BEREAVED BY SUICIDE SUPPORT N.IRELAND

Background Paper for Proposed Service Model

June 2015

Introduction

This paper sets out the background to a proposed service model which aims to provide support for those bereaved by suicide in Northern Ireland. The Public Health Agency (PHA) has lead responsibility for the implementation of the Protect Life Strategy and is currently rolling out a 3 year commissioning plan for Health and Social Wellbeing Improvement. The proposed model builds on existing practice and also draws on international evidence of effective practice.

During the timeline of the plan, it is expected that the new mental and emotional wellbeing and suicide prevention strategy will be issued for consultation. It is anticipated that the areas currently considered for procurement will continue to be strategic priorities, but final specifications will be informed by any specific targets set within the new strategy.

The current Protect Life Suicide Prevention Strategy[1] contains the following objective:

- ***'To ensure that accessible information and timely support, both at community / voluntary and statutory level, is available to all those bereaved by suicide, and to encourage the development of Support Groups / networks.'***

Please note – this work is supported by PHA Quality Standards for Services Promoting Mental and Emotional Wellbeing and Suicide Prevention which now includes specific standards for bereavement support available through: **http://www.publichealth.hscni.net/publications/quality-standards-services-promoting-mental-and-emotional-wellbeing-and-suicide-prevent**

[1] http://www.dhsspsni.gov.uk/suicide_strategy.pdf

2. Related policies & strategies

- Making Life Better – A Whole System Framework for Public Health 2013-2023[2]
- Protect Life – The NI Suicide Prevention Strategy and Action Plan 2012-2014[3] Cohesion, sharing and integration with OFMDFM
- Regional Promoting Mental Health Strategy, 2003-2008[4]. A new joint suicide prevention and emotional wellbeing strategy is in development and will be consulted on.
- Service Framework for Mental Health and Wellbeing, 2011[5].
- The Bamford Review - published a series of ten reports between 2005 and 2007, including one relating to promoting mental health and suicide prevention[6].
- Delivering the Bamford vision. The response of NI Executive to the Bamford Review of mental health and learning disability[7].
- Child Health Promotion Programme 'Healthy Child, Healthy Future, 2010[8].
- New Strategic Direction for Alcohol and Drugs, 2011-2016[9]
- Regional Hidden Harm Action Plan. Responding to the needs of children born to and living with parental alcohol and drug misuse in NI, 2008[10].

Other Key Strategic Drivers:

- National Confidential Inquiry into Suicide and Homicide by people with a mental illness. Northern Ireland Report 2011 & 2013[11].
- Providing Meaningful Care. Northern Ireland Report 2011[12].
- Findings of the evaluation of Protect Life Strategy 2011[13]

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[2] http://www.dhsspsni.gov.uk/making-life-better
[3] http://www.dhsspsni.gov.uk/suicide_strategy.pdf
[4] www.dhsspsni.gov.uk/**promoting_mental_health**.pdf
[5] http://www.dhsspsni.gov.uk/sqsd_service_frameworks_mental_health
[6] www.dhsspsni.gov.uk/**mentalhealth-promotion**-report.pdf
[7] www.dhsspsni.gov.uk/**bamford**_action_plan_2009-2011.pdf
[8] www.dhsspsni.gov.uk/**healthychildhealthyfuture**.pdf
[9] http://www.dhsspsni.gov.uk/new_strategic_direction_for_alcohol_and_drugs_phase_2__2011-2016_
[10] www.dhsspsni.gov.uk/**regional_hidden_harm_action_plan**.pdf
[11] www.dhsspsni.gov.uk/**suicideandhomicideni**.pdf
[12] http://www.publichealth.hscni.net/sites/default/files/ProvidingMeaningfulCareSHORT_REPORT.pdf
[13] www.dhsspsni.gov.uk/**protect-life-evaluation**-report.pdf

- Equality Agenda: The Northern Ireland Act 1998 Schedule 9 (4) (2) (b), requires the Public Health Agency to assess the likely impact of its policies on the promotion of Equality of Opportunity. In addition the Public Health Agency is required to report to the Equality Commission annually on the implementation of its equality scheme including progress on delivery of actions to promote equality of opportunity.

Public Health Agency Current Implementation Approach:

The PHA is committed to improving mental health and wellbeing and reducing levels of suicide in Northern Ireland. The PHA work with local organisations to provide mental and emotional wellbeing and suicide prevention services across Northern Ireland.

