HSE Bereavement Counselling Service for Traumatic Deaths in South East Community Healthcare:

A Review of the Operation of the Service

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Connecting for Life
South East Community Healthcare

HSE

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The HSE Bereavement Counselling Service for Traumatic Deaths in South East Community Healthcare (SECH) is delivered through the HSE Regional Suicide Resource Office and is funded by HSE Mental Health in SECH.

This current review was funded by the HSE National Office for Suicide Prevention. The review was undertaken by Dr Eve Griffin and Dr Selena O'Connell, with input from Dr Paul Corcoran, Dr Brendan McElroy and Professor Ella Arensman. The review process was facilitated by the service team (Tracy Nugent, HSE Resource Officer for Suicide Prevention and Service Manager; Mary Weldon, Service Administrator; and David Heffernan, Head of Service for HSE Mental Health in SECH), who provided access to relevant documentation, data and information.

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List of Abbreviations

CaPA:	Counselling and Psychotherapy for Adults who experienced childhood abuse or neglect
CAT:	Cognitive Analytic Therapy
CIPC:	Counselling in Primary Care
CORE-OM:	Core Outcomes in Routine Evaluation – Outcome Measure
DOC:	Director of Counselling
EMDR:	Eye Movement Desensitisation and Reprocessing
HSE:	Health Service Executive
IACP:	Irish Association for Counselling and Psychotherapy
IAHIP:	Irish Association for Humanistic and Integrative Psychotherapists
ICD:	International Classification of Diseases
MHS:	Mental Health Services
PSI:	Psychological Society of Ireland
PTSD:	Post-Traumatic Stress Disorder
SBLO:	Suicide Bereavement Liaison Officer
SCAN:	Suicide Crisis Assessment Nurse
SECH:	South East Community Healthcare
SHIP:	Self-Harm Intervention Programme

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1 Executive summary

1.1 Background

Bereavement by traumatic deaths – including suicide, homicide, murder-suicide and accidents – can significantly impact on an individual's mental and physical health, increasing risk of depression, complicated grief and suicide (1). In addition, those who are bereaved by sudden, unnatural or violent death often report higher levels of perceived stigma (2), as well as other factors including trauma and Post-Traumatic Stress Disorder (PTSD) (3), compared with those bereaved by natural causes.

As a consequence, individuals bereaved by a traumatic death may require specialised supports, particularly those tailored to the nature of the death and mental health conditions of the individual. People bereaved by suicide, who will account for a large proportion of traumatic deaths, have been identified as a key priority group for suicide prevention in Connecting for Life: Ireland's national strategy to reduce suicide, 2015-2024 (4), with specific actions to improve and standardise the availability of tailored supports in Ireland for those bereaved by suicide (Actions 4.3.1 and 4.3.2). A 2019 review of the literature in this area highlighted a lack of evidence on interventions for those bereaved by suicide (5). Additionally, a national review of suicide bereavement supports in Ireland found variation in services regionally, as well as gaps in the provision of evidence-based, specialised and standardised supports and interventions (6).

Since 2006, the HSE Bereavement Counselling Service for Traumatic Deaths in South East Community Healthcare (SECH) has provided counselling support to people bereaved by suicide and other sudden traumatic deaths, including homicide, road traffic accidents, industrial, domestic and agricultural accidents and drowning. This service facilitates health professionals to refer individuals, aged 16 years and over, to therapeutic counselling from trained Counsellors working in the healthcare area. This is the first independent review of the service.

1.1.1 Project aims and objectives

The aim of this project was to undertake a review of the service. The objectives were to review the operation of the service in terms of referrals and clients, pathways and onward referrals and to undertake a cost-effectiveness analysis. While some client outcomes are reported, it was not a primary aim of this project to examine the effectiveness of the therapeutic interventions delivered by the service. The project involved four key stages including developing a detailed description of the service, a review of an anonymised referral database held by the service, surveys of healthcare professionals in the service region and of Counsellors contracted to the service, along with a cost-effectiveness analysis of the service.

1.2 Key findings and recommendations

The findings from this report indicate that the service has a vital role in providing therapy for individuals bereaved by suicide and other forms of traumatic bereavement. The service works by utilising existing expertise and resources in the community, via qualified Counsellors. The model of service addresses two significant barriers in accessing supports, by providing a free service with a minimal waiting time to first appointment. For a subset of individuals completing therapy, it was possible to observe pre-post changes in psychological outcomes, as recorded by the Core Outcomes in Routine Evaluation –

Outcome Measure (CORE-OM). Significant improvements in client outcomes were observed, which is in line with studies of similar counselling service models (7). Furthermore, the service was positively rated by key stakeholders, including healthcare professionals who refer clients to the service and Counsellors working with the service.

The service also represents good value for money, with a cost per quality-adjusted life year (QALY) gained of €13,500, well below the willingness-to-pay threshold in Ireland of €45,000 (8, 9), driven by a considerable increase in health gain. This analysis was based on a sub-set of clients. Their representativeness of the overall client profile could not be fully determined, although they were similar to the overall sample who completed therapy in age and gender profile. The cost analysis included administrative staff costs, which are currently not covered by the annual budget allocated to the service. While the cost-effectiveness analysis has some limitations, it is argued that the estimated ICER of €13,500 is conservative. Further research using a larger sample of data from clients would clarify the extent of these limitations.

The findings add to the body of literature providing evidence for the need for specialised care for those bereaved via traumatic deaths – including suicide (10, 11). While therapeutic interventions are also accessible via other services in the region, the short waiting times, no cost implications for clients, direct referral procedures and the facilitation of clients via a skilled service team are key strengths of such a dedicated service.

In a policy context, the service provides supports for one of the key priority groups identified in Connecting for Life (4), and addresses challenges flagged in the recent report on improving suicide bereavement supports in Ireland (6). The service provides (specialised) therapeutic interventions – Level 3 and Level 4 of the Irish Hospice Foundation bereavement care pyramid (12). In addition, the service has developed comprehensive and useful resources and information for clients (Level 1), ensuring that every client referred to the service receives some information support.

While the service is not unique in providing bereavement counselling, it is unique in its focus on traumatic bereavement and suicide bereavement in particular. It is also unique in its minimal waiting times. In addition, the service is unique in its flexibility concerning the length and type of therapy provided, along with its integration with other services. Although not formalised in the service model, clients who may not be in a position to avail of therapy through the service itself are signposted or linked to other services within the community. This is in a large part enabled by the service being managed via the HSE Regional Suicide Resource Office. While there is significant potential to consider expanding the model of service to other regions in Ireland, contextual factors should be considered in establishing governance and service teams.

Most clients were referred to the service following a suicide and almost 75% were immediate family members of the deceased. The referral rate to the service was 31 per 100,000 population in the region. This means that, for every one death due to external injury (ICD-10 code V01-Y89) recorded between 2016 and 2020, approximately one person was referred to the service. More than one-third of individuals referred had been bereaved in the previous three months (35.2%) and these referrals were most likely to be friends of the individual who had died.

Recommendation 1: The existing service should be further resourced and supported as a standalone bereavement service, operated through the HSE Regional Suicide Resource Office.

Recommendation 2: The feasibility of establishing a similar model of service in other regions should be explored.

1.2.1 Expanding the service criteria

A small number of healthcare professionals who refer clients to the service, along with a number of Counsellors surveyed, suggested the service could be improved by offering counselling to people who have been bereaved by other types of sudden death and to younger adolescents.

While the service was initially set up to provide a service for those bereaved by suicide, it was expanded to include other forms of accidents and violent death. This was influenced by challenges for clients in acknowledging suicide as the cause of death of their loved one and evidence of trauma associated with other types of death (Kaltman & Bonnano, 2003). This demonstrates the potential flexibility of the service and its capacity to be responsive to emerging needs (including the expansion to include deaths by Covid-19 during the pandemic). It was recommended by referring professionals that deaths due to Covid-19 be added to the inclusion criteria, along with sudden cardiac deaths. Any expansion should be in line with service capacity and resources.

Young people represent an important risk group following traumatic (specifically suicide) bereavement, both in terms of psychological morbidity and transmission of suicidal behaviour (13, 14), underlining the need for age-specific supports. While not all young people will require specialised supports, therapeutic counselling has been shown to be effective for this group (15). Therefore, it is recommended that the service consider expanding the eligibility criteria for the service. This would require additional funding, expertise and research to support this.

Recommendation 3: The service should consider expanding the service criteria to key groups, including other sudden deaths and young people.

1.2.2 Improving attendance and uptake

Of those referred for therapy with the service, under half completed their therapy (41%), i.e. the full 12 sessions available to them. Reasons for non-completion included disengaging from the therapy before it was complete or not attending the first appointment. The findings from this review did not detect any consistent demographic profile among those who did not complete therapy, although men were slightly more likely to not attend their first appointment or to not engage with the service following referral. A recommendation of this review would be to further explore strategies to increase attendance at first appointment. Previous research has identified a number of strategies which may be effective, including choice of appointment time or Counsellor, preparation information (providing information about the service and treatment, education about psychotherapy), appointment reminders and case management (16). Information material and educational seminars for referring healthcare professionals may also be an effective strategy to improve uptake and attendance (16).

Recommendation 4: The service should explore strategies to improve uptake and retention of clients within the service, including additional information for referring professionals and clients.

1.2.3 Clients who have been recently bereaved

A significant proportion of referrals to the service were for clients who had been recently bereaved (within the previous three months). A small number of Counsellors identified that clients may disengage from therapy or need more time because they commence therapy too soon after the death. The Counsellors also suggested the appropriate timing was context dependent and difficult to quantify, but it may not be appropriate within the first three months of bereavement. While there is limited literature on this topic, a cross-sectional survey of people bereaved by suicide found that participants who started therapy sooner reported greater benefit of therapy (17). This extended to the immediate time following the death

where people who began therapy within three months of being bereaved perceived therapy to be more beneficial than those that began later.

The proportion of clients who were recently bereaved indicates a clear need for immediate supports for family and friends impacted by a traumatic death. The service has responded to this need via a pathway with the Suicide Bereavement Liaison Service in the area. For clients referred to the service who have been bereaved in the past two months, the service team offer them a choice to engage with the Suicide Bereavement Liaison Service, with an option of later being referred into the counselling service. This is in addition to providing information resources to the prospective client. This example of inter-agency collaboration and signposting is imperative to ensure that individuals bereaved receive supports at an appropriate time, and ensures a bridge to alternative care or supports. A recommendation of this research would be for the service to identify and formalise ways of integrating alternative care pathways for clients referred to the service who have been recently bereaved or may have complex needs. Given the documented challenges in waiting times for allied services, it may be necessary to enhance the existing services to tailor the support provided for those recently bereaved or those not ready for therapeutic counselling. A second recommendation would be to provide guidance to healthcare professionals in the area regarding appropriate referral pathways for individuals who have been recently bereaved.

Recommendation 5: The service should develop formalised care pathways with allied services, or within the existing service for those who are recently bereaved and for those who require additional supports.

Recommendation 6: The service should disseminate information for referring professionals on appropriate referral pathways.

1.2.4 Standardising assessment and care plans

One of the strengths of the service is its flexibility in responding to client needs, both in terms of care pathways and the type of therapeutic support provided. An initial assessment appointment is conducted by Counsellors, which involves completion of the CORE-OM tool. This process is also conducted at the last therapy session. It is recommended that the CORE-OM measures (or CORE-10) are fully completed at both time points for all clients, and returned to the service team on closure of the client file. This will ensure that client outcomes can be monitored on an ongoing basis. For the purposes of comprehensive assessment, it is recommended that the Counsellor's initial assessment also considers key biopsychosocial factors and does not rely solely on the CORE-OM measure.

One of the findings of this review was that, despite an overall improvement for clients who had completed therapy, there was a proportion of clients who continued to report some degree of suicidal risk at their last therapy session. It is recommended that the service develop a formal policy for managing suicidal risk among clients who attend for therapy. This may involve extending the number of sessions, the use of individualised care plans for example (18) and case management procedures to discuss individual referral requirements during or following completion of therapy.

