Postvention Support Service

Evidence Briefing Paper

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Version 1

Public Health Agency

HSC Public Health Agency

Contents

Introduction

When someone dies by suicide, those left behind have to deal with an overwhelming range of practical and emotional issues. Experiences of grief are unique, and each person who has been bereaved by suicide will be affected in their own way, even within the same family, as each had their own relationship with the person who has died, their own experiences of other losses and differing levels of support available. Many people can be affected and the pain of suicide loss can be felt by family, friends, colleagues or persons who have provided professional help and support prior to the death; it is important that each can access support and help needed

On 10th September 2019, the Department of Health published a new suicide prevention strategy for Northern Ireland, Protect Life 2(2019- 2024). It is a cross-departmental strategy with outcomes which will only be achieved through a co-ordinated response across government, statutory and community level.

The Strategy commits to *Ensure the provision of effective support for those who are exposed to suicide or suicidal behaviour; (*Objective 9) with a specific action to *"provide a consistent, compassionate approach to supporting those bereaved/affected by suicide, including family and social circle"*.

This firm commitment is a new action within the strategy and as such requires a new approach to supporting those that have been bereaved / affected by suicide.

The purpose of this paper presented the best evidence and the stakeholder engagement in relation to postvention services which took place in 2018 and 2021, and considers developments which have taken place during this time.

The PHA will use the learning from this paper to propose a model for bereavement support which aims to meet the needs of the people of Northern Ireland who have been bereaved / affected by suicide.

Postvention Support

Support after a suicide: A guide to providing local services (Public Health England, Oct 2016).

Postvention refers to the initiatives put in place to support those bereaved by suicide to avoid adverse outcomes and recover from their loss (Andriessen, 2009). The World Health Organization (2014) endorses postvention activity as an important element of suicide prevention strategies. The National Institute for Health and Care Excellence (NICE, 2018) guideline for '*Preventing suicide in community and custodial settings*' outlines that postvention support should offer sensitive, timely, effective and tailored support to those bereaved. The guidance also highlights the importance of providing training to help people who are supporting those bereaved by suicide.

The delivery of effective postvention support is dependent on the timely identification and referral of people who have been affected by suicide. Therefore, a strong interagency partnership is required to ensure timely access to support.

PHA service delivery

Current Services

PHA currently fund a range of post vention services however, there is inconsistency in service delivery across the region.

Current services include:

- Help is at hand support book. This provides practical guidance and emotional support following a sudden death that is a suspected suicide.
- Suicide support groups underpinned by peer support.
- Adult bereavement support service and therapeutic intervention some of which are delivered by Trusts and others within the community and voluntary sector.
- Children and young people bereavement support and family support service provided by the community and voluntary sector.

Progress Since 2018

Work to further develop postvention support services has been led by PHA since 2018 with contributions from stakeholders. There have also been a number of important developments during this time:

- Improvements to the SD1 Form
- Mental Health Strategy for Northern Ireland (2021 -2031)
- Development of training framework;
- Implementation of Recovery Colleges;
- Campaigns focused on raising awareness and de-stigmatising;
- Ongoing Surveillance of Suspected Suicides

Improvements to the SD1 Form

Based on stakeholder feedback in 2018, an evaluation of the SD1 process has been conducted with improvements made to the SD1 process including the introduction of a new SD1 form which ensures support is offered to *all* who have been affected by the death. Alongside this, a training video for PSNI on the SD1 process and bereavement support processes is now shared with all PSNI Officers and incorporated as a module in the Training Academy for new Cadets. Further, bereavement packs, which includes the Help is at Hand booklet, are provided to all PSNI Officers with the instruction to keep a supply in their patrol folders.

Mental Health Strategy for Northern Ireland (2021 -2031)

It is also important to note that there have been a number of additional reviews carried out at this time which will impact on services commissioned e.g. on the 29th June 2021 the Department for Health published a Mental Health Strategy for Northern Ireland (2021 -2031). The Strategy outlines three themes which underpin a vision of a society which promotes emotional wellbeing and positive mental health for everyone, which supports recovery and seeks to reduce stigma and mental health inequalities. The themes are:

1. Promoting mental wellbeing, resilience and good mental health across society
2. Providing the right support at the right time
3. New ways of working

There are clear links between the themes outlined within the strategy and the objective and actions within PL2 and as such this needs to be considered as we move towards services commissioned.