The PHA has adopted a 'continuum approach' to implement the current 'Protect Life' strategy. This approach spans from the promoting positive mental and emotional wellbeing to prevention / early intervention to crisis response and follow up support services. This model has been developed from evidence of what is known to be effective and learning from partnership working. This continuum uses both a population and targeted approach.

Below are each of the five areas of effective intervention:

- Building capacity & resilience awareness & education
- Early recognition of signs & symptoms
- Appropriate & accessible services
- Crisis Response and postvention / bereavement support
- Using & building the evidence, testing new approaches in the absence of evidence

It is imperative that action is taken across all elements in order to deliver best outcomes; if actions are limited to only a few sections then gains in overall outcomes may be affected. It is an integrated model that recognises the need to respond to risk factors but to also build protective factors.

3. Needs of those bereaved by suicide

The World Health Organisation states 'While grief is a "normal" response to the death of a loved one, the death of a loved one by suicide does bring an added burden to such loss. The needs of people bereaved by suicide are many and can be quite complex. Assistance and support can be forthcoming from a variety of sources. Each source of support can play an important role in helping the individual address their loss and promote the normal process of grieving'[14].

3.1 Number of recorded deaths:

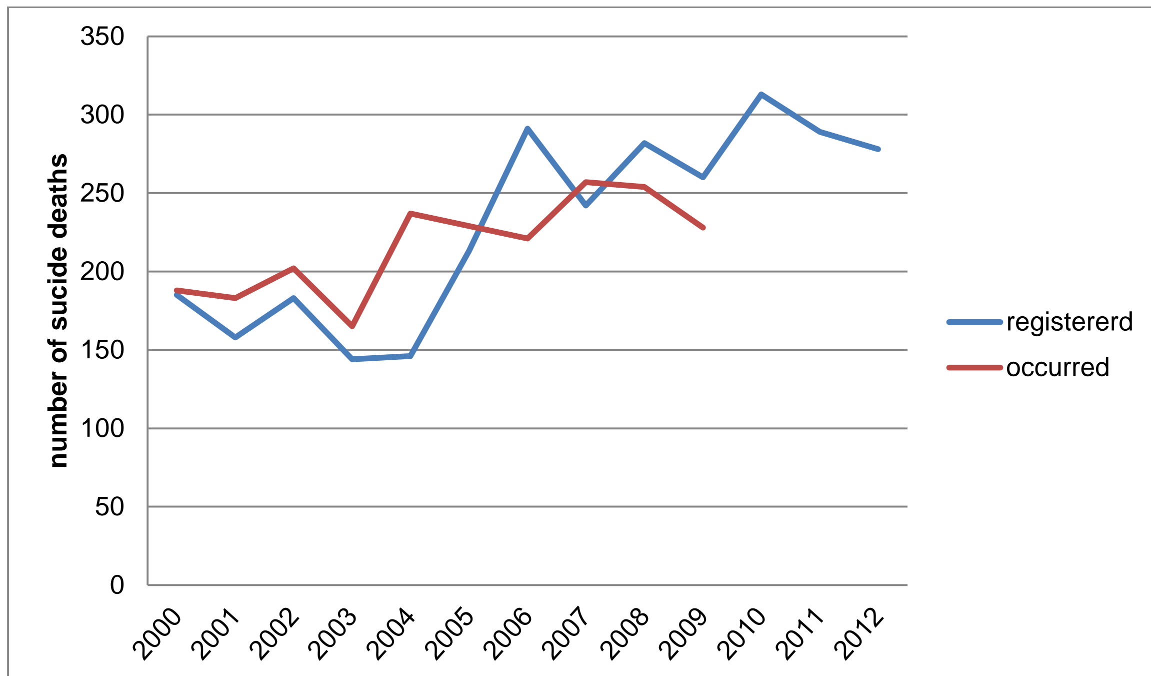
The numbers of deaths recorded by suicide and undetermined intent are reported by the Northern Ireland Statistics and Research Agency (NISRA). There can be a time lag of up to two years between the date of the death and registration of the death as a suicide due to the coroner's processes.

In recent years data has been published by NISRA regarding total suicide deaths per year, by year of *occurrence* of death, in addition to year of registration. However, the date of occurrence cannot be reported until after the death has been registered as a suicide, compounding the time lag.