Recommendation 7: Client outcomes should be systematically recorded by Counsellors at the initial assessment appointment and at the last session.

Recommendation 8: The service should review the development of protocols around individualised care plans and case management procedures to assess and manage ongoing suicidal risk of clients and to inform onward referrals where necessary.

1.2.5 Counsellor supports and policies

Counsellors contracted to the service were satisfied with the policies in place to support their work. This is reflective in retention of Counsellors over the period of the report. A key issue identified in the survey of Counsellors was the need for better access to supervision and/ or case management. All had supervision arrangements in place outside of the service. Since 2022, the service also funds personal supervision at a rate of 1:15 client sessions (an increase from the rate of 1:30 at the time of the survey). Most respondents indicated that they would like additional supervision as part of the service, which may need to be specialised to the nature of the counselling provided. Suggestions for this included monthly case management or group supervision. It is recommended that a senior Counsellor or clinician be appointed to facilitate this process.

All Counsellors are highly skilled and, while not a requirement of the service, all who responded to the survey had received relevant training in bereavement counselling. In addition, it is noted that the service team provide ad-hoc training in response to Counsellor needs. It is recommended that provision for additional or up-to-date training and Continuing Professional Development be available for all Counsellors as part of their service contract. In particular, intervention and postvention training programmes outlined in the Connecting for Life National Education and Training Plan 2021-2022 (19) should be offered to all new and existing Counsellors.

Recommendation 9: Counsellors should be further supported via monthly case management or group supervision, through the appointment of a senior clinical supervisor.

Recommendation 10: All Counsellors should have access to ongoing training and Continuing Professional Development as part of their service contract, including training offered via Connecting for Life.

1.2.6 Data recording and case management systems

The service records all referrals in an anonymised excel database. In addition to being used to provide an overview of the status of referrals, it is used to generate an annual report. It is recommended that an upgraded data system be developed to streamline data recording, and to facilitate detailed reporting on the activities and outcomes of the service.

The need for an electronic client data management system was highlighted by a small number of service Counsellors. An enhanced electronic referral and data recording system would support the referral process, the allocation of Counsellors, as well as data management of client files, including information on client outcomes. These could also serve to facilitate ease of communication and information sharing between referring professionals, the service team and Counsellors.

Recommendation 11: Funding should be provided for an electronic data management system to streamline the recording of key referral data and to support referrals and communication between referring professionals, the service team and service Counsellors.

2 Methodology

This research was conducted between June 2021 and December 2021.

The review utilised a mixed methods approach involving three stages of research. Stage one involved compiling a full description of the service and its operation, using document analysis supplemented by interviews with key personnel in the service. Stage two involved quantitative analysis of the referral database held by the service since 2015, including a cost-effectiveness analysis. Stage three involved surveying health professionals in the catchment area who are eligible to refer to the service, and surveying Counsellors contracted to the service (see Figure 2.1).

Ethical approval for this research was obtained from the Clinical Research Ethics Committee of the Cork Teaching Hospitals (Reference Number: ECM 4 (p) 13/4/2021 & ECM 3 (kk) 07/09/2021).

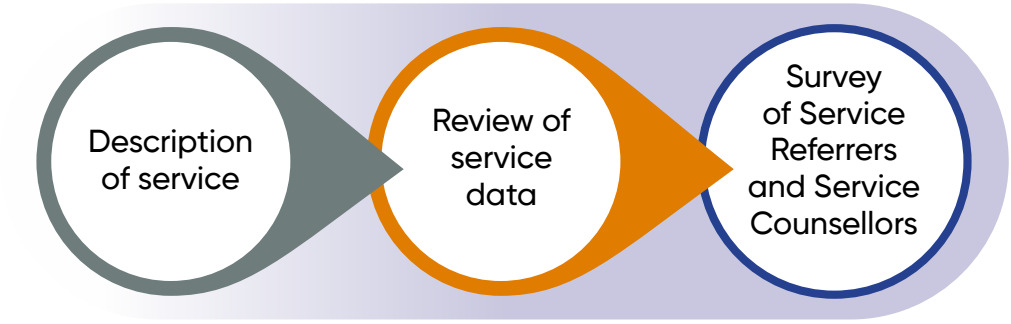


Figure 2.1: Stages of the review process

2.1 Stage 1: Description of the service

In this stage, analysis was undertaken of service documentation including service policy documents, communication templates/forms and information leaflets. Following document analysis, interviews with staff responsible for coordinating the service were undertaken in order to develop a complete description of the service and its operation. This included a full overview of the purpose of the service, governance structures, inclusion/exclusion criteria, catchment population, referral pathways, links with existing services, Counsellor criteria, training and supervision arrangements and referral/guidance for clients following use of the service. A summary of existing services in the area that offer interventions for a similar population was also developed.

2.2 Stage 2: Review of service referral database

A retrospective review and analysis of the electronic referral database maintained by the service was undertaken. The referral database has recorded data since 2008. Information held between 2006 and 2008 was recorded in hard copy. For this review, de-identified data for referrals received by the service between 1 January 2016 and 31 December 2020 were analysed. A list of data items included in this analysis are included in Appendix 1.

The Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) (20, 21) has been used by service Counsellors since 2017. CORE-OM is a 34-item self-report measure which is designed to assess levels of psychological distress and outcome of psychological therapies. Counsellors complete the

measure at the initial assessment with the client and at the end of therapy. The measure consistes of four domains (specific problems, functioning, subjective wellbeing and risk). All items are measured on a five-point scale from 0 to 4 and relate to the previous week. The internal consistency of CORE-OM has been reported as ρ=0.94 and the one-week test–retest reliability as Spearman's ρ=0.90 (21). A score of 10 or more is treated as a cut-off score for a clinical population i.e. people with a score of 10 or greater experience clinically significant levels of distress (22). A sub-sample of clients with CORE-OM data were also used to estimate the cost-effectiveness of the service, via a costing analysis.

Client feedback forms are sent to each client following file closure and provide information on satisfaction with the service. The forms include open-ended questions and well as questions asking clients to rate the service in terms of ease of access, quality of bereavement pack, length of time from initial contact to appointment, and the counselling setting.

2.2.1 Statistical analyses

Descriptive statistics were used to summarise the profile of clients referred into the service according to date of referral, gender, age group, type of bereavement, relationship to the deceased and time since bereavement. Analyses were also conducted to assess care pathways within the service, including time from referral to first appointment, number of sessions of therapy attended and reasons for not attending therapy.

The rate of referral to the service across the catchment area based on the number of deaths, as recorded by the Central Statistics Office was measured. The number of external causes of death (ICD-10 codes V01-Y89) and annual population estimates for the catchment area of the service were obtained from the Central Statistics Office (23). These were used to calculate the incidence rate per 100,000 of external causes of death, the referral rate to the service per death, and the referral rate per 100,000 population. These are presented for the period 2016-2020.

In order to assess changes in psychological outcomes before and after completing therapy, mean scores for the CORE-OM measure were calculated for all responses with three or fewer individual items missing. These mean scores were then multiplied by 10, to express the scores in whole numbers. Changes in CORE-OM scores were analysed using paired-sample t-tests.

Descriptive statistics were used to summarise rating items on the client feedback forms (n=122), to provide information on the degree of satisfaction with the service from a client perspective.

2.2.2 Cost-effectiveness analysis

The cost-effectiveness analysis was undertaken using a health service perspective. As such, only costs and outcomes that pertain to the health service are included. Costs can be calculated using top-down or bottom-up costing methods or a combination of both. Given their high quality, we calculated costs using the top-down method (8). All overheads were included again because of the high quality of the cost data (8). A deterministic, as opposed to a probabilistic, economic model, was applied. In this analysis, cost-effectiveness is presented using quality-adjusted life years (QALYs), which are a measure combining both quality of time lived and the quality of life (utility) in that time period, with scores ranging from 0 to 1, with 1 representing perfect health. The results of the analysis was presented as an incremenetal cost-effectiveness ratio (ICER).

Utility scores were generated by converting the CORE-OM scores to CORE-6D using a mapping developed by Mavranezouli et al (24) and applied previously (25). Utility scores were calculated for each participant where sufficient data were available at T1 and T2 (n=45). Although this is a sub-sample of

participants, their profiles are similar to the overall sample in both age and gender profile, and we assume that the calculated QALYs are representative of the larger sample. In order to estimate costs for all clients referred to the service, a conservative QALY gain of zero were applied to clients who did not complete therapy. Similarly, a QALY gain of zero was applied for those who did not engage with the service.

As it was not possible to calculate confidence intervals for costs or QALYs for those clients without utility score data, we were unable to generate a scenario analysis for the entire population entitled to the referred to the service. Therefore a scenario analysis was performed using utility score data from clients who completed therapy (n=45). As part of this, a sensitivity analysis calculated ICERs based on the lower and upper bounds of variation for calculated costs and QALYs, reflecting 'best' (costs at lower 95% CI and QALYS at upper 95% CI) and 'worst case' (costs at upper 95% CI and QALYS at lower 95% CI) scenarios.

All analyses were conducted using SPSS V27 and Stata 16.

2.3 Stage 3: Surveys of referring healthcare professionals and service Counsellors

Following a review of Stages 1 and 2, cross-sectional surveys were conducted to understand the operation of the service from the perspectives of healthcare professionals referring into the service and the Counsellors who are contracted to work for the service. Both surveys were anonymous and were conducted online using the Qualtrics Survey Platform between September and November 2021. The service team circulated the survey link to the eligible participants via their contact lists. Participants provided consent to participate in the research before beginning the survey.

All healthcare professionals who have previously referred to the service were invited to participate in the survey. In addition, further healthcare professionals who are eligible to refer to the service were invited to participate in the survey. A combination of rating questions and open-ended questions were used to gather information on key demographics (e.g. occupation, working arrangements), experiences of working with patients who are traumatically bereaved, and their utilisation and experience of the service. The survey took an average of 5.5 minutes to complete.

All Counsellors who are currently working for the service or who have previously worked for the service were invited to take part (n=30). A combination of rating questions and open-ended questions were used to gather information on demographics and background of the Counsellors (e.g. working arrangements, qualifications and training), experience of working with the service, supports available for Counsellors and the impact of Covid-19 on service delivery. The survey took an average of 33 minutes to complete and participants had the option of returning to the survey at a later time.

2.3.1 Statistical analyses

Descriptive statistics were used to summarise the profile of healthcare professionals according to their gender, occupation, working arrangements, experience of treating patients with traumatic bereavement and their knowledge and experience of engaging with the service. Descriptive statistics were also used to summarise the profile of Counsellors according to gender, professional experience, qualifications, time working with the service, and experiences of working with the service.

All descriptive statistics were completed using SPSS Version 27. Open-ended questions were analysed using content analysis techniques.

3 Description of the service

3.1 Service overview

The HSE Bereavement Counselling Service for Traumatic Deaths (South East Community Healthcare), hereafter described as *the service*, was established in 2006 and is funded by the Health Service Executive. The service is operated by the service management team, located in the HSE Regional Suicide Resource Office.

3.1.1 Purpose of the service

The purpose of the service is to provide therapeutic interventions to people who have been bereaved by traumatic deaths. The service was set up to meet a need for specialised bereavement support services in the area, with a particular focus on suicide bereavement. The rationale for having broad inclusion criteria beyond suicide bereavement was based on contextual factors including ambiguity in the classification of suicide deaths or ambiguity concerning whether a traumatic death was self-inflicted or accidental. The service falls under Level 3 and 4 of the Irish Hospice Foundation's Pyramid of Bereavement Care (12). While there are a range of other counselling/therapy services that may be available to residents of the region (Appendix 2), the service is unique in its focus on individuals who have been bereaved by traumatic death.

The HSE core values of *Care, Compassion, Trust and Learning* underpin the service. The service addresses a number of key actions in Connecting for Life: Ireland's National Strategy to Reduce Suicide, 2015-2024 (4), specifically those which seek to improve and standardise the availability of tailored supports in Ireland for those bereaved by suicide (Actions 4.3.1 and 4.3.2).

