Feb 2022 at 10:19	LA	8 Feb 2022 at 10:19	LA	
○ Knowing people who can help	1	1	8 Feb 2022 at 10:09	LA	8 Feb 2022 at 10:10	LA	
○ Lack of support for creating a service	1	1	8 Feb 2022 at 10:08	LA	8 Feb 2022 at 10:08	LA	
○ Language	1	1	8 Feb 2022 at 10:43	LA	8 Feb 2022 at 10:43	LA	
○ Media	12	19	1 Mar 2022 at 10:56	LA	7 Jun 2022 at 11:18	LA	
○ Multi agency working	21	79	9 Feb 2022 at 13:31	LA	7 Jun 2022 at 16:16	LA	
○ Multiple referrals	3	3	8 Feb 2022 at 10:47	LA	25 Apr 2022 at 12:37	LA	
○ NHS Commissioned	5	9	8 Feb 2022 at 10:13	LA	8 Jun 2022 at 14:43	LA	
○ No existing system	1	1	8 Feb 2022 at 10:22	LA	8 Feb 2022 at 10:22	LA	
○ No previous service	5	5	8 Feb 2022 at 10:12	LA	26 Apr 2022 at 14:...	LA	
○ No tender	1	1	8 Feb 2022 at 10:05	LA	8 Feb 2022 at 10:05	LA	
○ Other services	16	38	8 Feb 2022 at 11:40	LA	30 May 2022 at 11:...	LA	
○ police-led	9	12	8 Feb 2022 at 10:20	LA	31 May 2022 at 10:...	LA	
○ Prevention	4	5	8 Feb 2022 at 11:05	LA	20 May 2022 at 10:...	LA	
○ proposal	1	1	8 Feb 2022 at 10:08	LA	8 Feb 2022 at 10:08	LA	
› ○ referral	43	134	1 Feb 2022 at 18:13	LA	8 Jun 2022 at 14:29	LA	
○ Reporting	2	4	9 Feb 2022 at 12:30	LA	8 Jun 2022 at 14:42	LA	
○ Responsive to needs of community	4	6	8 Feb 2022 at 10:05	LA	7 Jun 2022 at 12:49	LA	
○ SD-1 form	1	1	8 Feb 2022 at 10:23	LA	8 Feb 2022 at 10:23	LA	
○ Skills, Training	23	95	8 Feb 2022 at 11:26	LA	8 Jun 2022 at 14:40	LA	
○ Staff	24	100	9 Feb 2022 at 11:31	LA	8 Jun 2022 at 14:40	LA	
○ Support	51	490	8 Feb 2022 at 11:12	LA	8 Jun 2022 at 14:27	LA	
○ Tender	1	2	9 Feb 2022 at 11:40	LA	9 Feb 2022 at 11:40	LA	
○ Third sector	3	14	8 Feb 2022 at 12:28	LA	22 Feb 2022 at 11:22	LA	
○ Timely	2	3	8 Feb 2022 at 10:19	LA	20 Apr 2022 at 13:...	LA	

Theme	Quotes

The Support	“Practical support, when we go out and do a first visit, we’re kind of, supporting them with what happens next. So we go out and we explain the processes and we explain who will be getting in touch with them and why they’ll be getting in touch. We’re a listening ear so they can talk about it and tell their story because a lot of the time, they can’t really be that honest, they can’t really explain to people in a lot of detail because they feel they can’t tell people because of the stigma that’s attached to suicide. We’re there for them to tell their story, explain how they are feeling. We then offer the practical support that goes with that but then we also risk assess so kind of talk to them about their wellbeing, how they have been in the past, whether they have any previous mental health history. We ask them about how they are feeling and if they are talking of low mood, we always ask them the questions around suicide so we ask them whether they have had any suicidal thoughts and ideation and then we match support to their needs. If they have a really strong support network then we kind of make sure people are aware of how they are feeling and encourage them to talk. If they haven’t, we look for professional support for them and then signpost them onto the relevant services for their needs. The whole point of our service is

	to very much make sure they have a support network around them to reduce that kind of isolation that does come with a suicide death" (SLO1, pg. 1, line 25 – pg. 2, line 9). "[Every life matters] phoned me, but with Covid and everything, well, at first they said we weren't allowed to go, but then they allowed me and my son to go. Obviously our local paper could phone in. Yes, he did, he supported me. I got a card off [them] when it was 12 months, just a 'Thinking of You' card off Every Life Matters and that. I thought, "Oh wow, how lovely is that?" I know it might just be a card, but it meant a lot to me" (B6, pg. 4, line 26-30). "people will say stuff to us that they can't necessarily say to their friends and family, particularly, you know, if there's been a difficult person whose passed away, there's going to be a lot of guilt there if there's been lots of things that have gone on but maybe they can't admit that or they can't admit that maybe the relationship wasn't so great to the family but they can to us" (SLO16, pg3, line 6-10). "And when I first lost my son, I couldn't even see how I was going to survive the next minute, looking back over a period of time and being unable to think actually, you know, IFUCARESHARE with me who helped with this, this and this, and I probably wouldn't have been able to do that if it wasn't for the support I was able to get. And I really do think the practical elements sometimes are just as important as the emotional elements in terms of having bought is just so important." (SLO17, pg. 8, line 25-30). "we're so bespoke, that's why it works because we tailor it to that person. We don't just say, this is Amparo, we've got these boxes to tick, and you must fit into these categories. We say, this is Amparo, what do

	you need from us?” (SLO16, pg. 8, line 15-17)
Referral Pathways	“We work really closely with the police, we have automated referral systems in place with every single of the police forces of the four areas that we are in… we accept referrals from every other professional, we accept self- referrals. We accept referrals for people that are just concerned about a friend. We accept referrals on social media. So, we are very mindful of what can we do to remove barriers in accessing our service.” (SLO15, pg. 6, line 12-27). “Initially it was through the coroner, discussions with the coroner because I was in contact with the coroner to talk about the death of [daughter], what was happening next and the coroner mentioned it during the conversation, whether we would be interested in being put

	in touch with Amparo. He didn’t really explain too much about Amparo was, it was just more that it was there to help people after a death and at the time, I probably wasn’t thinking very straight” (B1, pg. 1, line 9-14). “I think that's more to do with where the real time surveillance system sits. Where we get more police referrals, it's from a police led real time surveillance, where as if we're getting more from coroner's, it's generally coroner led real time surveillance. I think that's interesting point, because there's a number of different models of postvention, there's a number of different models of real time surveillance” (CEO1, pg. 2, line 23-27). “Well, they've got leaflets at GPs, at doctor's surgeries. And they connect with doctors, so a doctor will give a leaflet to someone. I mean, when the doctor came to see me, I was a wreck, and she offered us medication which I refused because, in my younger days, I had overreactions to medication, and I just said, "I'll battle on. I'll just try to get on with it." And then, I thought well I've refused that, so I don't know whether it was a week or a week and a half, that I rang If U Care Share, after that. So, they are being referred. They're so well- known in this area” (B8, pg.7, line 14-20).

Evaluation outcome measures	“We've looked at a range of measures and I think, you know, we pick them up and we’re like Oh my God, we can't use that. Oh my god. We can't use that. And it just, it just feels like a really difficult thing to measure. Anyway, we're gonna have to put something in place, because we need to start demonstrating some degree of impact. But actually, the impact is best demonstrated, I think, by testimonial from people we’ve supported, who are giving a kind of a narrative of their own experience. I mean, yes, we can demonstrate some really practical stuff, like helping people get engaged with services or getting them house or going through, you know, getting help them through the process of sort of investigations, etc. But, yeah, here's the narrative of how people have been helped, which is really most striking. But that's not really kind of like, yeah, robust.” (CEO6, pg. 6, line 18-26). “we give a percentage of the outcomes for the people who have worked within that area over that time period. This is what the outcomes have been and that support. So we’ve got better at doing that over the years. But we don't have sort of at the moment, a specific evaluation or feedback structure that we use. We are we did have back in 2018, an external evaluation done, which we paid for… So we're looking at some point to do another one of those to have an actual external evaluation done of the service. Just to keep that sort of updated really, that was back a couple years ago now. So we want to refresh that and look at it for the people who've engaged with the service since that evaluation.” (SLO17, pg. 16, line 33-pg. 17, line 8). “I don’t think we’ve had as many as we would have liked to be honest. Before I stopped, I started trying to do them during a closing visit but it was horrible because I was basically sat over somebody with an evaluation form, going “fill it out about me please”. Some people have

	been okay about that but other's haven't. We always give a stamped, addressed envelope and it's funny because people don't even, you know, you've got everything there, you quite literally just need to tick boxes and write a few words and yet they don't come back but that's perhaps, I wonder if that's because they feel like, they've had their closure visit, I now need to move on and I need to move forward and perhaps they don't want to sit there and… I don't know. You'd have to probably ring everybody who hasn't completed the form but you wouldn't know because they are anonymous!" (SLO16, pg. 8, line 22-31).