Figure 1 presents suicide deaths both by year of occurrence and year registered since 2000. The trend in 'occurred' data is a more accurate guide to the trend in suicides but it is not available in a timely enough manner to be useful. The data shows that a steep rise occurred in the registered suicide rate between 2004 and 2006. *It is important to note that this rise coincides with the reconfiguration of the coroner's service for Northern Ireland in 2004 when the coroner's districts were combined into one central service, and a backlog of inquests was subsequently cleared after 2004. This resulted in the number of suicides registered during 2001 to 2003 peiod being 12% lower than the actual number of suicides that actually occurred during that period. This clearing of the backlog also means that the number of registered suicides in recent years may appear to be articifcally inflated.*

[14] www.who.int/mental_health/prevention/**suicide**/resource_**survivors**.pdf

Figure 1: Numbers of suicides by year of death registration and year of occurrence:



A system has been developed with PHA, HSCT's and PSNI to report probable suicides and has the potential to yield more timely data.

In 2014, 268 deaths were provisionally registered[15] in Northern Ireland. This indicates a potential 11.5% decrease from the 303 deaths registered in 2013.

The latest three year *provisional* rate 2012/2014p is 15.5 deaths per 100,000 population.

The 3 year rate for 2011/13 was 15.9 deaths per 100,000 and for 2010/12 was 16.2 deaths per 100,000. The rate has remained above 15 deaths per 100,000 since 2008/2010.

Deprivation:

Department of Health, Social Services and Public Safety report published in 2014 highlighted that the most deprived areas of NI experience suicide rates three times higher than the least deprived areas[16] (See Fig 2 below)

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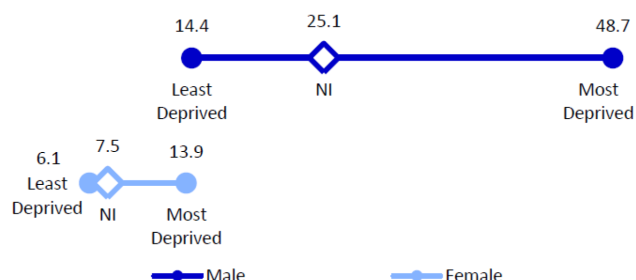
[15] Northern Ireland Research and Statistics Agency - http://www.ninis2.nisra.gov.uk/public/pivotgrid.aspx?dataSetVars=ds-5972-lh-73-yn-1999-2013-sk-74-sn-Population-yearfilter--

1. [16] www.dhsspsni.gov.uk/**hscims-2014-bulletin**.pdf

Figure 2: Crude Suicide Rate by Gender and Deprivation, 2010-12

In 2010-12 the crude suicide rate for males was notably higher than for females across all areas.

The suicide rate for males in the most deprived areas was 48.7 deaths per 100,000 population, eight times that of females in the least deprived areas (6.1 deaths per 100,000 population).



Source: Health Inequalities, DHSSPSNI, 2014

3.2 Impact of bereavement

NICE[17] states that: People closely affected by a death should be able to access all support within an appropriate physical environment that facilitates sensitive communication.

NICE also highlights that any appropriate and effective bereavement support needs to follow a stepped approach and include the following elements:

- information about local support services;
- practical support such as advice on arranging a funeral, information on who to inform of a death, help with contacting other family members and information on what to do with equipment and medication;
- general emotional and bereavement support, such as supportive conversations with generalist health and social care workers or support from the voluntary, community and faith sectors;
- referral to more specialist support from trained bereavement counsellors or mental health workers.

Providing individuals and communities with timely and appropriate bereavement support intervention not only offers support to help survivors grieve, but it can also serve as an important means to reduce the risk of further suicide. In the context of this work, **the PHA defines bereavement support as "*emotional, practical and information support services provided to individuals and / or groups of***

[17] https://www.nice.org.uk/guidance/qs13/chapter/quality-statement-14-care-after-death-bereavement-support

***individuals who have been bereaved through suicide to assist in the grieving process*".**

Consultations with individuals who have been bereaved by suicide (as part of the development of the PHA Bereavement Standards[18]) found that individuals highlighted the need for consistency of information at different times in relation to help and advice on practical matters. This is in line with evidence from reports addressing bereavement support needs[19] in particular, Beautrais (2004)[20] recommends:

- Help and advice about practical matters
- Information, which they may need again at a later time or from a different source.
- Support e.g. therapeutic intervention from relevant professionals
- Opportunities to talk to others bereaved by suicide e.g. support groups