3.1.2 Inclusion/exclusion criteria

The service is available for immediate and extended family members as well as friends, work colleagues, partners, carers and others who have been bereaved by a traumatic death. In the context of this service a traumatic death includes:

- Suicide
- Homicide
- Road Traffic Accidents
- Domestic, Agricultural and Industrial Accidents
- Drowning

Counselling can be provided to individuals, couples or families, but all clients must be aged 16 years or older. Parental/guardian consent is required for those aged 16 and 17 years.

Although not formalised, since the Covid-19 pandemic, the service has accepted referrals for clients bereaved by Covid-19.

3.1.3 Catchment area

The catchment area for the service is HSE South East Community Healthcare (HSE SECH) which has a population of approximately 497,578 (Health Service Executive, 2021). This includes Waterford City and County, Wexford, Kilkenny, Carlow and South Tipperary. Within the HSE SECH, the mental health services (MHS) are divided into Waterford-Wexford MHS and Carlow-Kilkenny-South Tipperary MHS. Referrals are accepted once a person a) has an address within HSE SECH, b) is accessing either a primary care service or c) a mental health service within HSE SECH.

3.1.4 Governance structures

The service has an identified service manager and service administrator who report to HSE MHS in SECH. Therapy sessions are provided by Counsellors working within SECH who are contracted to the service. In the case of risk to a client, the service manager would report to the HSE MHS in SECH and the HSE risk management structure. The Director of Counselling (DOC) for HSE SECH provides clinical consultation for the service when the need arises, when there is significant risk or when the service manager requests clinical guidance and support.

There currently is no designated oversight group for this service. The service manager oversees the operation and budgeting for the service and reports to the Head of Service for MHS in SECH. Many policies provide guidance for the service and are integrated into this service description. A full list of the policies and a brief description of each is included in Appendix 3.

3.1.5 Service Counsellors

As of September 2021, there were 18 Counsellors contracted to work for the service, who provided coverage across the counties in SECH. Counsellors who work with the service typically also work or have worked for other HSE services such as Counselling in Primary Care (CIPC), the Self-Harm Intervention Programme (SHIP), Counselling and Psychotherapy for Adults who experienced childhood abuse or neglect (CaPA), and Addiction Services. Counsellors must have:

- Professional accreditation with the Irish Association for Counselling and Psychotherapy (IACP); the Psychological Society of Ireland (PSI); or the Irish Association for Humanistic and Integrative Psychotherapists (IAHIP).
- Garda clearance: Counsellors are currently Garda vetted through their accrediting body and provide a self-declaration for same to the service. Since 2022, Counsellors are vetted through the HSE
- Professional indemnity to the value of €6.5m
- Tax clearance
- Children First Training
- Arrangements in place for supervision as per the requirements of their accrediting body

Training/experience in the area of trauma and/or bereavement is desirable but not required by the service. Counsellors are invited to a range of trainings pertaining to bereavement and suicide prevention/postvention via the Suicide Resource Office free of charge. The service arranges specific training based on emergent needs. The service also shares information on trainings offered by the Irish Hospice Foundation and the National Counselling Service which Counsellors can avail of. The service does not provide supervision to Counsellors but as documented, the service pays for one supervision session for every 30 counselling sessions a Counsellor delivers (rate of 1:30). Since January 2022, this has increased to a rate of 1:15.

There exists a clinical consultation service via the Director of Counselling (DOC) in SECH for Counsellors. If a Counsellor encounters a situation of risk relating to a client, they can liaise with the DOC to form a decision on an appropriate response. Once a decision has been reached, the service is informed, the decision is recorded, and the service is responsible for any referral to another service that follows. A diagram describing the governance structures is included in Appendix 4.

3.1.6 Service referral pathway

Referrals into the service can be made by all healthcare professionals working in the SECH. In order to refer into the service, a referral form is completed by the referring healthcare professionals which includes details about the client, the referrer details, the nature of their bereavement, details of other service engagement and other relevant information. Where the referrer is not a GP, the client's GP details must be provided on the form. Referrals are accepted in hard copy through the post or referrers can complete an electronic referral form and send by email via HSE or Healthmail email addresses.

The Suicide Resource Office receives and processes the referral. If the client has been recently bereaved by suicide (within past two months), both the Counselling Service and the Suicide Bereavement Liaison Officer Service will be described to the client and they will be referred into their preferred service. If the client initially attends the Suicide Bereavement Liaison Officer (SBLO) service, the SBLO can later refer them to the Traumatic Bereavement Counselling Service.

The referrer receives acknowledgement of receipt of referral. The process that follows for the client is outlined in Figure 3.1. A letter is posted to the client and to the assigned Counsellor who is to make contact with the client within three working days. This letter also includes information on the service, support services in the area, and a bereavement pack. The pack includes leaflets and information tailored to the situation of the client and details of the HSE Feedback Initiative 'Your Service Your Say'.

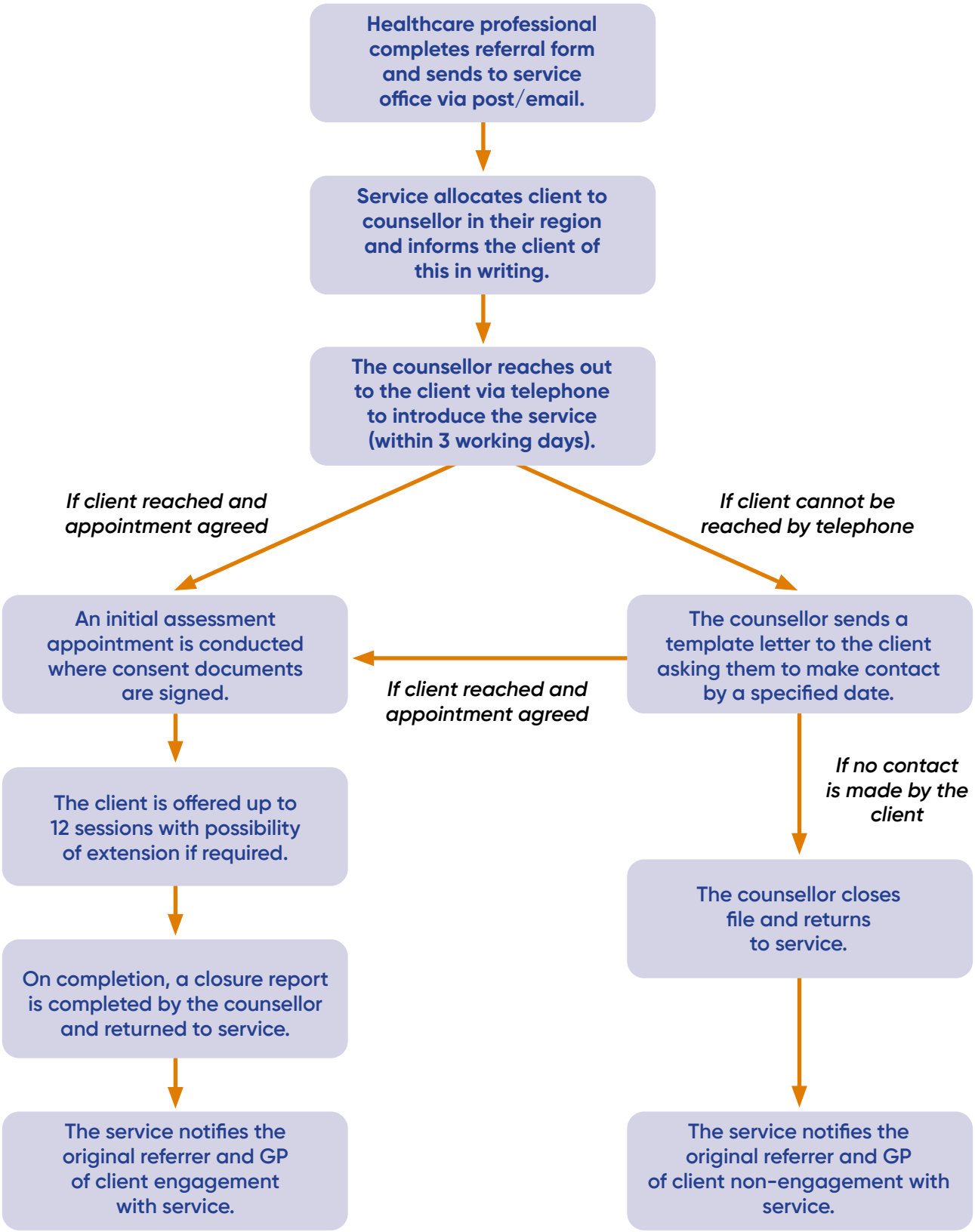


Figure 3.1. Process of client referral through to file closure

3.2 Counselling provided through the service

3.2.1 Initial assessment

An initial assessment is scheduled by the assigned Counsellor and typically lasts up to 1.5 hours. This involves completion and signing of key documents outlined below that are recorded in the client file.

- **Client Contract:** this document includes a confidentiality agreement and is signed at the initial assessment. Parental/guardian consent is required for those aged 16-17 years.
- **Consent for Information Form:** this document gives consent for Counsellor to contact/give information to a third party should the need arise. The Counsellor will inform the client in advance of contacting a third party.
- **Your Service, Your Say:** a HSE initiative to encourage client feedback on HSE services via paper or online forms. This is explained to the client at the initial assessment.
- **CORE-OM:** a measure to provide an indication of the client's wellbeing at the beginning of therapy. This is completed by the Counsellor in discussion with the client and will also be completed at the end of therapy.

3.2.2 Counselling sessions

The service does not stipulate the content of counselling – this rests with Counsellors. The client can be offered up to 12 sessions outside of the initial assessment. There is also flexibility for Counsellors to request further sessions for the client by contacting the service manager and providing a rationale for further sessions.

Additional sessions can also be requested after a client file has been closed. If a client requires 1-2 additional sessions, this request can be approved by the service manager provided the client file has been closed within the previous month. If a client requires two or more additional sessions, the client must be re-referred by original referrer or new referrer using referral form. The session allowance is decided on a case-by-case basis.

3.2.3 End of counselling

The CORE-OM is completed again in the final client session. On completion of the counselling, a closure report is completed by the Counsellor including a summary of the client details and original referral information, the activities undertaken in counselling and the reason for closure. It is advised that the client file be closed immediately including all original paperwork. It must be returned to the service team within one month of closure as per the File Closure & File Return Policy. The original referrer and GP are notified of the client's engagement either with the SBLO service or following file closure with the Bereavement Counselling Service.

A client feedback form is also used to gather information on satisfaction with the service and is given to clients at the end of counselling.

4 Review of service referral database

Between January 2016 and December 2020, 856 referrals were made to the service [annual mean (range): 171 (110-231)]. Since 2016 the service has seen increased referrals each year, with a two-fold increase in referrals between 2016 and 2019 (110 to 231; +110%). In 2020 referrals decreased by 23% from the previous year (Table 4.1). Since 2019, re-referrals to the service have been systematically recorded. In 2019 and 2020, 7.8% of referrals (32 of 407) were by individuals who had been previously referred to the service.

Table 4.1. Number of referrals, 2016-2020

	N (%)
2016	110 (12.9)
2017	150 (17.5)
2018	188 (22.0)
2019	231 (27.0)
2020	177 (20.7)
Total (2016-2020)	856 (100)
Average (2016-2020)	171

The vast majority of referrals made into the service were from primary care – via General Practitioners (n=635; 74.2%), CIPC (29; 3.4%) and the HSE SCAN Service (29; 3.4%). The other common referral source was via mental health professionals in emergency, liaison and community mental health settings (101; 11.8%). Other sources of referral included the Pieta SBLO Service (22; 2.6%) and private Psychologists or Counsellors (14; 1.6% - Table 4.2).