Development of training framework

The Public Health Agency (PHA) have worked with stakeholders to develop a Training Framework for Mental and Emotional Health and Wellbeing and Suicide Prevention (The Framework). The Framework is in line with the Protect Life 2 (PL2) Strategy to: *Reduce the suicide rate in Northern Ireland* and has been developed to provide guidance on the varying Tiers and types of training available in Northern Ireland to support knowledge and skills development.

The Framework provides a pathway through the Tiers of training and has been developed to encourage consistency across all Trust localities and appropriateness in skills and awareness development. The Framework will support community planning and other strategies and action plans on mental health, emotional wellbeing and suicide prevention. A separate commissioning process will be undertaken to ensure training programmes are available to meet outcomes within the framework.

Recovery colleges[1]

The Northern Ireland Recovery College provides free educational workshops to anyone who has an interest in their own Health and Well-Being. This may include Trust staff, individuals who use trust services, carers or anyone within the general public. Workshops are all delivered in community settings by experienced peer trainers (lived experience) alongside professional staff (learned experience).

[1] Recovery Colleges are not funded through PHA

Recovery Colleges assist individuals and family members/carers/friends develop awareness and an understanding in the care management of living with a specific mental illness. Recovery Colleges offer a range of courses which are open to all members of the public, over the age of 16, in each of the five Health and Social Care Trusts in Northern Ireland. Recovery College courses are designed and delivered by mental health specialists, carers and experts by experience. Courses included in the Recovery College directories have not (at the time of print) undertaken external evaluation.

Campaigns focussed on raising awareness and de-stigmatising

There have been a number of campaigns focussed on raising awareness and de-stigmatising. For example, the campaign: Holding On To Hope in a Changing World.

The PHA joined forces with Northern Ireland's six Health and Social Care Trusts, for the second year running, to create a campaign with the support of the Health and Social Care Board and community and voluntary organisations. A five-week social media campaign, HSC 'Holding On To Hope in a Changing World', linked World Suicide Prevention Day on Friday 10 September through to World Mental Health Day on 10 October.

The aim of the campaign was to help raise awareness of what we can do for ourselves and others to nurture hope in these challenging times. Some of the key elements of the campaign included a Hope Quiz and an Interactive Campaign Pack filled with resources and advice.

Depending on how people scored in the Hope Quiz, they were sign-posted to appropriate support, advice and external links within the Campaign Pack.

The resources were hosted on Minding Your Head website (MYH) and also linked to the COVID Wellbeing NI hub with 3,628 people having visited the Hope Quiz over five weeks and 2669 people visited the main Campaign Pack and 1568 people visited the mental health and suicide prevention training section.

Due to the interest in the section on challenging negative thinking, the campaign organisers arranged a free follow-up online webinar within one week of closing the campaign to build on momentum and interest. The webinar was entitled 'How to Challenge Negative Thinking – can we change the way we think?' and had 115 participants.

Campaign materials remain on the Minding Your Head website and follow-up social media posts with an email contact for people who were interested in future mental and emotional wellbeing webinars.

Ongoing Surveillance of Suspected Suicides

Official suicide statistics are not timely enough or detailed enough (due to potential disclosure issues) to pick up on important emerging trends to enable 'on the ground' intervention and support following a death that is a suspected suicide. However, The Police Service for Northern Ireland in partnership with the Public Health Agency and Health & Social Care Trusts operates an early warning system for monitoring suspected suicides at the time of a sudden death. This is used to offer and direct rapid support services to families of the bereaved and also to help give public authorities operational, early evidence of potential clusters of suicides. This process is an early indication of **suspected** suicides and not official statistics; therefore, no details are published from this source and it is not possible to report the proportion of these cases which are subsequently confirmed as suicide.

Involvement Process

The PHA started the process of engagement with stakeholders in 2018, prior to the publication of the PL2 strategy. A third-party organisation was commissioned to deliver stakeholder engagement events across Northern Ireland. During this process there were 12 public meetings held across the five Health and Social Care (HSC) Trust areas as well as a digital survey which could be completed as an alternative or for those who wanted to provide additional information.

In 2021 PHA developed an involvement process, outlining how it ensures those impacted by suicide had the opportunity to input to service development, the full plan can be found here.