Funding	“So I think that the sustainability of investment is what is required. So, as I stated, the Director of Public Health have funded this but as public health funds have been cut, every time the service comes up for recommissioning, it will be whether public health will still be able to fund it. So as you may well be aware that NHS England has provided some additional money. But that money again is, is temporary” (Comms1, pg. 4, line 4-8). “But we try really hard to not let that be our only source of funding. So, we also apply for grants on a very regular basis, to look for particular opportunities to grow, expand and cover things that we are doing. We also provide training. So, we have a contract with Public Health England to provide suicide awareness training and that helps provide a little bit of funding to help keep everything that we are doing going. So, we work really hard to make sure we are not relying on any one particular source. So, that gives us a little bit of flexibility, but obviously if you take that leap of faith and hire someone, which we are actually going to hopefully do in January, you then do need to work hard to make sure that gets covered” (SLO10, pg. 9, line 4- 12). “The contract has remained the same sum of money that we were given in 2010. We’ve got a bit of a strange situation in Cornwall, where I had sat down with our managers, senior managers and accountant and actually put together a bid, because I had said that this is not sustainable to continue, I need, we need to have additional hours and we need to have flexibility to develop more support. And we were ready to go in and have a meeting on the 7th of January with the commissioners, to put in a bid for a bit more money when I was called to meeting and told that Outlook Southwest is now going to be taken over by the NHS, and we're going to become part of Cornwall Partnership trust, which manages all mental health services.

	So, all that's been put on hold. So right now, I don't know what's going to happen. So, hands tied right now, I'd hope to at least increase [Employee's] hours by April 1st but that's not going to happen by April 1st. And certainly, we're operating on a shoe strong. But you know that that is because of circumstances, now that it's become a mandatory provision under NHS England. Certainly, they will have to look at increasing the funding because it's just not sustainable to continue on the same amount of money that we were funded for in 2010. But it's a political situation so we'll just to have to wait and see. Probably, if you talk to me in a year's time, hopefully I'll have to say "no, we've got more money." (CEO4, pg. 6, line 8-23). "I don't know what's gonna happen the next the next two years of NHS funding, at the moment we don't know where the next lot will come from." (Comms1, pg. 4, line 14-15).
Cost-effectiveness	"I just hope that other areas, if they can get funding, if they, because they have to look at the bigger picture, they have to think about it, if they can prevent future suicides, then that in itself is a saving so they can't be looking at, oh it costs this amount, they need to think about

	the implications when people do take their own lives and the overall costs there so they do need to

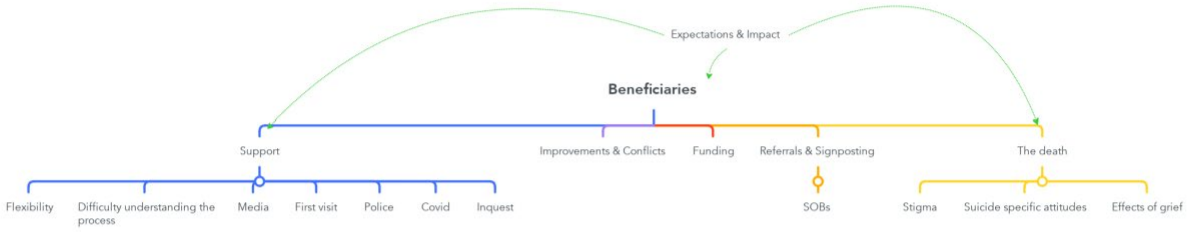
	look at the bigger picture and give Amparo an opportunity" (R1, pg. 9, line 5- 9). "I think, daily people are on bridges, threatening to take their own lives and the amount of resources that goes in to try and prevent that loss of life and the police and the other emergency services do a fantastic job, they really do but if we can prevent it, actually what you've just said, if we can prevent people from getting to that moment, where they are on a bridge, thinking about ending their life, there's a cost saving, in effect. The local authorities need to look at the bigger picture, really." (R1, pg. 9, line 16-21). "based upon the outcomes that are measurable and the outcomes that are qualitative is that, yes, they're cost-effective. They're cost-effective particularly when you look across the economy. So, it makes logical sense that they'd be very cost-effective across the whole health and social care economy, proving individual organisational cost-effectiveness. So, whether they're effective for the NHS, I think that's even harder still, though I still think it's probably true, but overall, absolutely, yes" (Comms3, pg. 7, line 6- 12).

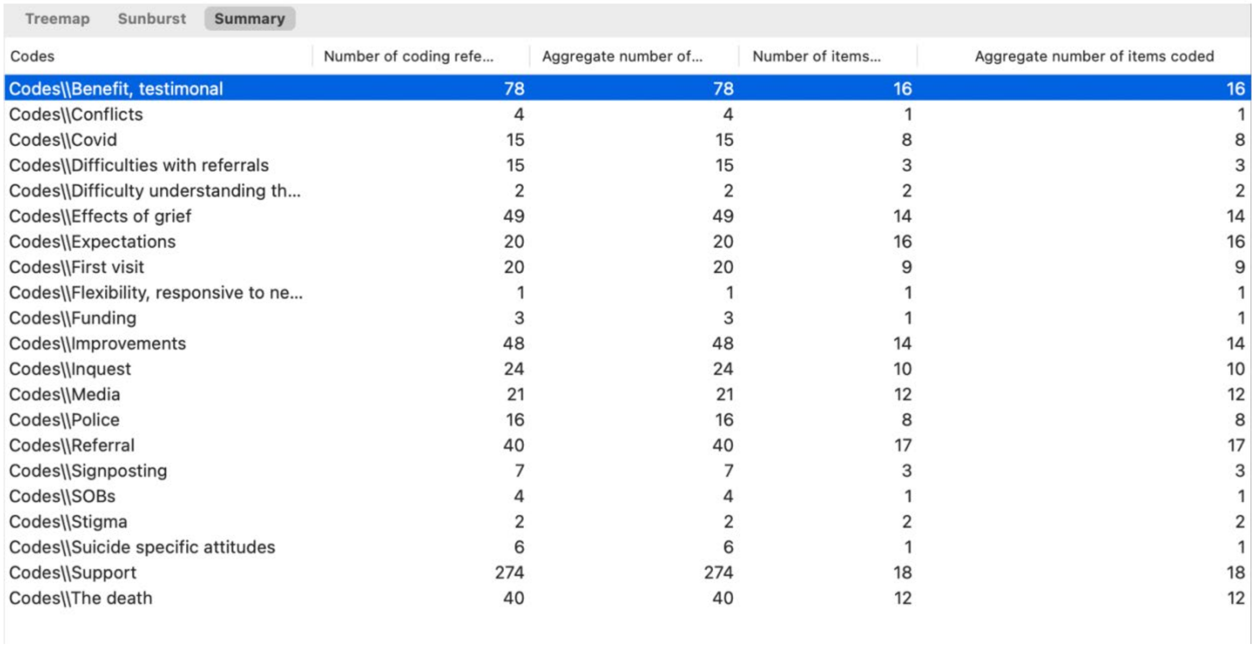
Challenges & improvements	“Anybody who's providing a service like this, and particularly if someone has died in use of the NHS, you have to be prepared for all those kinds of emotions. But once spending a period of time was the family, the anger dissipated towards me, the anger still remained towards the NHS, but you can see they were that it was starting to get across that my role wasn't there to defend the NHS, my role was to see how we could support them at this difficult time.” (CEO3, pg.4, line 26-31). “No, it was a bit. I suppose it was a bit disappointing at first, because they could only talk to me over the phone with the COVID thing. Nobody could come and see me” (B4, pg. 2, 8-9). “I think improvements could be made of anything, you know, regardless. I think the model we have is really good but it does perhaps needs expanding, tightening up in certain areas. There’s so much room for development. You could take it so far. I think one of the biggest ones is knowing who we are so things like the GP stuff that we’ve alluded to before this interview started. It is not through wont of trying and through wont of sending information in and phoning people and saying “we will come and talk to you about the service and we will send you all this information!” You still have people that say “no we don’t know who we are” (SLO16, pg. 12, line 31- pg. 13, line 6). “An area to be explored is whether the service needs to be offered at different times. So, in some way a potential negative effect is that when someone's immediately been bereaved, they may not be in the right place to understand what the service is or be referred into it.” (Comms1, pg. 3, line 29-32).

Appendix K

Analysis x Participant Group

Coding for beneficiaries





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Codes\\Conflicts	4	4	1	1
Codes\\Covid	15	15	8	8
Codes\\Difficulties with referrals	15	15	3	3
Codes\\Difficulty understanding th...	2	2	2	2
Codes\\Effects of grief	49	49	14	14
Codes\\Expectations	20	20	16	16
Codes\\First visit	20	20	9	9
Codes\\Flexibility, responsive to ne...	1	1	1	1
Codes\\Funding	3	3	1	1
Codes\\Improvements	48	48	14	14
Codes\\Inquest	24	24	10	10
Codes\\Media	21	21	12	12
Codes\\Police	16	16	8	8
Codes\\Referral	40	40	17	17
Codes\\Signposting	7	7	3	3
Codes\\SOBs	4	4	1	1
Codes\\Stigma	2	2	2	2
Codes\\Suicide specific attitudes	6	6	1	1
Codes\\Support	274	274	18	18
Codes\\The death	40	40	12	12

Theme & Subtheme	Quote
The Support	“Being able to sit and cry in front of them, as well. I held my tears back for the family. A lot of people didn't understand. A lot of people are frightened to speak to you. They don't want to upset you, but really, what you really are crying out for is people to listen. And to be able to- to be empathetic with you, which is hard for people to do sometimes. But knowing they were there was a big impact on me. I went every week, at first. And there was no timescale.” (B8, pg. 4, line 18-23).

	“It was the process with the whole coroners’ situation. I didn't have a clue. I didn't know. Nobody was really telling us. They gave us guidance. When they came on board, they took over a little bit and they were my link with the coroner. They started to help us with things that were going on with the coroner.” (B9, pg. 2, line 17-20).