Table 4.2. Sources of referral to service, 2016-2020

	N (%)
General Practitioner	635 (74.2)
Emergency/Liaison/Community Mental Health Staff	101 (11.8)
Counselling in Primary Care (CIPC)	29 (3.4)
Suicide Crisis Assessment Nurse Service (SCAN)	29 (3.4)
Suicide Bereavement Liaison Service (SBLO)	22 (2.6)
Other health professional	40 (4.7)

Most referrals received into the service were within the defined catchment region (n=808), with nine referrals made for clients residing outside of this region (Table 4.3). The rate of referrals per 100,000 population varied across counties within the service catchment region. The referral rate was highest in Waterford City and County (59.9 and 48.0 per 100,000, respectively) and lowest for Kilkenny (17.5 per 100,000).

Between 2016 and 2020, there were 723 deaths due to external causes recorded within the catchment region (ICD codes V01-Y89) (23), lowest in County Kilkenny (25.9 per 100,000) and highest in Waterford City (41.8 per 100,000). The regional referral rate per death was 1.1, indicating that for every death recorded in the region, approximately one person was referred to the service. This rate varied slightly across counties, ranging from 0.6 in Wexford to 1.4 in Waterford City and County.

Table 4.3. Referrals to service according to city/county of residence, 2016-2020

	Number of referrals in area[1]	Referral rate per 100,000 population	Number of deaths in area[2]	Rate of death per 100,000 population	Referral rate per death	Number of therapists[3]
Carlow	68	23.7	77	26.8	0.9	3
Kilkenny	88	17.5	130	25.9	0.7	3
Wexford	160	21.1	244	32.2	0.6	4
Tipperary South	171	38.0	52	28.9	1.0	6
Waterford City	146	59.9	102	41.8	1.4	5
Waterford County	166	48.0	118	34.1	1.4	
Region	808	30.9	723	28.0	1.1	18
Out-of-area	9	-	-	-	-	-

[1]Excluding known re-referrals (n=11). [2]ICD-10 codes V01-Y89. Figures for 2019 and 2020 provisional. [3]Counsellors contracted in 2020. Some Counsellors work across counties/part of a county.

4.1 Demographics of service referrals

The majority of referrals into the service were female (n=579; 67.6%), while 31.2% (n=267) were male, and a minority (n=10; 1.2%) were for a couple. Almost two-thirds of referrals were for those aged 16-44 years (n=122; 63.5%). Referrals for male clients were generally younger in age, with almost half aged under 35 years of age (n=29; 49.2%), in comparison with 37.1% (n=49) of females referred (Table 4.4).

Table 4.4. Demographics of individuals referred to service, 2019-2020

	N (%)
Gender	
Male	267 (31.2)
Female	579 (67.6)
Couple	10 (1.2)
Age group[1]	
16-24 years	46 (24.0)
25-34 years	32 (16.7)
35-44 years	44 (22.9)
45-54 years	31 (16.1)
55-64 years	27 (14.1)
65+ years	12 (6.3)

[1]Recorded since 2019. Unknown in 52 (12.7%) of cases.

In most cases, the individual had been bereaved by suicide (n=593; 69.3%; Table 4.5). Almost one-fifth of individuals were referred following an accidental death (161; 18.8%), including road-traffic accidents (101; 11.8%), domestic and workplace accidents (21; 2.5%; 17; 2.0%). A number of referrals (42; 4.9%) were also made following a homicide.

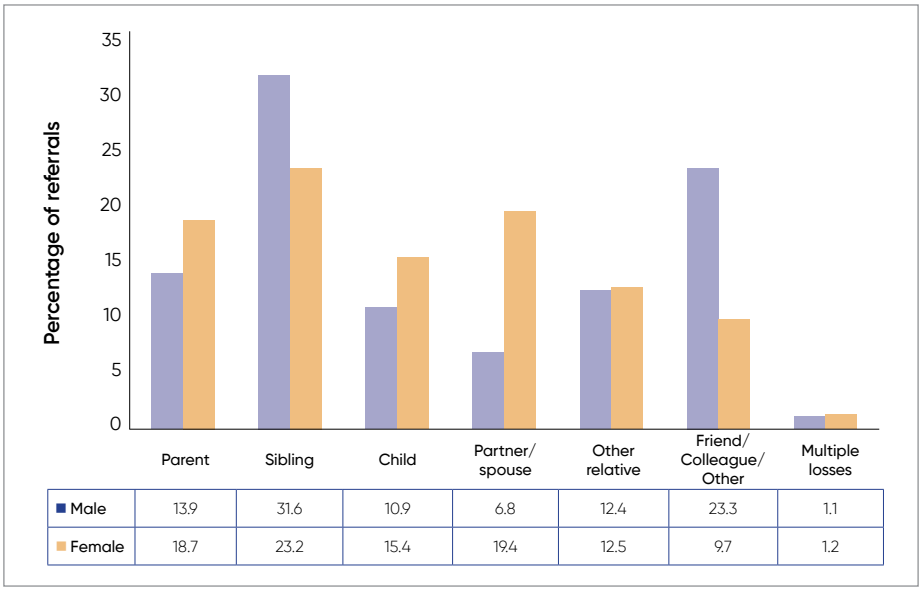
Table 4.5. Type of bereavement of individuals referred to service

	N (%)
Suicide	593 (69.3)
Road traffic accident	101 (11.8)
Domestic accident	21 (2.5)
Workplace accident[1]	17 (2.0)
Accident (not specified)	22 (2.6)
Homicide	42 (4.9)
Overdose	22 (2.6)
Drowning	17 (2.0)
Other	10 (1.2)
Not specified	2 (0.2)

[1]Primarily agricultural accidents (n=10; 58.8%)

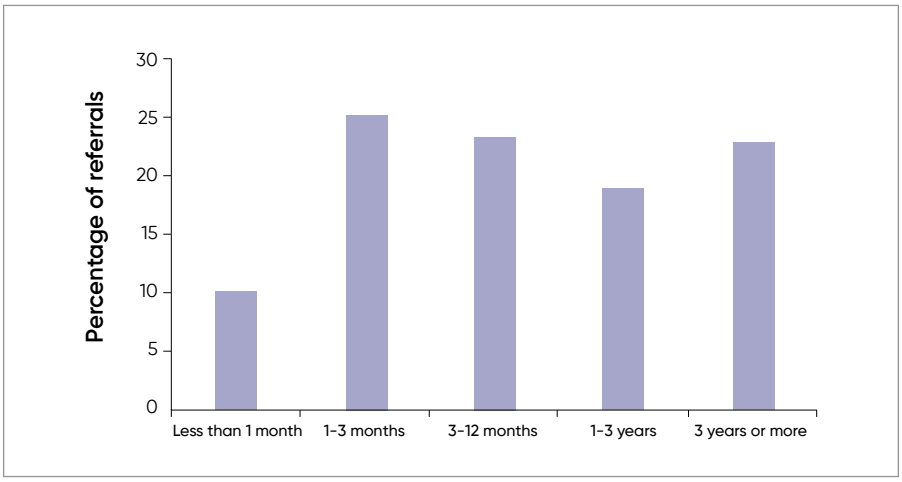
Most individuals referred were an immediate family member of the person who died. One-quarter (25.5%) were a sibling, 17.8% a parent, 15.2% a partner or spouse (current or former) and 13.9% were a child of the deceased. Other relatives accounted for 12.3% of the referrals, including extended family, and 13.8% of referrals were for friends, colleagues and other contacts of the deceased. Females were more likely than males to be a partner or spouse of the deceased (19.4 v 6.8%). Siblings and friends/colleagues referred to the service were more likely to be male (31.6 v 23.2% and 23.3. vs 9.7%, respectively – See Figure 4.1). While these patterns will reflect the higher incidence of male deaths due to external causes, males were generally under-represented among parents referred to the service (13.9% vs. 18.7%).

Figure 4.1. Relationship to deceased according to gender



The length of time bereaved varied considerably, from less than one month to more than 10 years. However, more than a third (127; 35.2%) of individuals referred to the service had been recently bereaved, within the previous three months (Figure 4.2). Males (n=18; 50.0%) and friends or colleagues of the deceased (n=14; 28.9%) made up a large proportion of those referred to the service within a month of bereavement.

Figure 4.2. Time since bereavement



4.2 Client outcomes

The majority of referrals received to the service were processed within one week of receiving the referral (733; 85.6%), and almost two-thirds (531; 62.0%) were processed within 24 hours of the referral being received.

At the time of analysis, 42 (4.9%) referrals recorded in 2020 were still actively engaged in the service. Of closed records (814; 95.1%), the median case duration was five months (inter-quartile range: 7).

In most cases, the individual referred to the service was recommended for therapy with an assigned Counsellor (740; 90.7%). Of these, under half of individuals completed their therapy (335; 41.1%). Just under one-third (238; 29.3%) disengaged with the therapy before it was complete, and a further 20.5% (167) did not attend their first appointment.

The remaining referrals to the service (74; 9.1%) did not receive an appointment with a therapist. This was due to the individual being referred to another service (20; 2.5%), declining the service (27; 3.3%) or not engaging (27; 3.3%) (Table 4.6).

Table 4.6. Care pathway for individuals referred to service

	N (%)
Therapy completed	335 (41.2)
Disengaged from therapy	238 (29.2)
Did not attend first appointment	167 (20.5)
Did not engage with service	27 (3.3)
Declined service	22 (2.7)
Referred to another service	20 (2.5)
Other reason	5 (0.6)

Those who completed therapy attended an average of 12 sessions (SD: 5) over a period of eight months (median, IQR=8). For those who started therapy and subsequently disengaged, an average of four (SD: 3) sessions were completed. For the small number of people who were referred to another service following therapy (n=29; 3.6%), the average number of sessions attended was nine (SD: 8).

4.3 Change in CORE-OM scores following completion of therapy

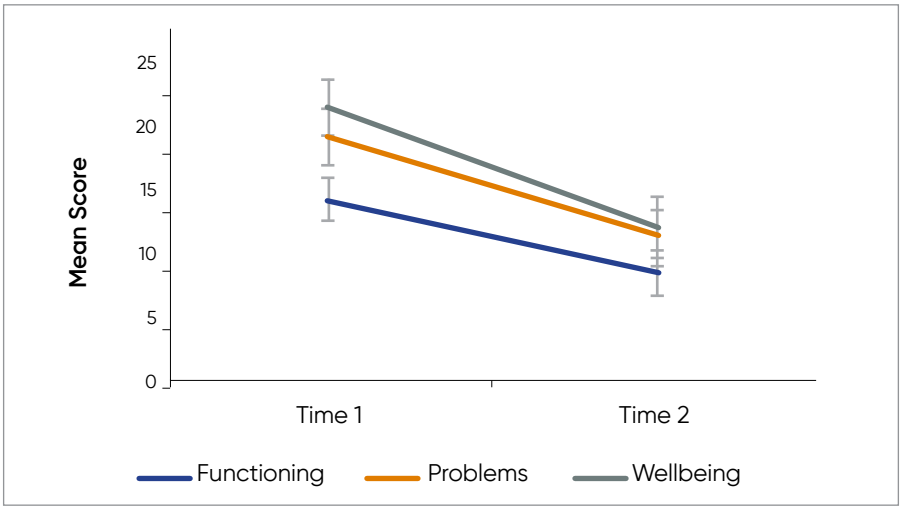
For a sub-sample of individuals who completed therapy (n=48), data from the Clinical Outcomes in Routine Evaluation – Outcome Measure (CORE-OM) were available for analysis. For this sample, measures were taken at Time 1 (pre therapy) and at Time 2 (post therapy). At Time 1, the mean CORE-OM score was 14.71 (SD: 5.23), with 82.7% of the sample above the clinical cut-off score of 10 or more (Table 4.7). The mean scores for functioning, problems and wellbeing sub-scales were 14.27 (SD: 5.71), 19.31 (7.73) and 21.6 (SD: 7.37), respectively.