The feedback from 2018 and the objectives outlined within the involvement plan have formed the foundation of the 2021 stakeholder engagement, with a focus on community-based pre and postvention services. It must be noted that whilst stakeholders were reminded to stay focussed to objectives 4.1 and 9.1 of the Protect Life 2 strategy, that due to the nature and scope of the subject, the conversation did span outside of these specific objectives.

This involvement process includes:

Pre-consultation:

Over 8 weeks, from15th February 2021 until 11 April 2021 there was an opportunity to reflect on feedback from previous involvements and consider what future models may look like. Consultation report can be found here.

Evidence paper:

This paper relates to step 2 and outlines feedback from the pre-consultation involvement as well as a summary of work that has taken place to date and other policy developments that may impact on any potential service which is developed. A proposal paper has also been developed which outlines the proposed model for future commissioned services.

Consultation period: Commencing (TBC)

The third phase will be development of formal consultation documents which will be made available for comment. These documents will be informed by the feedback from stage 1 & 2. These will outline the models of service in which the PHA intend to invest in.

Pre-Consultation: Analysis of feedback

Over an 8 week period, from 15th February 2021 until 11 April 2021, stakeholders had an opportunity to reflect on the feedback and recommendations from the 2018

Stakeholder Engagement and on progress since then to determine if these recommendations were still relevant and if further recommendations need to be considered. Participants were asked to identify support needs for those under 18 and over 18 in the immediate (first 3 months) , short term (3 months to 2 years) and longer term (over 2 years).

Full consultation report can be accessed here.

Stakeholder Feedback

The following table shows the themes and recommendations from both involvement processes and the action taken in response to these.

Themes Identified in 2018	Themes Identified in 2021	Response
Consideration given to the number of sessions offered in postvention support services Consistent high-quality service provision across the 5 Trusts, based on shared and best practice	• Timely Support/Reduced Waiting Times and Reducing Barriers to Services • Peer Support • Holistic Approach/Wraparound Service • Trauma Informed Practice/Evidence Based Practice	Themes reflected in the proposed model of support.
SD1 process to have an all-encompassing revision		A review of the SD1 process has taken place as outlined above. This process will continue to be monitored via SD1 oversight group.

Themes Identified in 2018	Themes Identified in 2021	Response
Improve awareness of services through improved communication strategy		**Objective 2** of the PL2 Strategy is to "Improve awareness of suicide prevention and associated services".
Ensure clarity regarding referral pathways and communicate these to key stakeholders and the wider community		Pathways are currently being reviewed as part of the review of crisis services which is an action included in the Mental Health Action plan.
Consistent training provided to medical staff		**Action 5.1 of PL2 strategy** is to establish a regional mental health collaborative across HSC Trusts using a Towards Zero Suicide approach and concepts for adult mental health to improve patient safety and to reduce levels of suicide. (***new action***) **Action 4.3 of PL2 strategy** Deliver a multi-sectoral training framework in suicide intervention for people working in the community (***new action***). **Action 7.2 of PL2 strategy** Develop and implement a regional training framework which will include suicide awareness and suicide intervention for HSC staff with a view to achieving 50% staff trained (concentrating on those working in primary care, emergency services, &

Themes Identified in 2018	Themes Identified in 2021	Response
		mental health / addiction services) by 2022. (***new action***) The Training Framework is now complete and PHA are commencing a process of commissioning.
Media monitoring and controls with a new focus to be placed on social media where possible		**Objective 3** of the PL2 Strategy is to "Enhance responsible media reporting on suicide".

Evidence Base

A systematic review by Andreiessen *et al.* (2019) identified suicide bereavement as a risk factor for adverse outcomes related to grief, social functioning, mental health and suicidal behaviour. Consequently, postvention has been identified as an important suicide prevention strategy (WHO, 2014).

Grief processes regardless of the cause of death can have an emotional and physical and behavioural response, however, those bereaved by suicide may experience greater shock or trauma (Jordan and McIntosh, 2011) and experience more feelings of abandonment, rejection or shame and have fewer social supports (Andriessen et al 2017: Pitman et al,2017). With suicide bereavement also being identified as a risk factor for adverse outcomes related to complicated grief (Mitchell et al,2004).

However, while there is some evidence of the effectiveness of general grief interventions, there is scant evidence of effectiveness of suicide grief interventions (Andreiessen *et al.* 2019).