	“Hopefully, things will improve for people in the future. But I found it hard with the COVID thing, I found it hard that I couldn't actually see people when I needed them face to face.” (B4, pg. 4, line 34-36). “One thing I have just thought of there, when you said about practical things, my mum has got really bad anxiety about driving. She only really drives very, very locally. And the aromatherapy massages are at If U Care Share. So, we used to try and arrange- The first appointment was in the office, and I drove. But the aromatherapies tend to be in the office as well. And they arranged it so it could be at a medical practice in our town, so my mum didn’t have to travel” (B10, pg. 11, line 1-6). “So they have a holiday home as well, in Exmouth, so we have had a few holidays down there actually. And whilst we were there, they offered - I don't know if I'm saying it right - Reiki massage? So they don't actually touch you, but it is absolutely amazing. They did some classes on- I can't remember what it's called now, but basically breathing exercises if you're feeling overwhelmed. And they gave you choices of being able to do these things. So yes, there are a lot of things that they do for you that cover, yes, physical, mental, everything” (B12, pg. 3, line 3-9).

	“Yes, they do. Yes, and they've helped me with the death of my daughter as well. When I go to see [PetesDragons], my counsellor, we don’t just talk about [husband's] suicide. It's my daughter who died of cancer at 44 years old as well, which was after my husband took his life. They're so supportive. They're so supportive in everything” (B13, pg. 2, line 31-34).
Conflicts & improvements	“I think that was the probably for us, suddenly we had a lot of support services which could have also been helpful to [daughter]. To find all those things after the fact is a little bit of a kick, really.” (B1, pg. 4, line 27-29). “Six weeks after is not good enough. I was fortunate enough to have heard about them before and self-refer, so I believe the biggest problem is that, when someone dies from suicide, your first involvement is normally with the police because it's normally the police that come to see you. At that point, I feel like there's not enough done by the police. Granted, the police just say, “There you are. This person has died. You’ll be in touch with the coroner,” so there wasn't enough information from the coroners’ service, and definitely there was no support from the police whatsoever. I'm not saying that the police have got to sit and counsel you, but my argument was that, if someone is murdered, then there

	would have been a… You would have been given a police liaison officer, but when someone dies from suicide, and until there's an inquest, you don't know whether or not there are any suspicious circumstances or anything. So, the point of call for these services to be involved should be immediately. It shouldn't be six weeks down the line or if you happen to know someone who knows about the service” (B9, pg. 6, line 34-46).
Funding	“The only thing, I mean I did feel for her a bit, when she originally came to us, there were 3 people doing the job, she said there were 3 [liaison workers] and unfortunately I think one of those left and she said she knew that nobody else would be employed and therefore, 3 peoples workload went onto 2 people and I just think, you know, it’s like any area of mental health, it has no funding anyway and you know, this is another area, she said that has a huge lack of funding which is so incredibly sad because it’s an incredibly supportive thing, you know, area. I wouldn’t say I would improve on her service because she was fantastic but I know she was very limited on her time because she was being stretched so far, it would be more helpful to have people in those areas, really” (B3, pg. 2, line 27- pg. 3, line 3).

Referrals	“I think it was a GP, and it was delivered here in Cornwall through an organisation called outlook Southwest... and the suicide liaison service was delivered through that vehicle. And I think it was the GP actually who said, from memory. Then I phoned up and self-referred by phone call to Outlook Southwest, who then responded by a specialist then phoning me back, well it didn't seem very long, you know, whether it was the same day or 24 or 48 hours, I can't remember” (B15, pg. 1, line 21-27). “I think it was almost a sort of whenever it's needed to, you know, did you realize there was a group, did you realize it was this, did you realize, you know, and did you want... I didn't... I actually felt I didn't need to do much else beyond that. I didn't feel the need to, to take, they weren't because obviously, I think they could be a really large I remember a comprehensive booklet. And that had lots of information in it. Lots of written down stuff, lots of other organizations as well. You know, from time to time, you know, they would ask were I interested in… to make a connection with them. And then, you know, the general bereavement charities and different ones and, you know, for help but to be honest, I felt that they kind of covered most things that I was needing them to at the time” (B15, pg. 6, line 22-30).

The death	“I think when you're in that kind of mindset, like you're still in shock, you can't quite believe what's happened, I don't know about other people, but it's just like a whirlwind. I had no expectations at all. They were there to help, and I think I saw them regularly for quite some time. Again, the first year, I'd say, is a blur for me. I didn't handle it very well. So, I wasn't really getting out of bed and seeing to my children. My sister had to come and live with me for a bit. So yes, I don't really remember much within like the first year.” (B12, pg. 2, line 8-13). “Because you are so dead inside, a little bit, aren’t you? You need to have something spelt out to you really. You don’t have to read too hard to find out what it is” (B1, pg. 4, line 13-14). “No, not really. Not that I can think of I mean, I did have in the early days, I did have issues with with flashbacks and images… So I had issues with blank walls. And it was in a particular room, there were two rooms that we had our interviews in when we were visiting when I was visiting and the way the chairs was that one of them I was facing a blank wall that had a round clock. And I just kept getting the image of my father in law's face in that clock. Because where he was when he was found, we had a closed white door behind him. And all I associate white walls with is that image. So we moved the room around, she took the clock off the wall. Because I've always you know, she said, You seem a little bit uncomfortable. You're not really giving me any eye contact. You're not you're not looking at me today because we were in a different room. And I said, I said I can't I said I'm so sorry. I just cannot look at their wall. And she got me to explain what you know why, what what the issue was and then as I say we moved the room around and the clock went down and wherever possible we didn't go in that room at all. I wouldn't say it was necessarily a negative on their part. It was sort of on my part, but they

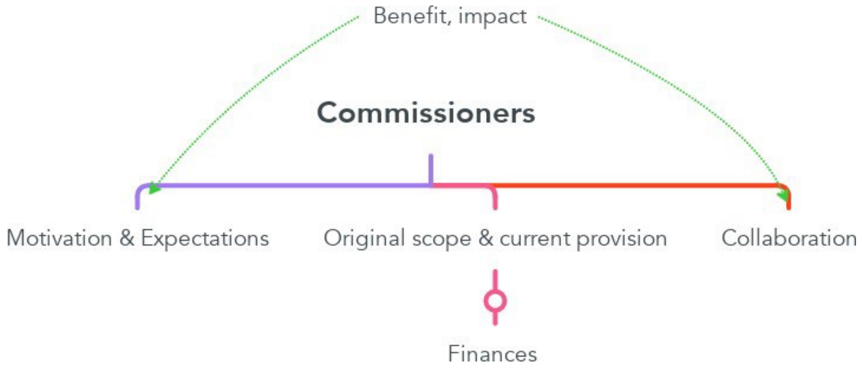
	facilitated putting it right" (B14, pg. 4, line 30-43).
Impact & Benefit	"It was absolutely crucial to me coping, absolutely, and I think it must have saved money in the end. I don't know how much it costs, but it must have saved money. Certainly, protected me and my physical and mental well-being and kept me from, you know, being a burden on the state and stuff in that way. As well, you know, because you know you are you are really, really vulnerable yourself at the time. So, I think having a service that was bespoke like that, is, is fantastic in some way, you know, you know, and hopefully part of it will also be looking at training to prevent people taking their own lives as well. And there it can't be in every circumstance because some people aren't even on the radar, you know, when it happened. You know, I'm sure that that suicide liaison service could also help, funded to be training professionals to assist as well, so maybe these things don't happen so often" (B15, pg. 8, line 16-25). "By giving us hope, by listening to us. Just being there. Letting us know that we weren't on our own, there was a future. And we were never rushed, we were never- There was no pressure. There was never, "Right, I need to see you again, I think you need to come back." It was all, "Right, we'll do this at your pace." We were just listened to. And I can remember- Like I say, the first appointment, we didn't know what to expect. We were let in and we were sat in this big room, the three of us, just waiting to be seen. And then the three support officers came in. And the first thing they did was come over to us and give us this massive hug. And I was just- I couldn't believe it. Because, like I say, I've had counselling before and it is vey clinical and you sort of get your hand shaken, don't you? And

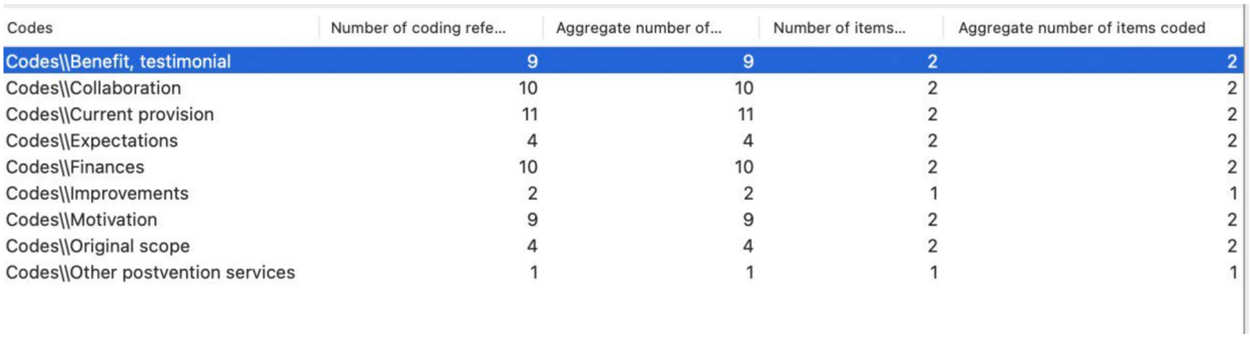
	you're sat down next to a box of tissues, and that's it. Do you know what I mean? This was very different. You felt like you were making friends or family. And just getting a hug of somebody, you knew straightaway that these people weren't just doing a nine to five job. When you were talking to them, you could see in their eyes that they understood. And that's what we needed, we wanted somebody to understand us and not judge us. And there were a lot of different circumstances around my dad's death, the lead-up to my dad's death. And there was a lot of gossip going around the town about what had happened and things, with him and my mum's marriage. And that was really difficult for us. So, although all our family and friends were really supportive, there was always this niggle in the back of our minds, thinking, "Yes, but what are they really thinking? What are they really thinking about my dad?" Whereas when we went there, we didn't get that, because they didn't know. And even if they did know, they had had a similar experience anyway. And they just understood. And that was just absolutely amazing for us" (B10, pg. 7, line 9- 32).