Table 4.7. Baseline mean scores for CORE-OM (n=48)

	Mean (SD)	Range
CORE-OM	14.71 (5.23)	5.29-27.35
Functioning	14.27 (5.71)	4.17-26.67
Problems	19.31 (7.73)	7.50-37.50
Wellbeing	21.60 (7.37)	6.67-35.0

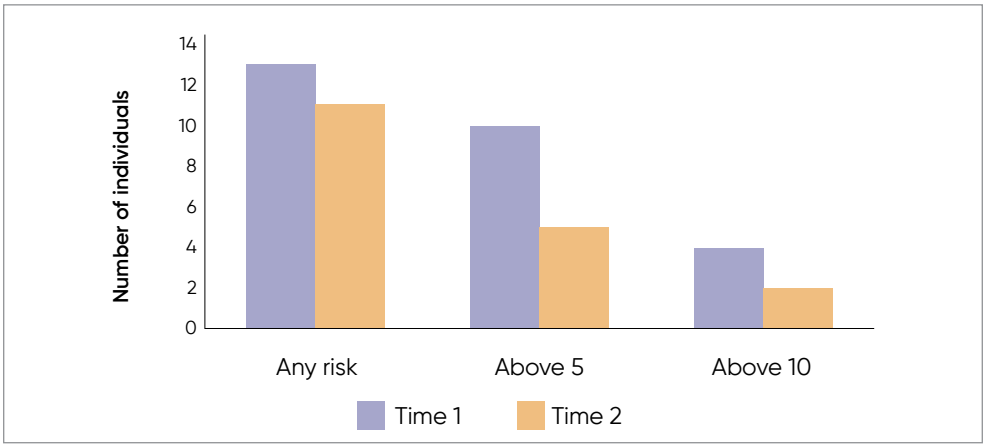
The overall mean CORE-OM score on completion of therapy was significantly lower than at baseline [8.7 (mean diff: -6.0; t=7.3(47), p<0.001)]. Similarly, there were significant reductions recorded for the subscales of functioning (mean diff: -5.7; t=6.6(47), p<0.001), wellbeing (mean diff: -7.9; t=7.1(47), p<0.001) and problems (-9.6; t=10.4(47), p<0.001) (Figure 4.3). Of clients reporting a score of 10 or more at Time 1, 25 (60.9%) reported improvements of clinical significance, with scores of less than 10 at Time 2.

Figure 4.3. Change in mean CORE-OM scores at Time 1 and Time 2 (n=48).



At Time 1, 13 individuals (27.1%) reported some indications of risk, as measured by the risk subscale of the CORE-OM. At Time 2, this number reduced to 11 (22.9%). In particular, the number of individuals reporting a risk score of five or more reduced from 10 to two (Figure 4.4).

Figure 4.4. Number of individuals reporting risk indication at Time 1 and Time 2.



4.4 Cost-effectiveness analysis

The unit cost of a counselling session is based on 2020 data. The total costs of the service were €130,033. This bought 1,469 counselling sessions implying a unit cost per session of €88.52. For clients who completed therapy (n=335; 41.2%), the mean number of sessions was 11.5 and the mean cost per client was €1,017.96 (95% CI 967.51-1,068.40) (Table 4.8). For clients who partially completed their therapy (n=238; 29.2%), the mean number of sessions was 4.7 and the mean cost per client was €540. The remainder (n=241; 29.6%) did not engage, a cost of zero was assumed for this group[1].

Across all three client groups, the average cost per client was €541 and the average health gain per client was 0.0399 QALYs. Consequently, the Incremental Cost-Effectiveness Ratio (ICER) for the average client is €13,500 (Table 4.8). Based on a willingness-to-pay threshold of €45,000 (8, 9), this indicates that the service is cost-effective and represents good value for money.

Table 4.8. Costs and outcomes used in the economic model

Level of Engagement	%	No. Sessions	Mean Cost (€)	Mean QALY gain	Weighted Mean cost (€)	Weighted Mean QALY gain	ICER (€)
Therapy completed	41.2	11.5	1,018	0.0969	419	0.0399	-
Disengaged	29.2	4.7	540	0	122	0	-
Did not attend/engage	29.6	0	0	0	0.00	0	-
Total	100	6.1	-	-	541	0.0399	13,550
ICER = Incremental Cost Effectiveness Ratio; QALY = Quality-Adjusted Life Year							

An additional scenario analysis was conducted for the group of clients who completed therapy, in order to better estimate their health gain and associated costs. For this group, the average cost per client of the therapy was €1,018 (95% CI 967.51-1,068.40) (see Table 4.9). These clients reported an improvement in quality-adjusted life years (QALYs) from 0.7284 at baseline to 0.8253 at follow-up, a significant increase of 0.0969 ($p<0.001$). The Incremental Cost-Effectiveness Ratio (ICER) is €10,506. The worst-case scenario, which represents the ICER if the costs are at the upper bound of the 95% confidence interval and QALYs are at the lower bound, is €22,366. This worst-case scenario is well within the threshold of €45,000 (8,9) outlined above.

[1] Administrative costs and partial fees paid to Counsellors are incorporated into the unit costs calculated for clients who engaged with the service.

Table 4.9. Scenario analysis for clients completing therapy (n=335)

Average cost per client (95% CI)	€1,018 (€967.51-€1,068.40)
Quality-adjusted life years	
Baseline (95% CI)	0.7284 (0.6766 – 0.7803)
Follow-Up (95% CI)	0.8253 (0.7853 – 0.8655)
Difference (95% CI)	0.0969 (0.1461 - 0.0478)
ICER (€/QALY gained)	€10,506
ICER (€/QALY gained) lower cost/higher QALY	€6,623
ICER (€/QALY gained) higher cost/lower QALY	€22,366
Ci=Confidence Interval; ICER = Incremental Cost-Effectiveness Ratio	

4.5 Client feedback

Client feedback on the service was largely positive, based on 122 completed client feedback forms. All those providing a response to the question if they would recommend the service to others (n=101), answered 'yes'. In terms of specific service aspects, 90% or more participants rated three components as excellent/very good (Figure 4.5): ease of access to service through a healthcare provider; the initial contact with counsellor/time from initial contact to first appointment; and the counselling setting e.g. venue, room, facilities. The quality of the bereavement pack was rated as excellent/very good by 73.5% (n=86) of participants while 23.1% (n=27) rated it as good and 2.6% (n=3) rated it as fair.

Figure 4.5. Client ratings of service components

"[The counsellor] allowed me to be myself and gave me time to open up. She understood me very quickly; I found it very hard to express myself and as soon as I did I felt an amazing sense of relief."

"Being able to talk to someone outside of my family & friends. Learning to cope with my grief, giving me the tools & advice to learn how to say no."

"Reassuring that it was normal to feel the way I felt and [the counsellor] was there to get me through my struggles"

"I'm very grateful for all the counselling I had, it changed my life, it made me accept my brother's death and come to some kind of peace with it."

"Extremely impressed with the professionalism of the service and the respect and help I was given."

5 Survey of referring healthcare professionals and service Counsellors

5.1 Survey of healthcare professionals in catchment area

In total, 34 healthcare professionals eligible to refer to the service provided responses to the survey (Table 5.1). Most respondents were female (n=23, 67.6%). The majority worked full-time (n=26; 76.5%). Half of the respondents were General Practitioners. Other professions represented included Consultant Psychiatry (n=5, 14.7%), Nursing (n=7; 20.6%), others (n=5; 14.7%) included Psychology, SBLO Service, Social Work and Occupational Therapy. There was representation across rural and urban areas across HSE SECH, with some respondents working across areas.

Table 5.1. Demographics of healthcare professionals (n=34)

	N (%)
Gender	
Male	11 (32.4)
Female	23 (67.6)
Occupation	
General Practitioner	17 (50)
Consultant Psychiatrist/ Psychologist	5 (14.7)
Nursing staff	7 (20.6)
Other	5 (14.7)
Location	
Carlow	7 (20.6)
Kilkenny	4 (11.8)
Waterford County	8 (23.5)
Waterford City	6 (17.6)
Wexford	13 (38.2)
South Tipperary	9 (26.5)

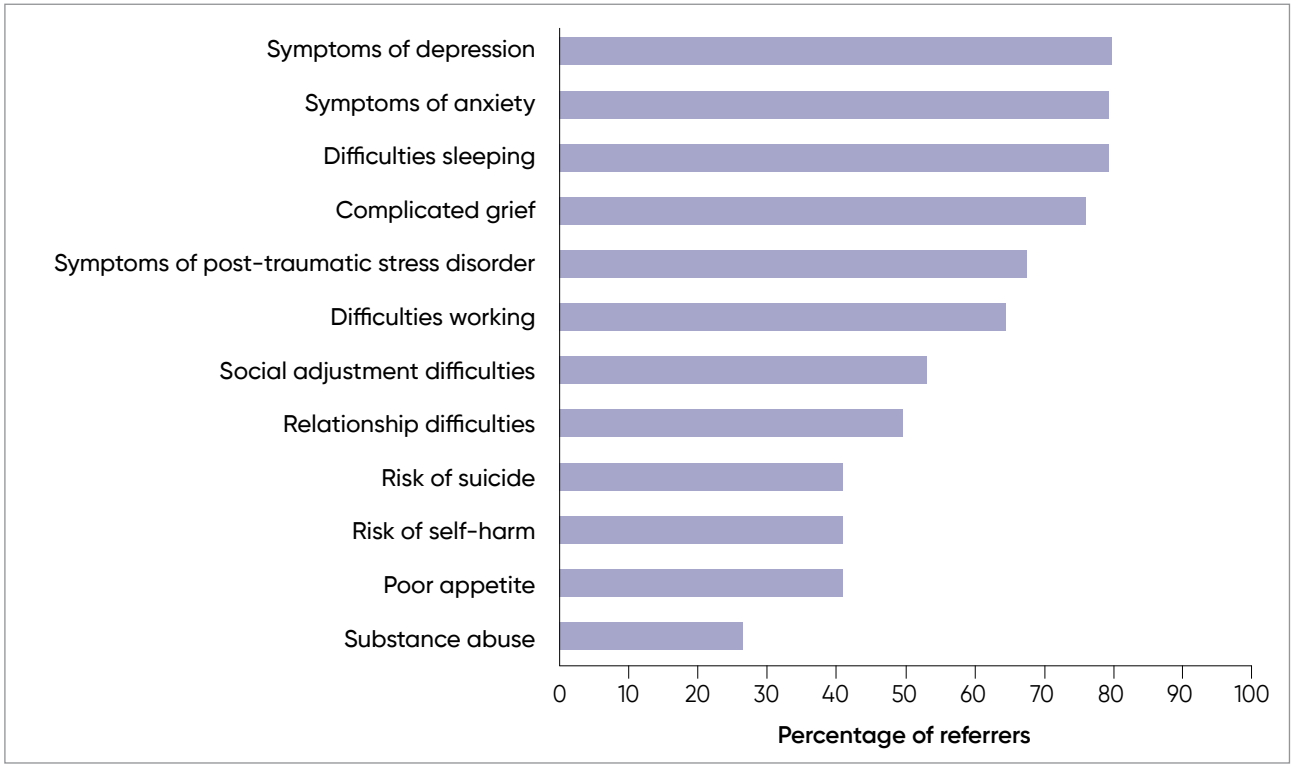
The GPs who responded had a minimum of 6-10 years' experience with almost half (n=8; 47.1%) working in the role for 21 or more years. The GPs worked in practices with 1000 or more patients and the average number of GPs in each practice (median) was 3 (range: 1-9).

The other healthcare professionals worked across a range of settings with approximately half working in Community Mental Health Teams (n=9; 52.9%). Participants were varying lengths of time in their current roles ranging from less than a year through to 21-30 years. Approximately half (n=8; 47.1%) were 1-5 years in their current role.

5.1.1 Experience of patients with traumatic bereavement

All respondents reported encountering varying numbers of patients who have experienced traumatic bereavement. Most of the respondents (n=26, 76.5%) stated that they encounter between one and 10 traumatically bereaved patients each year. Respondents were asked to identify the most common concerns of patients with a traumatic bereavement. Symptoms of depression, symptoms of anxiety and difficulties sleeping were the most commonly reported by referrers (n=27; 79.4%; Figure 5.1). Complicated grief (n=26; 76.5%), symptoms of PTSD (n=23; 67.6%) and difficulties working (n=22; 64.7%) were also prevalent concerns reported.