3.3 Impact of bereavement as a result of a suicide

It was reported that people in the US who had known someone who died by suicide within the past year were three times more likely to have suicidal plans, and almost four times more likely to have made a suicide attempt than those who did not. [21]

These statistics and the evidence referenced throughout this paper highlight the wider impact of a death by suicide. For example, a recent study presented at a Knowledge Exchange Seminar in Stormont parliament buildings on 14.1.15[22], stated that while estimates vary it is suggested that for every suicide that occurs, an average of six people suffer intense grief. Little is known about the impact of these deaths on the wider community, but estimates suggest that up to 60 people may be affected by each death.

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[18] http://www.publichealth.hscni.net/publications/quality-standards-services-promoting-mental-and-emotional-wellbeing-and-suicide-prevent

[19] www.nosp.ie/**review**_of_**bereavement_support_services**-1.pdf

[20] Beautrais, A. L. (2004). *Suicide Postvention: Support For Families, Whanau and Significant Others after Suicide: A Literature Review and Synthesis of Evidence.* New Zealand: Christchurch School of Medicine &Health Services.

[21] http://onlinelibrary.wiley.com/doi/10.1521/suli.32.3.321.22170/abstract

[22] http://www.niassembly.gov.uk/assembly-business/research-and-information-service-raise/knowledge-exchange/#e

It is known from current services in Northern Ireland that there can be a significant time delay between experiencing a death and availing of support. Evidence from a number of sources suggests that not all bereaved individuals require formal support, much support is provided informally by families and friends, while other professionals such as GPs are often approached by those looking for support. This in itself may indicate the need to provide information and support to those who may provide informal or more formal support. As highlighted earlier, NICE guidance supports such an approach and highlights that for some, spiritual support at times of bereavement is also important.[23]

As mentioned previously, it is recognised that individuals have different needs and circumstances and as such there is no single or 'right' way to respond to a suicide. However, it is essential that these differing needs and circumstances are considered as part of a bereavement service, as well as whether or not they wish to avail of formalised support services.

It has been reported by Progerson et al[24], that (60-80 per cent of the time) individuals do not require intervention regardless of the cause of bereavement but that where the reactions to the death are severe or complicated, intervention may be useful.

Risk Factors:

Family Risk

Family history of suicide: Suicide by a family or community member can have a major/significant impact on a person`s life. Losing someone close to you is devastating for most people. In addition to grief, the nature of the death can cause stress, guilt, shame, anger, anxiety and distress to family members and loved ones. Family dynamics may change, usual sources of support may be disrupted, and stigma can hinder help-seeking and inhibit others from offering support. Suicide of a family member or loved one may lower the threshold of suicide for someone

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[23] https://www.nice.org.uk/guidance/qs13/chapter/quality-statement-14-care-after-death-bereavement-support

[24] Prigerson, H. G., et al. (1995). Inventory of complicated grief: A scale to measure aladaptive symptoms of loss. *Psychiatry Research, 59*, 65-79.

grieving. For all these reasons, those who are affected or bereaved by suicide have themselves an increased risk of suicide or mental disorder[25].

Children and Young People at Risk

Children bereaved through suicide are at significant risk for a range of issues including anxiety, depression and social problems[26].

'Without the right conditions for healing, children and teenagers will carry their emotional wounds into the rest of their lives. We know that children who have a parent die are at risk. They are more likely than other children to experience higher levels of 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'.[27]

Further studies found that the impact on children of a death of a sibling [28] has an adverse effect on a child's life, leaving them at increased risk for significant psychological problems, leaving surviving siblings of bereaved children may be particularly vulnerable to maladaptation. A study to assess the psychiatric impact of sibling suicide on adolescents, although it was retrospective and consisted of a small sample size, found that the adolescents who had lost a sibling to suicide were more likely to suffer a new-onset episode of major depression. Most cases of depression began within a month of the death, and lasted for five months. All were still somewhat depressed six months later, at the time of the interview. Associated with new-onset depression were; previous psychiatric disorder, family history of psychiatric disorder and family history of depression. A presence of these factors may predispose some siblings to depression after bereavement to a greater extent than others.