	"The main thing was understanding that I had. I didn't feel lonely anymore. I didn't feel lonely and I didn't feel that I had no- It was very hard, the first appointment. I was still off work at the time. It was really hard to see that I would have a life and that there was hope. But on the other hand, I had that, because I was sitting in front of somebody that

	was doing that, and that did have a life again. So yes, it was hope and it was understanding, and not feeling alone anymore.” (B10, pg. 9, line 7-12).

Coding for Commissioners





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Codes\\Collaboration	10	10	2	2
Codes\\Current provision	11	11	2	2
Codes\\Expectations	4	4	2	2
Codes\\Finances	10	10	2	2
Codes\\Improvements	2	2	1	1
Codes\\Motivation	9	9	2	2
Codes\\Original scope	4	4	2	2
Codes\\Other postvention services	1	1	1	1

Theme	Quotes

Original scope & Current provision	“As we’ve said, this is a service that’s rapidly grown, rapidly in relative terms. Rapidly grown, and we’re now pushing them to occupy this space with the real-time surveillance where they need to connect to lots of potentially big entities in the councils and public health, and they’re rising to that challenge, but I don’t think we should underestimate how big an ask that is to know what’s helpful to share with your public health colleagues. You know, that’s something commissioners take a long time to get our heads around. So, I think they’re rising to the challenge, but we don’t underestimate the challenge that we’ve put in front of them” (Comms3, pg. 6, line 27-34).

	“So I think that the sustainability of investment is what is required. So, as I stated, the Director of Public Health have funded this but as public health funds have been cut, every time the service comes up for recommissioning, it will be whether public health will still be able to fund it. So as you may well be aware that NHS England has provided some additional money. But that money again is, is temporary. So, as far as we know, Cheshire and Merseyside, will get some of that additionality for two years. So it's how both the NHS and public health maintain funding for suicide bereavement in the long run. Well, suicide bereavement and suicide prevention because overall suicide prevention is the responsibility of public health, it’s up to public health to coordinate it. Public Health doesn't get any specific funding for this. So it's a difficult position when everybody says it's a good idea. But actually, if there's no budget line stipulated, you're always in an uncertain position. I don’t think I can say anything more than that, because I don't know what's gonna happen the next the next two years of NHS funding, at the moment we don’t know where the next lot will come from” (Comms1, pg. 4, line 4- 15).

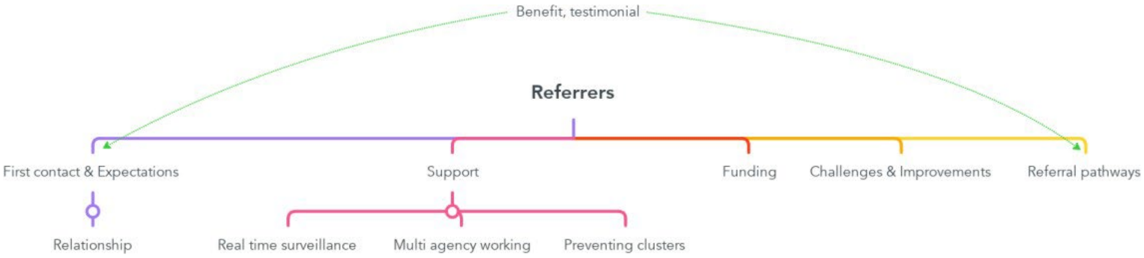
Collaboration	“inform both partners and local communities about the service” (Comms1, pg. 3, line 20). “Not only are they out there connecting with our local services, but they’re out there connecting with other bereavement services, trying to learn what they’re doing that’s better, and just trying to bring that home to Devon. So, I just don’t know what more you could ask of a provider” (Comms3, pg. 8, line 36-39). “Okay, so the people who looked at it were the public health suicide prevention lead. The police mental health lead. There was the coroner's. I can't remember who else. But what we actually did was get [name] over from Northern Ireland and talk to a group of partners. There were probably the probably about 12 or 15 partners in the room but I can’t remember who they were all were, but yeah, a range of local partners were interested in it” (Comms1, pg.1, line 38-42). “So when we put the case to the Director of Public Health, we were able to get eight of the nine directors of the nine localities in the area, eight of the nine agreed to fund the suicide liaison service” (Comms1, pg. 1, line 49-50).
Motivation & expectations	“Yes, I think it's necessary. When we first looked at the potential to commission, there were a number of different reasons that we identified. So, one was from a moral point of view, that those who have been bereaved by suicide should be able to access a support service. And then in terms of suicide prevention, we recognised that bereavement support is also preventative in itself. And then if you look at the economic argument, there's also a reason there so we approached it” (Comms1, pg. 1, line 18-23).

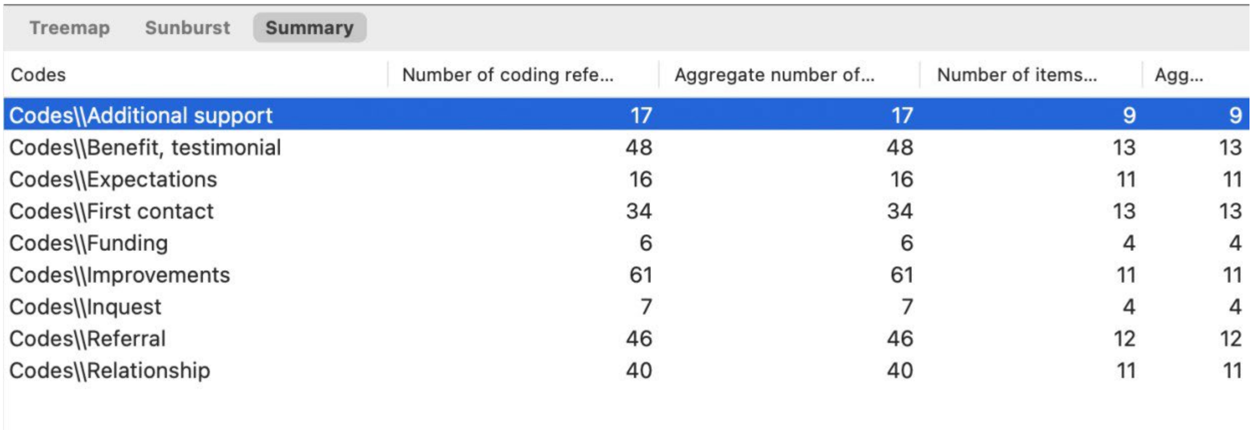
	"I think the service is clearly met expectations in how rapidly they respond to a referral and how the support the individual receives And the feedback is very positive from individual bereaved person. So I think that is all fine. I think that there could be more proactive work done by the service to ensure that key referral agencies have a very good understanding of the service. I think they could develop more communications that would actually support a wider range of agencies referring into them. And so, they do do some of this, you know, to ensure that GP's, other health professionals, members of the faith community, social work, there is a whole range of key workers that those bereaved may have some contact with. I think that the service has been more proactive than that" (Comms1, pg. 3, line 9-16). "I was just going to say, initially, I thought it was just a counselling service for somebody who's lost somebody to suicide. That actually isn't the service. It's much, much more than that. So, that was my initial thoughts" (Comms2, pg. 3, line 13-15).

Impact & Benefit	“It feels like as the commissioner I'm always having to push the service for creative ideas about how they can inform both partners and local communities about the service. So I don’t know whether it’s just this particular service or part of the being in the voluntary sector, but you could look and this is me, I'll just say this and I’ll stop going on. If, if you if you map where we have suicides in Cheshire and Merseyside, you could then do some thinking about well, this particular community over the last 10 years has seen so many, is there a different way in which we could engage with that community? So some of that happens, but a bit of a closer working in each area, I think, could enhance people's understanding of what the service is” (Comms1, pg. 3, line 19-26). “One standout positive is that one of the aims was that those bereaved themselves go on to consider suicide or take their lives. And as far as we know from internal audits that the coroner's have done, none of the beneficiaries of the service have taken their lives. And we, I think there's a statistic that we'd expect that 9% of those who take their lives have been bereaved. So, in terms of the aims of the service to prevent further suicides, its performing there, economically, again, performance you look at the cost of service against the cost of one suicide. Morally, it's supporting people at times of crisis.” (Comms1, pg. 3, line 34-40). “From my perspective, as a commissioner, it’s knowing that if the unthinkable has happened to someone, if they’ve lost a child or a parent through suicide, that they are not left without somewhere to go that is a safe pair of hands to support them. I know that sounds a bit wishy-washy, but we see the impact through the data. We value that, but for me, it’s knowing that that person is not left without support in a

	time that's unthinkable for most of us. So, I really value that confidence that we have that they're doing that job well" (Comms3, pg. 6, line 2-8).