Figure 5.1. Concerns of traumatically bereaved patients identified by referrers



5.1.2 Experience of referral and the service

Almost all respondents (31; 91.2%) were aware of the service and had previously made a referral to the service (30; 88.2%). One respondent who had not referred to the service reported that this was due to working with clients who would have already received interventions for traumatic bereavement. Of the 27 participants providing data on experience of referral, all rated their experience of referral as 'Excellent' (n=18; 66.7%) or 'Good/Very Good' (n=9; 26.5%)

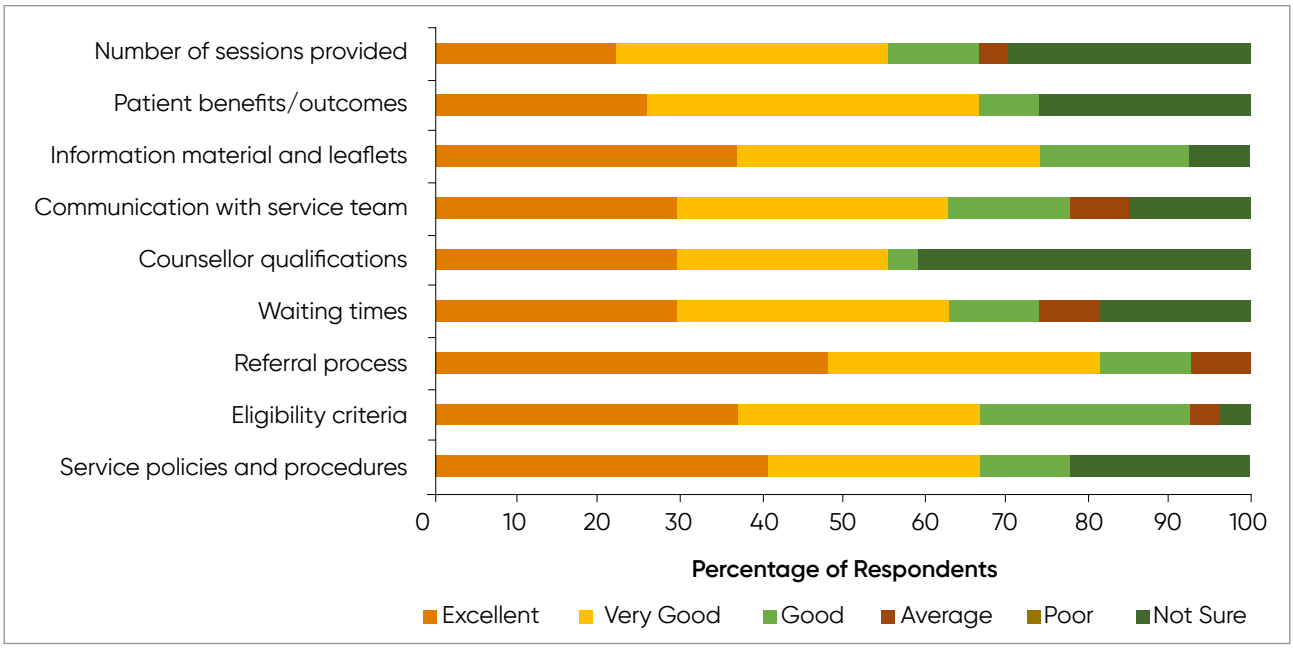
Ratings of specific aspects of the service are presented in Figure 5.2. Respondents rated most service features as 'Excellent' or 'Very Good'.

In the qualitative comments, short waiting times were a frequently highlighted benefit in experiences of referral (n=10; 37.0%). Respondents also commented on the ease of the referral process (n=4; 14.8%) and the prompt response to referral from the service (n=6, 22.2%). Communication with the Service Team was also positively appraised, and one respondent noted that "staff have been helpful in terms of providing information & guidance re suitability of referrals for the service". Four participants (15.4%) suggested that feedback on client attendance and engagement should be provided to referrers.

While the overall eligibility criteria of the service was rated positively by respondents, six respondents (21.3%) suggested the criteria could be expanded to include other causes of death, including sudden causes of death, substance misuse or Covid-19. Two respondents (7.7%) felt that inclusion of people under 16 years would be beneficial.

A number of the 27 respondents in this section were 'unsure' about certain aspects of the service, including qualifications of the Counsellors (11; 40.7%) and the number of therapy sessions provided by the service (8; 29.6%), which may reflect a lack of familiarity of the service structure. Two participants (7.7%) commented on the need for more sessions per client. A number of respondents (7; 25.9%) were 'unsure' about the patient outcomes/benefits of the service. However, benefits and positive feedback from patients were highlighted in open-ended responses (n=7; 25.9%).

Figure 5.2. Referrer ratings of service components



5.1.2.1 Unique contributions of the service

In a specific question asking about the uniqueness of the service, most respondents (n=22; 84.6%) felt this service provides unique support. The main reason this service was viewed as unique was due to providing **specialised support** (n=12; 46.2%), particularly in relation to the service focusing specifically on bereavement, with respondents noting "very little bereavement counselling services available". The precise focus on traumatic bereavement was also highlighted by many, for example:

"The emphasis on the traumatic nature of the death is different to support which might be available from other providers."

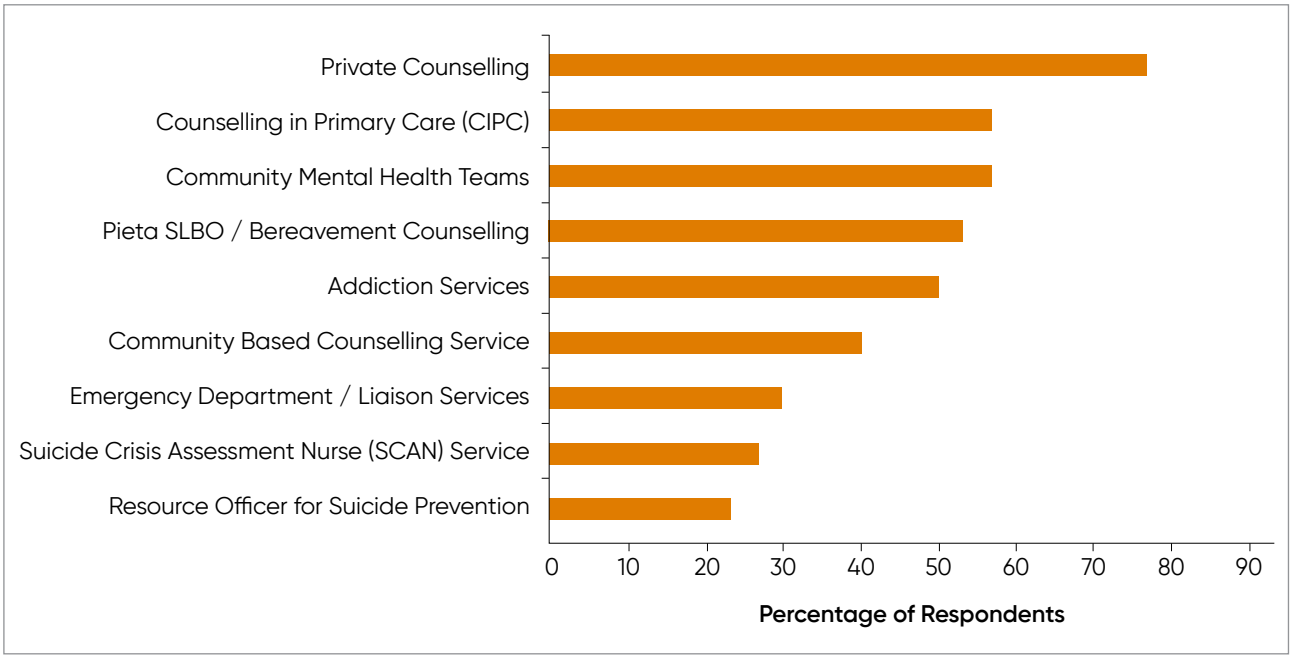
"Due to its specificity, I believe the support being specialised in traumatic deaths is rarely found in other services. It ensures highly qualified, specialised support is given that 'general' Counsellors may not be able to provide."

The other reasons provided for why the service was unique included **short waiting times** (3; 11.5%), **free service** (3; 11.5%), **accepting people who do not meet criteria for other services** such as CIPC or 16/17 year olds who have little else available (n=2; 7.7%) and the **lack of availability of other appropriate counselling** (n=2; 7.7%).

5.1.3 Alternative referral options

Respondents were asked to provide reasons for not referring patients to the service. The most common reasons were the length of time since bereavement (n=10; 38.4%) as well as concerns over the mental state of an individual (n=9, 34.6%). Participants identified other services in the area for referral of patients with a traumatic bereavement (Figure 5.3). Private counselling was the most commonly reported (n=23; 76.7%). CIPC and Community Mental Health Teams were each commonly used for referral (n=17, 56.7%) followed by Pieta SBLO/Bereavement Counselling and Addiction Services, respectively. Two participants (6.7%) reported other services to which they refer which were primary care psychology and private clinical psychology.

Figure 5.3. Other referral services used for patients with traumatic bereavement.



5.2 Survey of service Counsellors

All Counsellors who currently or previously worked for the service were invited to take part (n=30). In total, completed surveys from 18 Counsellors were received, representing 60.0% of the group. Of these, four were no longer working with the service. Two participants provided partially complete responses and therefore, some of the later responses are drawn from 16 participants.

Table 5.2 provides the characteristics of the Counsellors who responded to the survey. There was representation across different backgrounds, including time working as a therapist and practice locations across the SECH. All respondents are engaged in private practice and some combined this with other working arrangements.

Table 5.2. Characteristics of participating Counsellors (n=18)

	N (%)
Gender	
Male	3 (16.7)
Female	15 (83.3)
Years' experience	
Between 1 and 10 years	3 (16.7)
More than 10 years	15 (83.3)
Practice Location	
Carlow	2 (11.1)
Kilkenny	3 (16.7)
Waterford County	5 (27.8)
Waterford City	7 (38.9)
Wexford	4 (22.2)
South Tipperary	4 (22.2)
Employment arrangements	
Private practice	18 (100)
Employed by School/Third Level Institute	3 (16.7)
Employee Assistance Programme	5 (27.8)
Role within other organisation/charity	5 (27.8)
Contracted to a service	13 (72.2)
Client groups	
Adults	18 (100)
Adolescents	14 (77.8)
Families/Groups	3 (16.7)
Couples	9 (50)
Time working with service	
Less than 2 years	9 (50.0%)
2-6 years	2 (11.1%)
More than 6 years	7 (38.8%)

Respondents reported varying lengths of time employed with the service, ranging from under one year to over 10 years, the largest proportion of whom had less than two years' experience with the service (n=9, 50.0%). Four respondents no longer work for the service, and their time of employment ranged between 1-6 years. Of the 11 participants who provided an estimated annual number of clients seen from the service, the median number of clients per year was 12 with a range of 1-30.

5.2.1 Counsellor qualifications and training

Most Counsellors were accredited via the IACP (n=16; 88.9%). Those not accredited with the IACP were accredited with IAHIP. Some Counsellors had dual accreditation with other bodies. Almost all Counsellors (n=17; 94.4%) completed at least one form of training in suicide prevention/suicide risk management with an average of three different types of training completed by each Counsellor (Table 5.3). The remaining respondents had training in suicide bereavement.