Impact of Suicide Bereavement

Suicide can have wide ranging impacts on those who are bereaved and can impact individuals' physical, psychological and social lives. There is evidence that due to the intentional and often sudden nature of suicide, those bereaved experience greater shock and trauma than bereavement by other causes (Andriessen, et al., 2019a).The impacts include (but are not limited to) the following:

Physical:	Suicidal behaviour including attempts, non-suicidal self injury (NSSI), insomnia, poor appetite, low energy, and uncontrollable crying (McKinnon & Chonody, 2014; Pitman, Osborn, Rantell, & King, 2016)
Psychological:	Rumination, anger, guilt, difficulty finding meaning in life, feelings of rejection, sense of abandonment, stigma, shame, being held responsible for the death, feeling judgement by others, depression, anxiety, grief and complicated grief, suicide ideation, and psychological distress (Andriessen, et al., 2019a; Evans & Abrahamson, 2020; Gehrmann, Dixon, Visser, & Griffin, 2020; McKinnon & Chonody, 2014; Peters, Staines, Cunningham, & Ramjan, 2015; Pitman, Osborn, Rantell, & King, 2016; Shields, Kavanagh, & Russo, 2017)

Social:	Avoidance of and withdrawal from social situations/social isolation, feeling silenced, reduced social functioning, occupational dropout, and social anguish (Andriessen, et al., 2019a; Evans & Abrahamson, 2020; Pitman, Osborn, Rantell, & King, 2016; Shields, Kavanagh, & Russo, 2017; Trimble, Hannigan, & Gaffney, 2012)

Few studies have explored the differences between the impacts of bereavement following suicide compared to bereavement following other causes of death. However, Pitman et al. (2016) surveyed 3,432 young adults who had experienced a sudden bereavement since the age of 10 years. Experiences were compared for three groups: those bereaved by suicide, natural and unnatural causes. The impact of bereavement for suicide was similar to bereavement by unnatural causes for outcome measures of suicide attempt, suicidal ideation, NSSI, depression and occupational dropout. However, those bereaved by suicide experienced poorer social functioning following their bereavement. There were also differences between those bereaved by suicide and those who died by natural causes: suicide bereaved individuals were more likely to attempt suicide and had higher rates of occupational dropout. It should be noted that this study was cross-sectional and may have been biased by low response from males, selection bias due to recruitment via universities, recall bias etc. and important outcome variables were not included in the study (eg grief, substance misuse). Nonetheless, the findings highlight that suicide bereavement can be traumatic with adverse outcomes for individuals.

The experience of blame is one of the impacts of suicide bereavement that differs from grief resulting from other causes of death (Shields, Kavanagh, & Russo, 2017). In a systematic review of evidence spanning 2009 to 2019, Evans and Abrahamson (2009) identified 11 studies based on Western adult samples. Participants in the studies were mostly female, bereaved by a family member between 30 days and 35 years prior to taking part in the research. Findings indicated that those bereaved felt that others blamed them and held them responsible for the death. In addition to blame from others, bereaved individuals may also blame themselves for the death. One theory is that blame could be due to assumptions that those bereaved had missed some signs of suicidal thoughts and intentions. With it further presumed that if the signs had been recognised, the death would have been prevented (Evans & Abrahamson, 2020). Another possibility is that blaming others is anger displaced from the deceased to the bereaved person (Shields, Kavanagh, & Russo, 2017).

Regardless of whether blame is attributed to the self or others, a sense of blame can be pervasive and has a detrimental impact on those bereaved. Blame can have wide ranging social impacts on those bereaved including disengagement and lost contact with others. In social situations, avoidance of blame can leave those bereaved feeling silenced – prevented from talking about the deceased or their loss. This can

reduce the likelihood of disclosures by the bereaved individuals about their loss and social support available to them (Shields, Kavanagh, & Russo, 2017).

Shields et al. (2017) conducted a qualitative systematic review to explore the experiences of bereaved individuals with a view to describing the grief process. The early months following the bereavement are characterised by the adverse outcomes described above. This is a time of intense pain, distress and fear and is filled with anger and suffering. According to the authors, key elements of the grief process are coping with emotional pain, finding new purpose and meaning in life, and continuing a positive bond with the deceased. While this is a complex process, if these elements are achieved, positive growth is possible. If individuals are unable to navigate this process, it is possible that they will develop complicated grief.