Coding for Referrers





Codes	Number of coding refe...	Aggregate number of...	Number of items...	Agg...
Codes\\Additional support	17	17	9	9
Codes\\Benefit, testimonial	48	48	13	13
Codes\\Expectations	16	16	11	11
Codes\\First contact	34	34	13	13
Codes\\Funding	6	6	4	4
Codes\\Improvements	61	61	11	11
Codes\\Inquest	7	7	4	4
Codes\\Referral	46	46	12	12
Codes\\Relationship	40	40	11	11

Theme	Quotes

First contact & expectations	“I think it means that we’re not- We deal with a lot of dead bodies and a lot of bereaved families. So, for us, we’re not just dealing with numbers. We’re genuinely trying to make life better for people who have been bereaved by suicide. Whilst we have a certain amount of tact and expertise around the matters, we don’t have the time to pick up the pieces to help the family rebuild their lives. So, it’s offering that. It’s going that extra step to say, “Right, here are the tools to help you rebuild your lives,” which obviously we don’t have to do. Unfortunately, in our role, it is very factual. We investigate the incident, deal with it, done. But that doesn’t necessarily mean to say it closes the book for us. We need to know that the family are going to be okay. So, for us, by giving them that contact, we know that they’re going to have that care that they need after we’ve finished our intrusive investigation” (R8, pg. 2, line 9-19). “Reduce suicides, definitely. I think the principle is really, really good and I think, it seems to be working, we’ve not had, we did check if there’d been, all the people that had been referred to the service, they’ve not, as yet, gone on to take their own lives, which is a positive thing. Definitely suicide prevention and also, the coronial service, part of our role is to prevent future deaths so it does fit in with the coronial service as well” (R1, pg. 2, line 18-22).
	“I think really it's a recognition that people bereaved by suicide have very much at higher risk themselves of dying by suicide. And so by creating really strong links with that service, and ensuring that as many people as possible have the opportunity to link in with them, that we will reduce suicide rates within the county” (R10, pg. 2, line 1-3).

Referral	“Not on the very first time that the coroner’s officers speak to the family, because it’s always to arrange a post-mortem because inevitably with a suicide, there’s a post-mortem. So, I normally get my staff, once the post- mortem has happened and they speak back to the family, they then mention Amparo and ask if anybody would like to be referred and quite often it’s a no at that time because again, it’s probably only 2 days afterwards. We don’t get much take up then. But then during the sort of 8, 10, 12 weeks until it comes to inquest, if the officers speak the family, they will offer them the service.” (R2, pg. 2, line 8-17). “Our main contact is, so say we speak to a next of kin, we say there is a support service available, would you like us to refer you, they say yes, we will then fill a form in which I’ve not brought with me but we will in a form, we email it on and then Amparo, they reply saying “thanks, we’ve received this, we’ll make contact” and we very rarely have a lot of contact from them between that point and the inquest. Sometimes the next of kin may raise some concerns which will be within the remit of the inquest so the Amparo support worker will get in touch with us and say “Mum’s raised these concerns, can I let you know about them?” or whatever but otherwise, we probably wouldn’t have much contact with them” (R1, pg. 2, line 25-32). “So this is instead of waiting for a coroner’s verdict to come in, which can obviously be quite time-delayed, real-time alerts are where we start gathering the data on a much more real-time basis. Therefore, we can see the facts, see where the intervention needs to go in, and any developing trends and methods. And obviously, work with other organisations too, to try and best counteract that

	really. It's quite patchy nationally. Some areas are further on than others, with their real-time surveillance. We've been established in Cumbria for, I'd say, a couple of years or so, or coming up a couple of years. That's where we, as the Police, look at any suspected suicides that have come in and then they go out as an 'alert' to a set list of people. Obviously, when the coroner's verdict finally comes in, it may or may not be ruled as a suicide. But from the circumstances at the outset, it appears to be suspected suicide, therefore it goes on to help us. I can use it. So from that initial start, once Every Life Matters in Cumbria had more capability, we were then able to start working with them, so that as the suspected suicides came in, they were our main referral that we offer. It's almost a springboard into all the other local and national offers there can be. So yes, it came about as a working partnership that came together and it works really well" (R11, pg. 1, line 32- pg. 2, line 14).
Support	"Some of the things that cause the biggest stress for individuals is the property of their loved ones who have passed away. Now, when officers

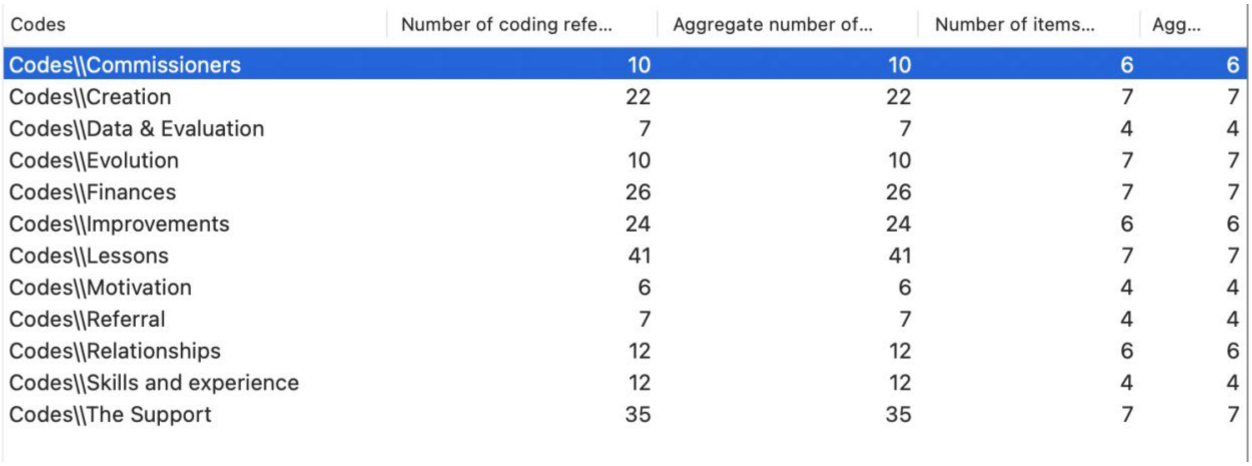
	go to the scene, they complete a coroner's report, they might seize some things for the coroner and book him into the police property store, a police station, but then they work on different shifts. So as far as they're concerned, all those they've done that job, they move on to the next job. And with them working shifts, it's really hard for relatives to get in touch with that person. So by having the relationship we have with Amparo and their staff know that they can come to me and say so and so needs keys for property, or they want they're asking about mobile phone or some piece of property, or can they have a copy of the note that was left? So we're able to work that out for them, due to that relationship we have if they just tried to contact the officer in the case, that that they would struggle because the officers are on night shifts or on days off, you know, they're constantly out responding to jobs, so it's really difficult for them to reach them. So by having a point of contact within the police service, it's really helpful. It helps to reduce some of the stress that people might feel about recovering a car belonging to a loved one or, you know, having access to property that's been seized" (R7, pg.5 line 49 – pg. 6, line 11). "It might be things like, let's say for example, even though the coroner's office will ask them "do you have any concerns with medical care?" for example, or care from the mental health services, or care from the GP service, at the time they might not think that they do but later on down on line, they might think, hang on a minute, I'm not happy with the GP at all. They might say it because there's somebody actually with them. They might think, "do you know what, we asked that GP 5 months ago, we said that, you know, John was feeling really low and the GP just palmed it off. We've forgot to tell the coroner's officer this!" So the Amparo

	support worker will then give us a call or drop us an email and say "by the way, Mum's mentioned this before, she didn't think of it before but she's mentioned this and it might be relevant to the inquest". Things like this." (R1, pg. 3, line 2-11). "That was only I think, through Pete's Dragon, been supporting members of that peer group, that they approached Pete's Dragon to say, well, there's been another death, which then came to me and then we obviously flagged it up through the appropriate channels" (R12, pg. 4, line 32-34).
Challenges & improvements	"No, not at the moment. As long as we can get the initial conversation, so I'm not so sure at the scene, I think that's too raw, too soon. The initial conversation with the coroner's officer so either before or after the postmortem. Sending these [leaflets] with the interim death certificates and then meeting them in person when we take statements because we don't see them at inquest, we probably wouldn't mention it again so I don't know, there's something there if the inquest clerk could do but by then they will

	have been asked a number of times.” (R1, pg. 8, line 29- 33). “I don’t like police officers asking at the scene, I think it could be too soon because they go to a scene, somebody appears to have taken their own life, you’ve got devastated family, they do have a form to fill in, they’ve got to fill in all the details, they’ve got to fill in the id section, is that the right time to then say “by the way, there are support services available?” they’ll still be in shock! They’ll still be in disbelief and to say, you know, there are support services for suspected suicide, I think it might be too much at that time.” (R1, pg. 3, line 19-25).
Funding	“Petes Dragons aren't able to pick up anyone that's outside the area defined to them. So if there were agencies that Petes Dragons could refer me to for the specific area that these people live in, that would be a great help. Because I don't have a directory, I mean, I'm just thinking I’ve got a family member, a lady committed suicide, two children one's in Plymouth, the daughter can access Pete's Dragons. But the son who's suffering the same bereavement lives in Bristol, he's asked for help. And we don't have any contacts in that area, other than Cruse who've got a really long waiting time. Having sort of a national directory, I suppose, would be really good” (R12, pg. 3, line 8-15). “The only improvements I would say could be made is to get more funding and more staff to do the amazing work they do, but that obviously isn’t a reflection on them. I think they do amazingly with the resources that they’ve got, and I always have every confidence

	when I refer into them.” (R11, pg. 3, line 27-30).
Benefit & impact	“From a coroner’s officer’s point of view, there’s slightly more work because we have to cover a lot when we speak to families so we are then covering that as well. That’s not a problem because it’s for the greater good, to prevent future suicides. I can’t say that we’re seeing a decline in suicide rates because we’re not, we’ve seen a slight increase but that increase may be even bigger if it wasn’t for Amparo but it’s so hard to measure that, it’s really really hard. All we do know is that for the people who have been referred and been in the service, they have then, as yet, touch wood, not taken their own lives which is a really positive indicator but it’s really really hard to measure” (R1, pg. 6, 20-27). “Yeah, it's really reassuring to know the people who, who are really, you know, really very vulnerable and very much in need of the support that the service can offer. And it's really great to know that we can support that. I think it just, it feels very reassuring to know that there's a professional service who will meet that need. Yeah, it's quite difficult to imagine a time when they went when they weren't now when there's not somebody there to support people at that, at that really vulnerable time.” (R10, pg.2, line 33-38).