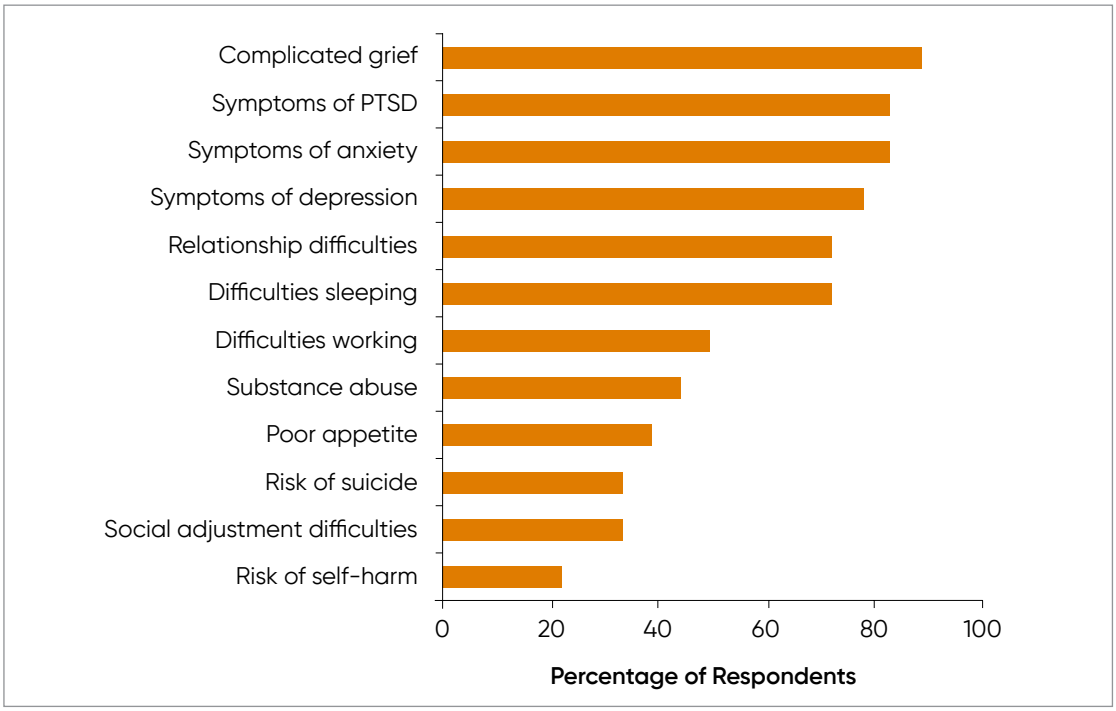
Fifteen Counsellors (83.3%) had at least one form of specialist training pertaining to either bereavement in general, suicide bereavement or traumatic bereavement. Half of the Counsellors reported training in approaches for people who have experienced trauma or who have been traumatically bereaved, including Sensorimotor Psychotherapy, Eye Movement Desensitisation and Reprocessing (EMDR), person-centred approaches and Cognitive Analytic Therapy (CAT).

Table 5.3. Training completed by Counsellors

	N (%)
Highest Educational Qualification	
Bachelor's degree	5 (27.8)
Masters/Post-graduate Diploma	13 (72.2)
Accreditation	
IACP	16 (88.9)
IAHIP	3 (16.7)
Training type	
Suicide Prevention / Management Suicide Risk	17 (94.4)
STORM	5 (27.8)
ASIST	16 (88.9)
START	1 (5.6)
Understanding self-harm	12 (66.7)
safeTALK	11 (61.1)
Contextual Conceptual Therapy	2 (11.1)
Other	2 (11.1)
Bereavement (general) Training	9 (50)
Suicide Bereavement Training	8 (44.4)
Traumatic Bereavement Training	9 (50)

Counsellors identified a range of concerns that clients who have been bereaved by a traumatic death report (Figure 5.4). The most reported symptoms according to Counsellors were complicated grief; symptoms of anxiety, depression, symptoms of PTSD; relationship difficulties and difficulties sleeping.

Figure 5.4. Primary concerns of clients reported to Counsellors



5.2.1.1 Beginning counselling with the service

The Counsellors' responses suggest that the appropriate time from bereavement to therapy is difficult to quantify. It can vary considerably and depends on the person. Counsellors emphasised that the client must be ready and many highlighted that therapy is often not suitable too soon after the death, such as within three months of bereavement. Quotations to support these perspectives are provided below.

"3 months. In my experience clients who attend within 3 months of the death often indicate shock, numbing or other psychological states that make clinical work unsuitable."

"I do not think there is a definite appropriate time. If the client needs it then that is the time. It can vary but my experience informs me that it is when the client themselves are in need."

"If the client is very recently bereaved, I would suggest 3/6 months after, sometimes friends and families have moved on and they assume the bereaved person is ready to do the same. Person would need to be monitored during these months by GP etc to see how they are coping. It is very individual to the person also."

"It's different for everybody but sometimes I believe it's too soon after the loss."

"Length of time varies from one client to another but overall the earlier the better as clients need therapeutic space to process own issues and understand the grieving process. Clients seen early on can also decide if time is right for them then or at some time in the future."

"Perhaps three months, but to be flexible with this. The reason I am saying this is that over the past year I have had 4 or 5 clients who were referred who didn't want to be referred for some reason and did not want to pick up the phone or engage with service."

"Referral should be when the client is ready to engage. This would vary from person to person. If the referral is too soon the client is not ready and still in shock."

5.2.1.2 Completing counselling with the service

Counsellors reported various reasons that clients might end their counselling with the service before 12 sessions are complete (Table 5.4). The most common reasons from the perspective of Counsellors were that the client had disengaged (n=12, 66.7%), or therapy was complete in fewer than 12 sessions (n=9, 50%). Other reasons were referral to another service, unforeseen circumstances in a client's life such as moving area or beginning the therapy too soon after bereavement.

Several reasons were identified to explain why a client may require more than 12 sessions. Half of Counsellors referred to a client 'needing more time' (n=9). In this case, progress was being made but it was slow and certain issues had not been resolved. Another reason was new challenges or issues arising for the client during therapy such as new information about a will or other family events and anniversaries (n=6, 37.5%). Other reasons included the presence of complicated grief, the client experiencing ongoing symptoms of trauma or the client beginning therapy too early and therefore not making progress until later sessions.

Table 5.4. Reasons for variation in session number

	N (%)
Reasons for completing fewer than 12 sessions (n=18)	
Disengaged	12 (66.7)
Therapy complete in fewer sessions	9 (50)
Referral to specialised service	6 (33.3)
Unforeseen client circumstances	5 (27.8)
Client not ready / not right time	3 (16.7)
Reasons for extension beyond 12 sessions (n=16)	
Need more time	9 (56.2)
New challenges arise during counselling	6 (37.5)
Complicated grief	2 (12.5)
Trauma symptoms persist	2 (12.5)
Counselling started too early	1 (6.3)

Over half of the participating Counsellors (n=9) reported referral of clients to other services. These services included SHIP, CaPA, CIPC, Rape Crisis Service, as well as other counselling services and free local grief services. Only one Counsellor reported keeping on a patient(s) privately following the allocated sessions.

5.2.1.3 Service policies

Most of the Counsellors rated the service policies favourably, most often as 'excellent' or 'very good' (Figure 5.5). No policy was rated as poor. However, there was some variation across the policies.

For the *Eligibility Criteria*, three participants (16.7%) rated this as 'good' and one participant (5.6%) rated the criteria as 'average'. In open text responses, a common suggestion for improvement was to include people who have been bereaved by other sudden/unexpected deaths (n=4; 22.2%).

Counsellors rated the referral process as excellent or very good. Ratings and open text comments were positive about *Communication with Service Team*, who were described as 'very helpful', 'very approachable', and 'always accessible and supportive'.

Figure 5.5. Counsellors rating of service policies

Regarding the number of sessions provided to clients, positive feedback from Counsellors included the flexibility to extend or reduce the number of sessions (n=4; 22.2%). Two Counsellors (11.1%) noted that 12 sessions tend to be too few and that, for example, 15 may be a better target at outset of counselling.

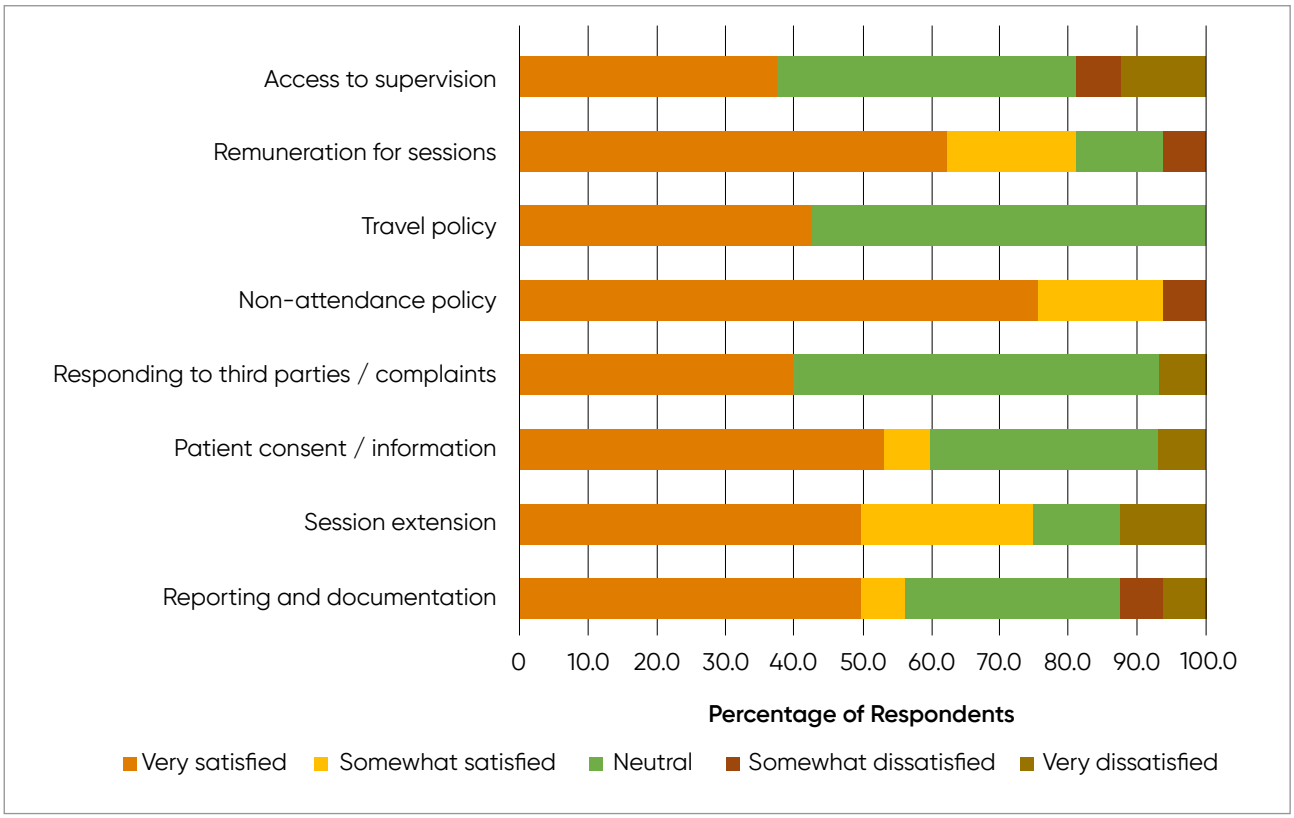
5.2.2 Policies to support Counsellors

In relation to policies that exist to support the Counsellor in their work, many respondents were 'very satisfied' with these policies (Figure 5.6) and provided open text responses to support these answers. Comments were largely supportive of the work and policies of the service.

One area where comments varied was in relation *Session Extension* or to the process of requesting extensions. While two respondents (12.5%) valued the flexibility around extensions and the effort in understanding each individual case, two others (12.5%) sought more structure around the process of requesting extensions. Two participants (12.5%) were dissatisfied with *Reporting and Documentation*. This was reflected in the qualitative comments where two participants sought to move to an electronic system for managing client data.

Another issue identified was the need for better *Access to Supervision* within the service with three participants (18.8%) dissatisfied with this aspect of the service. Specific questions were posed around supervision associated with the service. Many respondents (n=10; 62.5%) indicated that they would like to see additional supervision as part of the service. Five participants provided comments around the need for further support/supervision for the specific context of bereavement counselling as provided by the service. This could include monthly case management or group supervision.