Complicated grief has been likened to post-traumatic stress disorder (PTSD) with similar symptoms including anger, guilt, avoidance of situation, having difficulty finding meaning in life, intense rumination (Andriessen, et al., 2019a). Complicated grief goes beyond normal grief processes as people become 'stuck' in their grief and this has a significant impact on their daily functioning and prevents them from returning to the same levels of functioning and wellbeing experienced prior to the death (Peters, Staines, Cunningham, & Ramjan, 2015). The DSM criteria for complicated grief must be met for a minimum of six months (McDaid, Trowman, Golder, Hawton, & Sowden, 2008). However, Ali (2015) cautions against incorrectly labelling someone as having complicated grief as this is a mental disorder and the labelling of such may further marginalise individuals who may already feel marginalised as a result of the bereavement.

Whilst the academic research has focused on the adverse impacts of suicide bereavement, evidence is starting to emerge that personal growth (also referred to as positive growth or post-traumatic growth) can occur following the death (Andriessen, Krysinska, Kolves, & Reavely, 2019b). Personal growth involves gaining a greater sense of self-awareness and sense of self, greater self-confidence, building a desire to get the most out of life, and greater empathy towards others (Shields, Kavanagh, & Russo, 2017; Ali, 2015). A recent systematic review (including 11 studies published between 2009 and 2018 concluded that personal growth is possible after suicide bereavement (Levi-Belz, Krysinska, & Andriessen, 2021). The likelihood of personal growth will be impacted by various factors including resilience, coping strategies, severity of grief, and levels of disclosure and social support.

Despite the lack of evidence of effective postvention and the experiences of suicide survivors remain under researched, both NICE (NICE, 2018) and the recent report From Grief to Hope: The Collective Voice of those Bereaved or Affected by Suicide in the UK (McDonnell S, 2020) have outlined the necessary elements of what a postvention service should entail.

Children and young people

Like adults, children and young people are bereaved by suicide and the impact on them can be similar to that of adults. There is evidence that suicide clusters most commonly occur among those under 25 years old (Cox, Robinson, Williamson, & Lockley, 2012). Suicide clusters refers to a number of deaths and/or suicidal behaviour that occurs temporally or geographically close to another suicide, or where other similarities are thought to occur that connects the behaviour in some way (Niedzwiedz, Haw, Hawton, & Platt, 2014). It is thought that suicide clusters may result from a contagion effect whereby exposure to suicide may normalise the behaviour (Cox, Robinson, Williamson, & Lockley, 2012).

Furthermore, Andriessen et al. (2017) concluded following a systematic review of evidence that the impact of suicide bereavement for adolescents includes guilt, blame, anger, shame, rejection, stigma, relief, gratitude in living, depression, anxiety, PTSD, substance abuse, increasing smoking, drug and alcohol misuse, fighting, and social adjustment problems. The authors noted that, unlike adult populations, social support among adolescents following suicide bereavement may contribute to intensified co-rumination, thereby preventing recovery. Findings were mixed with regard to increased suicidal behaviour and appeared to be influenced by research study design with increased suicidal behaviour observed in cross-sectional studies but not studies that included control groups. While firm conclusions are limited by a lack of research regarding this issue (Andriessen, Dudley, Draper, & Mitchell, 2017), this highlights that suicide bereavement can increase the risk of imitation behaviour among this cohort.

Schuurman (2003) reported that bereaved children are more likely than other children to experience higher levels of reactions depression; an increase in health problems and accidents; poorer school performance, more anxiety and fear; lower self-esteem; a destructive belief that all events in their lives are beyond their control, and less optimism about succeeding in later life. More recently Fauth et al (2009) reported that bereaved children are one and a half times more likely than other children to be diagnosed with a “mental disorder”.

Winston’s Wish (2020) refer to bereavement by suicide as “Grief with the volume turned up”. They report that a death through suicide delivers a double blow to families – not only do they have to cope with a sudden and often unexpected death, but they also have to deal with the way their relative has died. We know that death through suicide creates a greater sense of isolation for the mourners. Reports over the last few years suggest that friends and relatives of people who die by suicide have a 1 in 10 risk of making a suicide attempt after their loss.

The Economic Cost of Suicide

People bereaved by sudden death of a close friend or family member are estimated to be 65% more likely to attempt suicide if the deceased died by suicide than if they died by natural causes (*Pitman et al. 2014*). This equates to a 1 in 10 risk of a suicide attempt. Significantly, a prior suicide attempt is the single most important risk factor for suicide in the general population (WHO, 2014). Furthermore, the economic burden of suicide is profound and has far reaching implications for individuals, family, friends, the healthcare sector, employers and government. Despite the abundance of research in the area of suicide, few studies have considered the economic burden (McDaid et al. 2016), however it is suggested that the cost of each suicide is around £1.67 million (2009 prices), with 70% of that figure representing the emotional impact on relatives Platt et al (2006)[2].