Coding for Service CEOs



Codes	Number of coding refe...	Aggregate number of...	Number of items...	Agg...
Codes\\Commissioners	10	10	6	6
Codes\\Creation	22	22	7	7
Codes\\Data & Evaluation	7	7	4	4
Codes\\Evolution	10	10	7	7
Codes\\Finances	26	26	7	7
Codes\\Improvements	24	24	6	6
Codes\\Lessons	41	41	7	7
Codes\\Motivation	6	6	4	4
Codes\\Referral	7	7	4	4
Codes\\Relationships	12	12	6	6
Codes\\Skills and experience	12	12	4	4
Codes\\The Support	35	35	7	7

Theme	Quotes

The Service	“Quite quickly on, we became aware that it wasn't just next of kin, there were significant family members, and colleagues, and again, that we had to change lanes in order for it because we thought it'd be next to kin. So, we had to bring in that significant family member kind of category into the into the work that we did. We've also done, we wrote the original community response plan that didn't exist. So, we'll be doing much more community response plans. And what else have we been doing? Those are the main points that I think have changed the potential beneficiaries. But we get so few finder of the bodies it’s unbelievable, you know, that you always hear the story of man walking dog. We've never heard that story and then thinking reality or, and they’re not being made aware of the service for them. So, you know, if someone does come across the body, I imagine that's really quite traumatic. Because you know, finding someone that you know, their body, must be traumatic, but to be completely random” (CEO1, pg. 6, line 46- pg. 7, line 5). “And then once we've made contact, we offer a face to face appointment within seven days. And that's exactly the same across all of them. So I think the difference is you'll find is, is in certain areas, that there's a bit of an increased onus on the police to make referrals, for example. Whereas in other areas, it's more like coroner's. I think that's more to do with

	where the real time surveillance system sits. Where we get more police referrals, it's from a police led real time surveillance, where as if we're getting more from coroner's, it's generally coroner led real time surveillance. I think that's interesting point, because there's a number of different models of postvention, there's a number of different models of real time surveillance and I think I was talking to [SASP] last week before, saying it'd be really interesting to look at the data on the different approaches to real time surveillance, and then maybe look at a single model across the whole country. I think that's it you know, I'm not jumping the gun but I think the development that needs to happen is there needs to be a bit more of a continuity across the different areas of the country. They're all very different the services that are delivered you know, if you look at what Outlook Southwest its really quite different to what we do, which is really quite different to IFUCARESHARE up in the northeast, which is different to the tomorrow projects in the Midlands, I think it's it's okay, there's differences but there needs to be some some similarities. So they can be different types of services but their own standards for the service that are consistent across the different areas. And then you could also argue that needs to be a service in every area which still isn't the case. It's growing. We can see it growing. Not being most development in the last six months but I can imagine that's because Coronavirus. I think the only development at the moment is Scotland moving forward" (CEO1, pg. 2, line 15-39).

Finances	“I don't know what's going to happen. So, hands tied right now, I’d hope to at least increase [Employee’s] hours by April 1st but that’s not going to happen by April 1st. And certainly, we’re operating on a shoe strong. But you know that that is because of circumstances, now that it's become a mandatory provision under NHS England. Certainly, they will have to look at Increasing the funding because it's just not sustainable to continue on the same amount of money that we were funded for in 2010. But it’s a political situation so we’ll just to have to wait and see. Probably, if you talk to me in a year's time, hopefully I’ll have to say “no, we’ve got more money” (CEO4, pg. 6, line 16-23). “To run it across a wider footprint, yeah. I think it really does need that. It's happening slowly. But part, part of the problem is when the investment is coming from NHS England, it's expected that after the investment has happened, public health will pick it up. And I don't know if it's public health will have the budget to pick it up. So it's, it's, it's, that's a big thing, there might be this big investment. And then it could all drop off a cliff at the end, because all the funding could just stop. And that will be a real negative situation to go into, but after all the work that has been done to, to demonstrate that this is this is a nationally, this is a service that's required across the whole population. It gets the funding, and then public health to say no, we can't afford that anymore, that will be the real wasted opportunity.” (CEO1, pg. 7, line 31-39).
Challenges & Improvements	“When we brought in the introduction of CORE-10, my first thoughts about it were I was a bit nervous. I didn't think our beneficiaries were going to like this. It would make us much too clinical. We would feel like

	mental health services, and bearing in mind a lot of our beneficiaries have issues with mental health services because they feel they might have failed their loved one. So, we can't afford to feel NHS-y in any way. So, I was concerned about it, but we just developed a way of using it that was very relaxed. We don't read it out and all of that. We just hand it over on a clipboard, and we just ask them to tick, multiple choice, just tick the results. We take it back. We might use it to… If there's a concern on there, we'll just quickly scan it. Yes, if they're having suicidal thoughts, we will address that, but the chances are they're going to tell us anyway. We're very offhand about it. We don't make a big thing of it. I know in mental health services they will talk people through each and every question. It's quite intense, so I wanted to make sure that didn't happen. Our beneficiaries have adapted to that really quickly. They know they've got to do their clipboard sometimes, and they just do it and hand it back. Then it's forgotten about. They don't even ask the results, most of the time. They're not interested. But on a positive, personally, I've had some experiences where I've been trying to advocate for a young person that they may need some more specialist mental health, or that actually things at home are so bad that they, maybe, need to be removed from the house. By being able to back up what I'm saying with CORE-10 scores, I get results from the other agencies that I never got before. So, overwhelmingly, I think it's an absolute positive" (CEO7, pg. 8, line 17- 37). "So, the services is kind of funded by the lottery for five years. What we couldn't do, which became we kind of had an inkling might happen is we really struggled to recruit appropriate workers for the service. We've got quite a skill shortage in Cumbria. So, we've sat

	on the funding for about, probably about nine months before we actually recruited a kind of a permanent staff member.” (CEO6, pg. 2, line 18-22).
Referrals	“It's all around GDPR and data, to be honest. The police share that data with us, on the condition that we do not contact families ourselves. Actually, that's something that goes to the very… For me, even in the early days, I never wanted to be approaching the families before consent, before they gave their consent. Now, it was easy in the early days because, if they picked up the phone and rang us, that was them saying they wanted us. With referral, with the alerts coming in from the police, there are some people who still feel incredibly ashamed that their loved one might have taken their own life. Therefore, they would be horrified if someone rang and said, “I'm suicide bereavement support. Would you like our support?” because they do not want to accept that that happened. I would

	hate to think that we would ever increase someone's level of distress by doing that, so I’m quite happy with the way it works at the moment that they get to decide and choose. Then the police let us know” (CEO7, pg. 4, line 7-18). “Yeah, I mean, it's actually very, very much coroner led. And then a couple years ago, we were set a target to increase our referrals from non-coroner resources. And that's, that's worked really well, I think it's about informing the whole community of the services available. One of the things I've talked about previously is the kind of the timeline continuum. And if you think when someone's been bereaved by suicide, they're the first agency they come into contact is likely to be the police and or the ambulance service. And the next agency that will be in contact generally, again, may or may not but usually is the coroner then the next agency is usually some kind of mortuary, morgue type services, they need to go out there to get the body, etc, then it might be a funeral director. And then it might be Citizens Advice Bureau, for example. So what we need to do is ensure that every agency on that continuum is aware of our service. So then if they miss a first contact, then someone else is then saying, she needs support. And that offer is continually going, bare in mind what we were saying before about people forgetting conversations that they had at the beginning. So if they're offered the service, ie if they're offered the service by the police, at the beginning, and they say no, because they don't, they don't know, what they don't know. They don't know if they need the service or not, then that that referral could be lost forever. If we if we ensure

	that every agency knows that the service and is aware of how to make a referral in, and then that person won't be won't slip through a net, of them saying no, you know, no, I don't need the service when they had time to think and they say, actually I do" (CEO1, pg. 6, line 18-35).
Relationships	"I think ultimately, for us, the overwhelming experience with commissioners has been good, I think, overwhelmingly, but I think the biggest thing I would like to say to commissioners, and unfortunately this isn't even commissioners' fault, but that working such tight deadlines, with the uncertainty of where you're looking in the future, can be really, really difficult. We are chasing our tails quite often and delivering a service where we haven't had money yet. We're very much in that hard place and biggest rock because we're not going to say, "No" to somebody, but we also have a service that needs to be funded. So, I think, ideally, if I could blanket send the message out, it would be a system where there is that clarity and that security, but, unfortunately, I am realistic that the response to that is, "Unfortunately, it's above our heads." So, yes, I'm realistic with that, but yes, I think this is something for commissioners that should already be a priority. However, if it isn't, I would very much encourage that it is made a priority and that postvention is up there as a service that is offered to people within

	the area” (CEO2, pg. 7, line 39-49). “Yeah, really worth it because I think that, you know, that they really do need the support, that’s the feedback that we get, but it's, it's similar with prisons. We've been trying to get the service embedded into the, into the prison service for five years. It's just it's still a massive uphill push. And we're still not fully embedded in prisons, particularly in a place like Doncaster, but three or four prisons, I think. So it's certainly you know, how we make it happen over there. And then how do we use that model to go through the whole prison service? You know, that's a real gap at the minute.” (CEO1, pg.7 line 24-29).