[25] http://www.who.int/mental_health/suicide-prevention/world_report_2014/en/

[26] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2864072/

[27] http://www.tdcbookstore.org/store/p20/Never_the_Same%3A_Coming_to_Terms_with_the_Death_of_a_Parent_Item_%23560pb.html

[28] www.barnardos.org.uk/**sibling**.pdf

A thematic review by Public Health Wales of deaths of children and young people through probable suicide highlights that experiences of suicide in the family or local community are risk factors in suicide amongst children and young people. [29]

An independent evaluation [30] of a Northern Ireland initiative for Children and Young People who had been bereaved highlighted that:

- It is vital that all children and young people receive the support that they need after the death of someone close, to help them to express their feelings and develop their coping skills

- The young people said they wanted to 'meet people with similar stories at different stages, as well as to make new friends and enjoy the 'banter'

- The informality of the group meetings has also helped some members with healing and the different stages of the grieving process, with one member saying 'it's not like counselling, it's more informal with less pressure.'

Wider Community Risk

As part of the Knowledge Exchange Seminar Series (KESS) – Evidence of Bereaved by Suicide Support needs for NI[31] a 'Grief Study' found that:

- Over the study period bereaved persons were 40% more likely to experience poor mental health compared to people who had not been bereaved. The likelihood of poor mental health is further increased in the case of sudden bereavements, including following accidents and suicide. The study found in the group bereaved through suicide poor mental health was experienced twice as frequently as in the general population. For young people under 25 years findings showed they more likely to have poor mental health following bereavement in any circumstance than those bereaved aged between 25 and 64 years. Furthermore men were more likely to experience poor mental health

[29] http://www2.nphs.wales.nhs.uk:8080/ChildDeathReviewDocs.nsf/5633c1d141208e8880256f2a004937d1/ce6956a584dd1f6b80257c9f003c3fa1/$FILE/PHW%20probable%20suicide%20web.pdf

[30] http://www.cruse.org.uk/sites/default/files/default_images/pdf/Areas/Northern-Ireland/TheRainbowMakers.pdf

[31] http://www.niassembly.gov.uk/assembly-business/research-and-information-service-raise/knowledge-exchange/#e

after being bereaved through illness, whereas women suffered more often following bereavement through suicide.

Findings from another study 'Towards an understanding of the role of bereavement in the pathway to suicide'[32] included the fact that bereaved family members and significant others, may require more nuanced, multi-dimensional interventions, provided over extended periods of time, in order to facilitate varied and complex grief processes. This study further found that a focus on empowerment, education and information may provide results that are as effective as increasing access to psychological services and suggested these approaches should exist in tandem.

Findings within this study (from the NI context) advise two key elements of postvention follow up. Firstly prioritise access to support services for all those affected by death by suicide, regardless of their kinship to the deceased. They suggest much of the current focus in care provision is on the immediate family and there has been a longstanding neglect of the wider reverberations of suicide on the extended social circle. Secondly, it is important to be mindful of the broader community impact of the rise in suicide. This study shows that there is a broad community impact to these deaths, similar to those reported in the Lancet (Pitman et al, 2014[33]).

4.0 Current provision of support for those bereaved by suicide

Bereavement support is currently provided in each HSC area, although the provider varies. There are a number of ways people who have being bereaved may access support services:

1) The Sudden Death (SD1) notification system. This is a system where, when a PSNI office attends a death which they consider may be a suicide, they complete a form which is sent to an identified HSC lead officer. The form

[32] http://www.niassembly.gov.uk/assembly-business/research-and-information-service-raise/knowledge-exchange/#e

[33] http://www.thelancet.com/journals/lanpsy/article/PIIS2215-0366(14)70224-X/fulltext

adds the next of kin / significant other if they wish to avail of bereavement support, which is then followed up by the relevant HSC Trust lead.

2) General access to bereavement support is also available more generally. Belfast has a number of services for adults and a service for children / young people provided by the community & voluntary organisations. The south eastern area also has services provided by the community & voluntary sector (including SD1 follow up) but does not have a separate service for children / young people. The northern area has a service for adults provided by the Northern HSC Trust and a children's / young person's service provided by community & voluntary sector, with SD1 follow up provided via Trust. The southern area has a community & voluntary provider with Southern HSC Trust staff following up initial SD1 contacts. In the western area the Western HSC Trust provide SD1 follow up & wider bereavement support services. There is no specific children / young person's service in the western area.

Although the approach and providers vary within each area, the aims of bereaved by suicide support are similar, i.e. to provide support for individuals, families and children who have been bereaved by suicide and takes the form of group support, counselling, crisis response and resources / self-help guidance.