Figure 5.6. Ratings of policies to support Counsellors

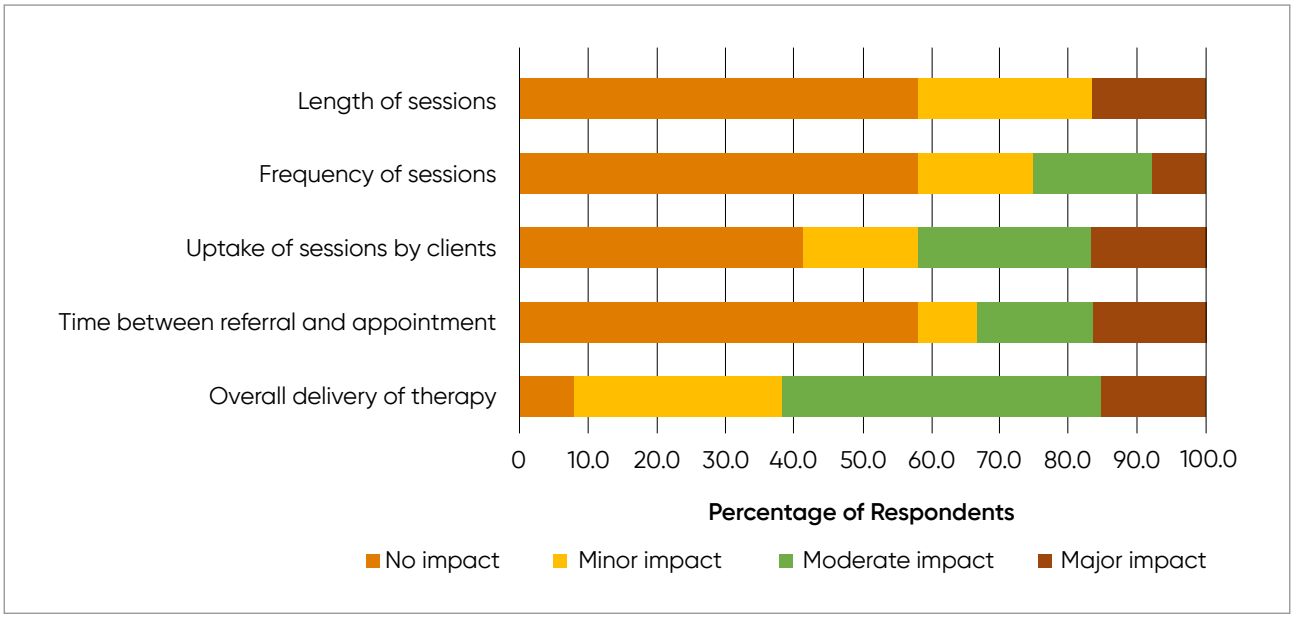


5.2.3 Impact of COVID-19 on service

Approximately 12 participants completed all questions on impact of COVID-19. Eight respondents (61.6%) reported that COVID-19 had a moderate or major impact on the overall delivery of the service and only one respondent felt it had no impact on overall delivery (Figure 5.7). Considering specific aspects of the service, seven respondents (58.3%) felt there was no impact on the length of sessions, frequency of sessions and the time between referral and appointment. Impact on the uptake of sessions by clients was reported more frequently with only five Counsellors (41.7%) reporting no impact on session uptake.

The Counsellors drew on different methods of communication in response to the pandemic using telephone and/or online platforms for counselling sessions and continue to offer remote methods in combination with face-to-face in some cases. One of the most prominent ideas reported by Counsellors was that phone counselling is challenging/not suited for traumatic bereavement counselling (n=6, 50%). Other challenges of using remote methods, each reported by one participant, were differences in clients' preferences for remote methods, as well as lack of control over distractions, and lack of privacy in the home environment. Remote methods were valued for reducing transport challenges for clients by one Counsellor.

Figure 5.7. Counsellor ratings of impact of COVID-19 pandemic on the service.



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7 Appendices

Appendix 1. Data items – electronic referral database

Data item	Format
Patient code	Arbitrary identifier
Date of referral	Date (dd.mm.yyyy)
Patient gender	Male/female
Patient age range	Age category
Relationship to deceased	Free text
Cause of death	Free text
Re-referral	Yes/no
Length of time since death	Months, years
County of referral	Free text
Referral source (type of health professional)	Free text
Counsellor code	Arbitrary identifier
Number of sessions	Number
Notes	Free text
Extension of counselling	Yes/no
Outcome	Free text

Appendix 2. Other services providing bereavement counselling in SECH area

Support Service	Eligibility	Nature/Content	Access
Barnardos Childhood Bereavement	Children and adolescents	Bereavement counselling	Free
Cancer Support Services	Children, adolescents, adults	Counselling for people impacted or bereaved by cancer Centres in each county of SECH	Free Self-referral Referral by other agencies or families (consent required)
Community Based Counselling Services e.g. Talk to Tom; Teac Tom; CSAW	Children, adolescents, adults	Generic counselling Some suicide specific charities Varies across SECH	Low cost/no cost Self-referral Referral by other agencies or families (consent required)
Faith-based services e.g. St. John's Pastoral Care Waterford Bereavement Counselling Service	Adults over 18	Bereavement counselling	Free
Counselling services in Education	Secondary School Students Students attending HEIs	General counselling	Free
Family Resource Centres	Children, adolescents, adults	Generic counselling Varies across FRCs	Low cost/no cost Self-referral Referral by other agencies or families (consent required)
HSE CIPC	Adults over 18 Medical card holders Mild to moderate psychological difficulties	General counselling service Up to 8 sessions	Medical Card required Primary Care referral required
MyMind	Children, adolescents, adults	General counselling (possibility of accessing counsellors with bereavement experience)	Fee for service (sliding scale)
Pieta Suicide Bereavement Counselling	Children, adolescents, adults who have experienced loss to suicide	Suicide bereavement counselling From 8 weeks after death	From 8 weeks after death
Pieta Suicide Bereavement Liaison Service	Families, adults and children bereaved by suicide Level 2 non-therapeutic support in the immediate aftermath of a death by suspected suicide	Up to 8 sessions	Self-referral Referral by other agencies or families (consent required)

Support Service	Eligibility	Nature/Content	Access
Private Counselling	Open criteria	General counselling (possibility of accessing counsellors with bereavement experience)	Requires independent searching Fee for service (possible concessions)
Rainbows	Group support for children aged 7-16 years	Group support Available in school and community based settings across SECH	Free
Support groups/1:1 support e.g. HUGG; Kilkenny Bereavement Support	Adults over 18	Support groups and one to one support General or suicide specific	Free
Turn2 Me	Adults over 18	General counselling service	Free (6 sessions) Self-referral

Appendix 3. List of service policies

Eligibility to Attend Service Policy/ Eligibility to Refer Service Policy describes the eligibility criteria for professionals referring to the service and prospective clients.

Initial Contact Policy stipulates the process the Counsellor must follow to contact the client to arrange an initial assessment.

Referral of Clients with Intellectual Disability Guidance Document outlines the steps to determine the appropriateness of the service for clients with intellectual disability.

Appointments Policy outlines processes of initial assessment, typical number of sessions and scenarios for extension of counselling.

Client Notes Page Policy outlines documentation that must be completed by Counsellor and client.

Consent for Information Policy describes the information sheet to be signed by the client giving permission to share information with third parties should the need arise.

Reports to Third Parties Policy outlines guidance for third party requests for information relating to the counselling.

Complaints Policy outlines the responsibilities of the complaint recipient and the processes through which client can make complaints. The primary avenue for complaints is through the 'Your Service, Your Say' online site. Paper versions of the form can also be made available.

Non-Attendance Policy outlines the policy for responding to clients who do not attend appointments. This policy applies to clients who do not attend two consecutive appointments. The Counsellor follows up to provide one final opportunity to engage or re-engage. If the client does not engage/re-engage the file is subsequently closed and returned to service.

Travel Policy covers circumstances where travel is required on behalf of the Counsellor to deliver the service. This must be agreed in advance with the service manager.

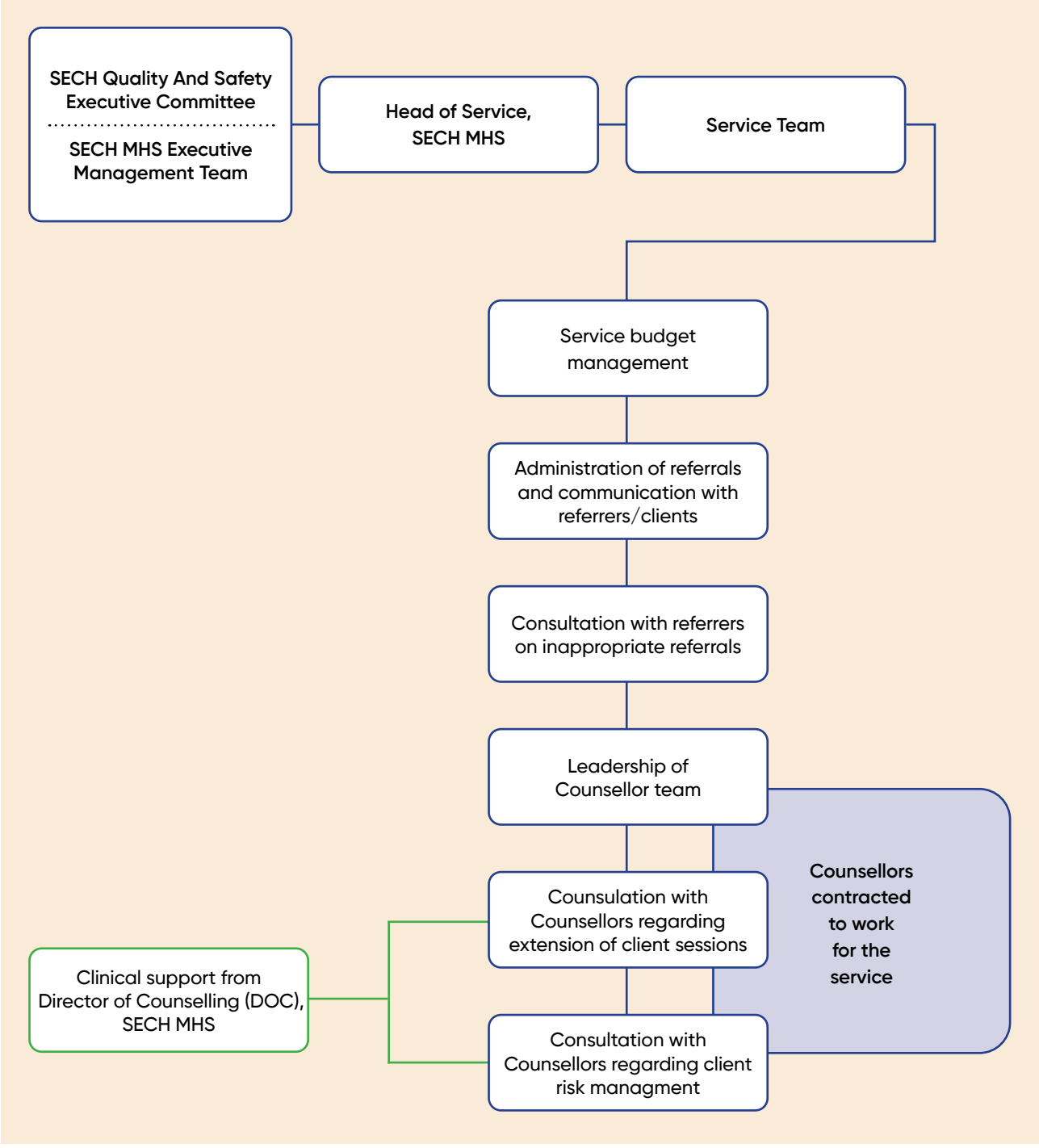
Case Management Policy details the processes of requesting counselling extensions, managing clinical situations, and supervision arrangements.

File Closure and File Return Policy outlines the steps that must be followed for documentation at completion of counselling.

File Retention and Disposal Policy covers practices relating to retention of healthcare records and their disposal in line with Data Protection Legislation.

Dignity at Work Policy for the Health Service is a document seeking to encourage dignity and respect for all HSE employees and outlines the policies and procedures for handling contrary behaviours such as bullying and harassment.

Appendix 4. Service governance structure



National Suicide Research Foundation