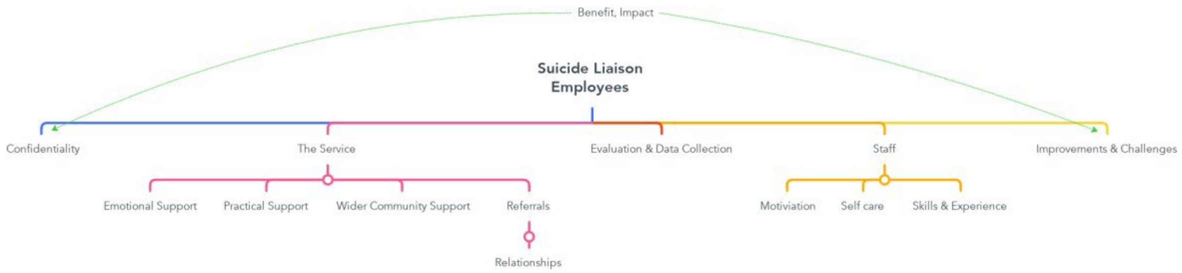
	"It's been variable, it depends on on the officers involved, we had a fantastic liaison officer out in the West Coast, very passionate about the work. And really keen to make sure the families got support. So she was our main referrer. The police in the north, it's been, we probably had half the amount of referrals, in the south will struggle to engage with the police, although we haven't had a worker in place until recently. So there's quite a bit of work in terms of building up relationships with the police and ensuring that they're making referrals. What we try to do, which we might go back to, is make referral automatic. So people are having to opt out rather than opt in. That's something we discussed to begin with, we might go back to the police and talk about kind of making those adjustments. And then when an officer does go to a family, there's an automatic referral to us. And actually, families are being asked to opt out of that. So at least they get one contact from us. So yeah, it's difficult with some officers to establish that relationship. We've got the best one we had was in the west she's she's actually been seconded now to go and do real time audits work, she'll be back in a year. So we've got a replacement now we need to work with so that's going to be really interesting in terms of how we develop a relationship with them, and whether that stream of referrals still come through. So we got I think we were getting referrals for around 65 to 70% of the next of kin in the west of the Coast, West Coast of Cumbria. And it would be around 30-35 north and probably that 10 in the south. So it's it's it's highly variable, the South will go up significantly now we've got the worker in place. So yeah, it's it's really about developing your relationship and helping them understand the nature of the service. Yeah, tricky" (CEO6, pg.8, line 3-20).

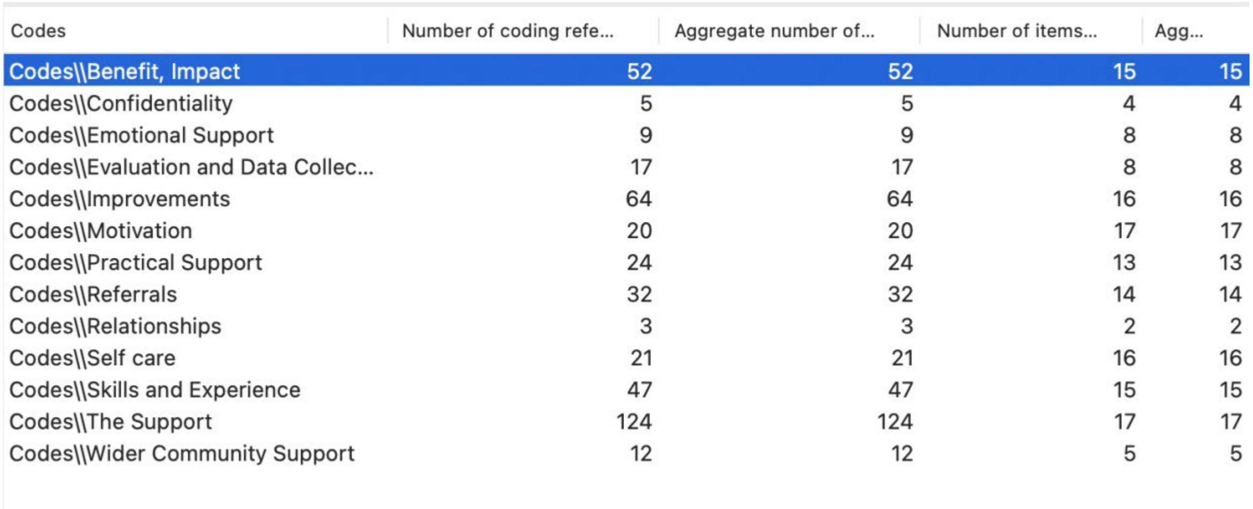
Skills & Experience	“Confidence, I think is number one and kind of belief in your ability to hold the ring in a situation, which is massively challenging. And if I'm honest with you, I think it's a skill that's actually quite hard to train, to teach. I think that having that self confidence, one of our facilitators who you might talk to… you'll know if you do, you know, tends to understate herself along the way, actually, she's very good. And, certainly to start with just having that self confidence. So I think number one is an element of self confidence. Number two, massively important is active listening skills. Resisting the temptation to do you know, the “Oh yeah, I've been there. I've experienced that” you don't need to because everybody's been bereaved. That's a given. So I think that active listening skills absolutely crucial, that's something you can train. I think the other or another key thing is accepting and understanding and internalising the fact that actually we're working with people, people who are by definition, how risk of suicide and having been bereaved. And you know, when we do lose someone to suicide from the group that actually we're not responsible for that. This is a self help process. people choose to opt in, they choose to opt out, they choose to engage, we are not responsible for that. So I think that's hugely important, because otherwise could be very, very damaging. I was really clear about that. But along with that, another really important thing is not doing or saying anything, which might actually be the wrong thing. I'll give an example, I'll get back to that first meeting we had in [town] and I'm 10 years on, 11 years on, I'm still acutely embarrassed about what I did. We ended up going around the

	group people saying who they were, and it ended up with people talking about their bereavements and their loss. And there was this group of 20 people, there's as I say, 15 of them have something to say. The other five all had something to say about how they could help everybody. But it was getting round towards the far end of the group. And I realised that there was some people there who have been bereaved who waited for ages to say something and had all this other stuff would be really, really pent up and het up. And I said, Oh, you know, this is starting to feel like sudden death. As I said it, a bit too late, I realised that actually, for people who have been bereaved by suicide, using that phrase, in that context, was actually probably the most unhelpful thing I could possibly have done, that stays with me to this day." (CEO5, pg. 3, line 19-44). "Yeah, we we have someone in mind and ideal kind of lead person, [name] probably is closest to it, so we're looking for someone. And they're really hard to find. We're looking for someone, ideally, who has some form of counselling or therapy experience, who understands the process of therapeutic relationships, process of grief. That's quite important, and someone who can sit comfortably with people in extreme distress. And that's challenging itself. So yes, someone who has a kind of a good grasp of therapeutic relationship and their self within that relationship, is able to manage their self. Ideally, we'd be looking for someone who has experience of bereavement by suicide themselves, although that's not critical, it's preferable. We'd also be looking for someone who has experience of other forms of multi agency working so that that ability to work with lots of other agencies around the care of an individual Yeah, and someone who is, is compassionate, and flexible, and willing to go the extra mile.

	You know, Paul got a referral on Tuesday for an individual and he is at their house on the Sunday morning, which is the first time they can see and that's the kind of the kind of commitment we're looking for things staff, obviously, we can't ask for that too much. But you know, we're looking for someone who really cares about the clients and cares about the work. So it's quite quite a mix. And those kind of people are really hard to get and they usually get paid tonnes more than we're offering as well. So yeah, it's a particularly a challenge. We don't, we don't pay a lot, we can't afford to pay a lot." (CEO6, pg. 9, line 1-16).