Postvention support

Postvention support is an umbrella term for a range of services and supports that can help following suicide bereavement. There is consensus that one-size-fits-all approaches are not effective and support should be tailored dependent on individuals' needs (Ali, 2015; World Health Organization, 2014). Postvention support may be most critical in the first year following the bereavement (Levi-Belz, Krysinska, & Andriessen, 2021). Types of supports may include community response plans, psychoeducation, crisis counselling, individual and group counselling, journal writing, mentoring, responsible media reporting, helplines, support groups and health recovery promotion (Andriessen, 2009; Andriessen, Krysinska, Kolves, & Reavely, 2019b; Cox, Robinson, Williamson, & Lockley, 2012; Rawlinson, Schiff, & Barlow, 2009). Although there is a wide range of services described in the academic literature, robust evaluation has been lacking which means we do not have clear understanding of the effectiveness of these services.

Not everyone who is bereaved by suicide will want or need postvention support. However, for those who do want or need support, there is consensus that different types of support may be required at various stages of the bereavement process (McKinnon & Chonody, 2014). In the immediate aftermath of the death, support from family, friends and the community is at its highest and during this period, practical support may be all that is required (Trimble, Hannigan, & Gaffney, 2012). As this support wanes, other formal supports may be helpful. Trimble et al. (2012) suggest that support should allow for emotional expression and should help to contextualise and normalise the bereavement experience.

[2] Cost of illness studies consider economic costs under the three broad headings of direct costs, indirect costs and intangible / human costs.

The World Health Organization (2014) recommends that surveillance to identify individuals bereaved by suicide and outreach may raise awareness of available support and promote help-seeking (Szumilas & Kutcher, 2011). Known barriers to seeking support include fear of judgement, stigma, lack of knowledge and/or energy about what support exists and how to access it, previous disappointing experiences of similar types of support for other purposes (Andriessen, Dudley, Draper, & Mitchell, 2017; Trimble, Hannigan, & Gaffney, 2012).

Effectiveness of interventions

It is difficult to know what types of postvention support work best, who they work best for, in what circumstances or for how long. This is due to the lack of robust evaluation of postvention initiatives and the variability within available evidence relating to interventions investigated, target populations, and methodological issues (whether studies were controlled or not, sampling strategies, inconsistency across studies for measurement tools and outcomes).

Overall, the evidence is mixed across studies. Systematic reviews have indicated that postvention can help improve anxiety (Andriessen, et al., 2019a; Szumilas & Kutcher, 2011; McDaid, Trowman, Golder, Hawton, & Sowden, 2008), social acceptance (Andriessen, et al., 2019a) and self-blame (McDaid, Trowman, Golder, Hawton, & Sowden, 2008). Findings were more mixed for improvements in social adjustment and depression (Andriessen, et al., 2019a; Szumilas & Kutcher, 2011; McDaid, Trowman, Golder, Hawton, & Sowden, 2008), complicated grief (Andriessen, Krysinska, Kolves, & Reavely, 2019b; McDaid, Trowman, Golder, Hawton, & Sowden, 2008), and suicide ideation (Andriessen, et al., 2019a). In terms of interventions, family-based therapy and complicated grief therapy have been indicated as showing promise in helping to alleviate grief symptoms and training has been effective to support postvention efforts (Andriessen, et al., 2019a; Szumilas & Kutcher, 2011).

There is also evidence of risks that can be associated with postvention, highlighting the importance of careful consideration of how postvention is implemented. For instance, Panesar et al. (2022) cautioned that while families can be a protective factor against suicidality, they can also present as a risk factor. Szumilas and Kutcher (2011) also identified risks associated with whole-school approaches to postvention. One study in their systematic review recorded negative associations between postvention support delivered to the whole school; two deaths, six hospitalisations and 30 suicide attempts were recorded subsequent to postvention. The potential risks for postvention highlight that approaches should be tailored to individual need.