4.1 Summary from evaluations of current local Bereaved by Suicide Support services

An Independent evaluation of a Trust led service for adults which is mix a of 1:1 and support groups found the following:

- Service model developed and evolved over time 'driven by service user needs'.
- Service users were very positive about their experience of the service, the qualitative feedback from individuals who have benefited from the project included comments from people who are of the view that the help that they received via the project supported their mental health and well-being very significantly, and, for some individuals, saved their lives.

- Users stressed the importance of being able to meet others with similar experiences.
- The service provides information and helps individuals and family connect to others services appropriate to their needs.
- The service also supported community capacity building in communities particularly impacted by suicide.

2. Evaluation of a voluntary organisation providing a support service for children & young people in one area found the following:

- Several participants commented that they found the immediacy of the response of the service to be excellent. They felt that their children needed support promptly following the bereavement and that there was “no waiting around”.
- Flexibility of where the service was delivered was appreciated by participants. Some commented that the service being delivered in the home meant that it was more relaxed for the child and that it eased the child into the work in their own surroundings. This was particularly in the case of younger children. Where the service was delivered in school, this was also found to be positive. “All his classmates know, he’s not hiding anything”. Another participant replied that she did not mind where the service was delivered. Her teenager chose to do the work in school and she felt that this gave him “the space to keep it out of the family home”.
- Several participants commented on how reliable they found the service. The staff member comes every week and “never lets the child down”. Two participants mentioned how they appreciated that it was their choice to avail of the support. They did not feel forced to do anything and knew that they could stop the work at any time.
- Two participants also commented on how reassuring they found the service to be.

  “I don’t feel as scared. It’s good knowing that the kids have someone to talk to. A friend who they can trust, that isn’t family”.

"I felt a lot of pressure and strain. ___was very clingy after her daddy's death. The staff member was there to give me back-up, to ease this and reassure ____not to be worried".

5.0 Summary and Next Steps:

The key themes emerging from the above are:

- Those who have being impacted by suicide, regardless of their kinship to deceased, may need:
  - Help and advice about practical matters
  - Information (which they may also need again at a later time or from a different source)
  - Emotional Support e.g. therapeutic intervention from relevant professionals
  - Opportunities to talk to others bereaved by suicide e.g. support groups
  - Opportunities to connect with other local relevant services
- Age appropriate services should be available for & accessible to children & young people as well as adults.
- Community Gatekeepers*, professionals and others who come into contact with those bereaved need training & support.
- The wider community can be significantly impacted by a suicide(s) and consideration needs to be given to providing appropriate support / building knowledge and skills within the community.

***Gatekeepers** can be identified as those who could potentially be in contact with vulnerable individuals, including for example:

- GPs & Primary Care staff
- Accident & Emergency staff
- Pharmacists
- Relevant Managers (HSC frontline sector)
- HR Personnel (HSC sector)

- Accredited sports coaches
- Those working with survivors of abuse
- Church (religious/faith leaders)
- Key influencers of young people e.g. teachers, youth-workers
- Those who work with people who have mental health difficulties
- PSNI custody officers
- Frontline prison staff with 'inmate listeners'
- Call Centre staff (regional helpline providers)
- Undertakers
- Fire Service
- Ministry of Defence / British Legion

Given the evidence highlighted in this paper, the following are the aims and objectives proposed for a Bereaved by Suicide Support model.

Aims of proposed model:

To promote a healthy grieving process, recovery and increase resilience for those who have been bereaved by suicide, through providing timely and flexible support to individuals, families and / or local communities who have being affected by death by suicide.

To ensure that those bereaved are offered appropriate support informed by available evidence of effective practice and which meets the PHA quality standards for bereavement support.

Objectives:

Support services will:

- Provide timely emotional support to those bereaved, including at difficult times of the year such as holidays or anniversaries
- Provide practical information as appropriate to those who are bereaved
- Promote positive mental and emotional well-being as well as awareness of mental ill health.

- Provide information & raise awareness of local services which may be beneficial to those bereaved
- Provide information & raise awareness amongst others of the impact bereavement by suicide can have on individuals or families.

PHA will consult on a model for bereavement support, proposing the above aims and objectives as core elements of any future service model (please see attached Consultation Questionnaire).

If you require a printed copy of this paper or the consultation questionnaire or an alternative format, please email Lisa.carson@hscni.net.