Coding for Suicide Liaison/Employees





Codes	Number of coding refe...	Aggregate number of...	Number of items...	Agg...
Codes\\Benefit, Impact	52	52	15	15
Codes\\Confidentiality	5	5	4	4
Codes\\Emotional Support	9	9	8	8
Codes\\Evaluation and Data Collec...	17	17	8	8
Codes\\Improvements	64	64	16	16
Codes\\Motivation	20	20	17	17
Codes\\Practical Support	24	24	13	13
Codes\\Referrals	32	32	14	14
Codes\\Relationships	3	3	2	2
Codes\\Self care	21	21	16	16
Codes\\Skills and Experience	47	47	15	15
Codes\\The Support	124	124	17	17
Codes\\Wider Community Support	12	12	5	5

Theme	Quotes

Confidentiality	“So, we try not to see the same family members, we will have different support workers take on different family members, if say it's a really big family, and that's just not doable, then we kind of work together to see which support workers should take on which clients you know, I’ve had it before where a couple didn't want to be seen by the same support worker. So, we basically said you know, okay, then we'll have to wait for another support worker comes available, while one is taken on which they're absolutely fine with.” (SLO14, pg. 3, line 37-42). “Yeah 100%. So that taps into consent, which is why I was asking you, are you asking about consent. So that is that is GDPR added at its best and worse, really. People that are bereaved by suicide are at an increased risk of suicide, therefore GDPR should not apply because this is a matter of public health, okay, we are not trying, not one service in the country doing what we do, no one is trying to sell anything. What we're trying to do is support the people that have been bereaved. And we are not forcing anyone to opt in to something that they don't want. They don't need, we just want them to know, okay. Now, if you trust a police officer, who is overworked,

	completely overwhelmed, again, COVID, for example. There's so many things that can go wrong at the time. Number one, they may forget to ask number two, they may only ask the person in front of them, and the person in front of them might be might think, Oh, this is only for me. It's not for the 20 people that I know that are really, really affected" (SLO15, pg. 7, line 5- 15). "Both, either, both. And we always try to tag team and we always try to have different practitioners with different people. But if we're only commissioned to have a really, really small amount of staff, and if we have a family of 17 referred in, it's really difficult, but we are a confidential service. We explain into great detail what exactly that means, we explain safeguarding to people. So people really need to have all the information so they are able to then make an informed decision. And if they are comfortable knowing that different people from the same family are being supported by the same practitioner, it shouldn't matter. This is a, it's up to us, the professionals to have the necessary mechanisms in place to ensure that we manage the situation well, so there will be constant supervision, everyone gets supervision, everyone gets caseload reviews, everyone gets client reviews, everyone gets a lot of support in place to make sure that we are looking after our staff well" (SLO15, pg. 7, line 45 - pg. 8 line 4).

The Service	“It's very much initially, it might be that practical support. So, it could be a sort of linking in with funeral directors explaining the process from the coroner, to the funeral to the inquest, what the inquest will be like, sort of a very much liaison as well. I know with some clients at the moment, I’m liaising with the police to pick up the belongings so they don't have to go and collect the belongings and then I will take them to them and drop them off. So, it's very much a practical side, but then there's also the emotional side. So, we provide a lot of emotional support whilst they're waiting for possibly counselling or waiting to decide whether that that is something that they want to do. And so yes, so it's very practical and emotional based” (SLO6, pg. 1, line 44-51). “So, our main core support... So, our goal really is just to come alongside people and enable them to grieve naturally as much as possible. We believe that although grieving feels unnatural, it is a natural process that we all have to journey and go through in these times. So, we mainly provide an opportunity to listen, to normalise what people are facing and give them some tips and advice about wellbeing or practical things around inquests, funerals and sorting things out. But generally just trying to provide somebody to go on that journey with them for as long as they need it. There is no limit to our service. But we also do have access to more specialised support. We have got a series of counsellors that we internally refer beneficiaries onto if they need a little bit more specialised support. We have got some services outside of us, some other therapies and interventions, like emotion-focused therapy, EFT, the grief recovery programme, prolonged grief disorder sessions that we can refer people on to if they are struggling in some of those more specific ways” (SLO10, pg. 2, line 35 - pg. 3, line 7).

Evaluation	“Well, again, that I think is something which is a little bit on the backburner in terms of setting up a service, but it’s something that we do want to focus on increasingly. So, at the moment, it's tended to be not that structured, although we want to make it more structured. It's tended to be where we've perhaps invited feedback from various individuals, which might be in relationship, for example, to where people have either offered freely their own particular feedback to us, when we've kind of asked them feedback. So, for example, in coinciding with World Suicide Prevention Day, there was a journalist who wants to do a piece on three remembrance events, and also wanted to contact somebody who had experienced our service to get their perspective, their lived experience on their bereavement, but also on the support they received from Every Life Matters. So again, we've kind of captured some of that, in terms of some of that feedback, as well, at different times, it’s something that we are kind of looking at, in terms of what's the most helpful way of trying to kind of gather feedback over time. We're interested, obviously, in terms of the kind of almost on the national level, what constitutes good, really, and obviously, there's a lot more now that that started to be available around that in terms of the kind of national suicide sort of postvention kind of networks that are out there. So, we'll certainly be looking at that. We've had discussions, for example, with IFUCARESHARE in terms of what they do, and a number of other kind of postvention services in terms of if you'd like some of those, you know, questionnaires or surveys or ways in which they've got feedback from people in terms of deliberative service. So certainly, work in progress. But we're very conscious of, of needing to do more.” (SLO12, pg. 7 line 34- pg. 8 line 9).

	“Yes, that is a bit of a mixture. We did have a feedback [form 0:20:22] that we went through at the end of our time with an individual and then we did not really think we were getting much from it. So, we are in the process of trying to recreate it and re-figure that out. We have some outcome measures with things like our contract with Devon CCG means we have to contact people within 72 hours of a referral. We set ourselves a goal of within 48 hours and have never missed that. So, everyone who refers in to us gets to have a phone conversation at least within 48 hours of making that referral in. Those sorts of things, and around the care that people receive and how quickly we respond, we monitor really tightly and make sure we are meeting those standards” (SLO10, pg. 7, line 3-9). “In the beginning, I found it quite difficult, because some of the questions are quite direct, but I do think it’s good practice. People, they’re used to being asked those sorts of questions. Yes. I think it’s good, you know, because there’s more outside funding and accountability. That progression, there needs to be evidence. So, I think it is good practice. Also, you know, it would highlight somebody at risk that maybe wasn’t presenting at risk until… because not everybody would offer that information. Yes. That’s something that would be picked up on a caseload call as a result of a CORE-10. So, yes, I suppose, in answer to your question, initially, I didn’t feel comfortable,

	but, you know, I realise the importance on quite a few level" (SLO11, pg. 5, line 38 – pg. 6, line 7).
Staff	"Well, all sorts of things. I think having- Obviously, besides the practical skills of being a very good listening, being a good communicator, being able to manage a very busy diary, being able to deal with highly emotive situations and individuals in distress, and being able to sit with all of those things. It is also about things like having some personal experience, I think is really helpful, so that level of empathy just goes that bit of a layer deeper. I think you need to be quite- Have that odd balance of being quite empathic and compassionate, but also mature enough to be able to have that separation where you are not taking all that stuff on yourself. Because it is not easy, hearing people talk about death all the time. It has a bit of a drain to it in itself, so I do think you need a little bit of maturity and a bit of- You need to be grounded. I think it is really important that people have good support networks. It is not the sort of job you can do if you do not have a good plan for your own wellbeing. So, I think somebody who is able to look after themselves and show how they do that consistently is really important. But even things like, for us, really important to have very decent IT skills, because of the way of all our reporting, admin and how we monitor everything. That stuff is essential for keeping beneficiaries safe. So, those are actually really important things too" (SLO10, pg. 7, line 27-42). "I mean, one of the current requirements, I guess, is kind of I guess is where you go from kind of essential to desirable, really. So certainly, I think one of the key things was to have experience in working with people in quite emotionally kind of challenged environments. So that might well be specifically some experience of bereavement or other

	kind of traumatic, particular events that people can experience. So to really begin to have a full understanding, obviously desirable, would, would be that if you've had some lived experience yourself, in some way, as well. So I think obviously, empathy is really, really important quality, to have good communication skills, good people skills, really, you know, the ability to be able to listen to reflect, I mean, in terms of obviously, understanding the grief process, and, and particularly permanent suicide, being able to sort of demonstrate, I guess, those required listening skills of being able to guide somebody, you know, through a process of beginning to understand their own emotions. So, yeah, I guess a background in that respect. So certainly, in terms of the people that have been recruited, a lot of the people on our team have, you know, exhibited high level, high kind of levels of communication and people skills over time and worked in a number of different settings, supporting people through something difficult. And so they bring to bear I guess, a lot of that kind of experience they've had in supporting people in that way. Yeah, commitment towards being very sort of person centred. You know, being non-judgmental, is really, really important. Taking people as they are. And being okay, I guess, with being able to tolerate, you know, very emotionally charged experiences, you know, being able to, if you like, be with the person, but also being able to look after yourself and, and maintain a certain amount of distance, where that's important for you to be able to kind of

	continue to do the job. When you come across, you know, the grief and the pain that people experience, it's really important to be able to look after yourself as well, you know, in that respect." (SLO12, pg. 9, line 23-pg. 10, line 2).
Improvements & Challenges	"I think it's just those boundaries sometimes. And, and obviously, you know, my staff are only available between nine and five, we're not a crisis service. And sometimes that crisis, support gets very, I would say, blurred, those lines get blurred. And often, like, for example, the client that might, a member of my team has turned the phone on, there's lots of sorts of really concerning messages from a client that was received over the weekend. Well, she wouldn't have had her phone on at the weekends. So, it's just sometimes, you know, we have to also remind people that, you know, we only work between these hours, and we aren't a crisis service. And, and, you know, there are the numbers, here are the numbers for those services. And I think sometimes that is, that's a struggle for clients, because we're developing a relationship with them." (SLO6, pg. 3, line 1-9). "Oh, yeah, I think it's something that's needed afterwards. And again, trauma focused, counsellor, it's very hard to get from, like a GP, or, its only specialist services, just trying to get people into these services. It's a problem and maybe it's something that Amparo as a group could offer, as most of the people who work for them are trained counsellors." (SLO5, pg. 4, line 7-10).