McKinnon and Chonody (2014) argue that the benefits of postvention may take 3-4 years for individuals to regain psychological strength and find meaning in life. They

estimate that even after five years, levels of trauma and distress may be much higher than reported by others. Nonetheless, the authors argue that support can help individuals develop adaptive coping skills which Shields et al. viewed as an important component of recovery and personal growth.

Evidence of effectiveness of postvention is hampered by a lack of research in this area. One explanation may be the concern for protecting research participants as ethics committees may view this population as particularly vulnerable (Ali, 2015). However, individuals who are bereaved are in the best place to help inform the future direction of support. Provided that ethical considerations are collaborated on and carefully considered with additional supports provided, further research is needed to further understanding of what works best in postvention.

NICE (2018) outlines findings from an 'evidence review for interventions to support people bereaved or affected by a suspected suicide'. The aim of this review was to examine interventions which could be delivered in community settings to provide support for people bereaved by suicide and to encourage them to seek help. This may include:

- providing information about grief and bereavement by suicide (leaflets, verbal info, social media)
- giving information about bereavement support services (sign-posting)
- community or peer support.

Following this review NICE (2018) made the following recommendations:

NICE Guidance Recommendations

- Those bereaved by suicide should be automatically given the 'Help is at Hand' resource published by PHE, during the early stages of their loss (cost £0.67p) (PHE, 2015);
- Parents of young children should be automatically given 'Beyond the Rough Rock: Supporting Children Bereaved by Suicide' as this provides practical advice for families, when they are immediately informed of the death etc. (cost: £5.99) (Winston's Wish, 2011);
- Parents of young children/young adults should receive immediate guidance on what to tell their bereaved children;
- GPs should have access to a comprehensive and up-to-date list of local and national support for those bereaved or affected by suicide;
- GPs should attend evidence-based suicide bereavement training, to help increase their confidence dealing with this vulnerable population;
- NHS Commissioners should provide specialist suicide bereavement support via the NHS or third sector; and
- GPs need better support (i.e. practical and emotional) to enable them to care more effectively for those bereaved by suicide.

From Grief to Hope: The Collective Voice of Those Bereaved or Affected by Suicide in the UK:

The report outlined that the following components were necessary elements of a postvention bereavement service:

A co-ordinated, proactive response with regular follow up to reduce feelings of isolation

- Signposting to resources and services
- Tailored help and personalised support
    - Individuals needs vary as to the support required and there is no one size fits all solution to supporting those bereaved by suicide.
        - Timely access to counselling services
        - Face to face (practical and emotional) support
        - Support for communities .(Localities / workplaces / Schools)
- Training and education
    - Confident, compassionate and skilled workforce
- Raising Public Awareness

Glossary

Community Response Plan (CRP)	The purpose of a CRP is to monitor and prevent the potential development of potential clusters of suspected suicides occurring in the relevant Trust locality or across a community of interest. It is also intended to facilitate early detection of such clusters or community concerns and to provide a timely response by all sectors of the community to address any needs and prevent further deaths occurring. It is intended that each locality plan will provide a consistent template for action that can be implemented within any community / locality.
Direct costs	The cost of resources used as a direct result of suicide.
Grief	The primary emotional and natural reaction to the loss of a significant other, encompassing psychological, physical and behavioural responses to the death.
Indirect costs	The monetary valuation of lost productivity associated with premature mortality and are typically calculated by multiplying the value of wages by the estimated number of years
Intangible / human costs	The value of lost life over and above forgone productivity and also the pain and suffering of family and friends
Postvention	The term postvention describes activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation**,** (Support after a suicide: A guide to providing local services by public health England, Oct 2016)
Postvention service	A postvention service is an intervention conducted after a suicide, largely taking the

	form of support for the bereaved (family, friends, professionals and peers.
Psychoeducation	Psychoeducation (PE) is defined as an intervention with systematic, structured, and didactic knowledge transfer for an illness and its treatment, integrating emotional and motivational aspects to enable patients to cope with the illness and to improve its treatment adherence and efficacy.
Therapeutic Intervention	This term is an umbrella term that covers a wide range of interventions which may include e.g. play therapy, music, drama, art, talking therapies, cognitive behavioural therapy (CBT) etc.
Wrap-around service	Wrap-around a team-based, collaborative case management approach. A case management approach represents a point-of-delivery, rather than a system-level, approach to coordination. The concept of Wrap-around programming is used to describe any program that is flexible, family or person-oriented and comprehensive – that is, a number of organisations work together to provide a holistic program of supports.

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