Review of General Bereavement Support and Specific Services Available Following Suicide Bereavement

Petrus Consulting
in association with
St Vincent's University Hospital / UCD
Advisory Team

Feidhmeannacht na Seirbhíse Sláinte
Health Service Executive

Chapter

Page

1	Key Points and Recommendations	2
2	Introduction	6
3	Information Available to the Bereaved	8
4	Role of Self-Help Groups	13
5	Models of Service Provision	16
6	Training and Development for Bereavement Support Services Staff	23
7	Current Profile of Service Delivery in Ireland	30
8	Future Service Delivery	50
9	Costing of Service Delivery	60
Appendix i	References	66
Appendix ii	Bibliography	70
Appendix iii	Terms of Reference	72
Appendix iv	Research Methodology	73
Appendix v	Definitions	77
Appendix vi	Principles for Community Suicide Postvention Initiatives	78
Appendix vii	Selected Training Courses	80
Appendix viii	New Zealand - The Postvention Support Initiative	81
Appendix ix	Citing This Report and Contact Details	83

1 Key Points and Recommendations

1.1 Introduction

This Chapter summarises the key findings and main recommendationds in the report.

Information Available to the Bereaved (Chapter 3)

Most organisations should review the theory behind their information resources in the light of recent developments in the field of bereavement theory and research. Written material should state the approach and theory that lies behind the recommended strategy.

Literature should be carefully reviewed prior to publication and, where possible, tested with a sample of the target audience, to assess the impact of quotes and images, readability and length. A generic leaflet with a brief summary of grief and local contact information, with a selection of specific resources addressing practical, emotional and coping strategies may best meet the range of needs.

Age-specific literature should be made available on a national basis.

There is a lack of literature for diverse orientations, whether religious, cultural, linguistic, sexual or ethnic in origin. Such groups should be actively consulted in the development of supports and services.

The recently published "You Are Not Alone - Help and Advice on Coping with the Death of Someone Close", (National Office for Suicide Prevention, 2007) is an excellent resource for those bereaved by suicide and should be maintained and updated as necessary.

Information resources dealing with traumatic loss, such as the loss of a child, loss by road traffic accidents and loss through natural disasters should incorporate or reference information for those bereaved by suicide.

Leaflets need some brief guidance on when and where to seek professional help in the event of intense or unusual bereavement reactions, which may indicate complicated grief.

Leaflets should have a publication date and a contact phone number[1], along with an internet address where possible. Legal and financial information would be best published centrally.

Every leaflet should contain a reference to an internet address for the Citizens Information Board.

Any organisation with a website that is providing bereavement support services and information should ensure that they have a link to the website of the Citizens Information Board and perhaps a subsection that is aimed specifically at young people.

Role of Self-Help Groups (Chapter 4)

Self-help groups should be appropriately constituted and should ensure that the possibility of re-traumatisation for members is minimised.

Suicide self-help groups should ensure that all members are appropriately trained and that there are detailed supervision and referral arrangements in place. Critically, those wishing to establish or join a group should be carefully assessed for suitability, particularly where they themselves have been bereaved by suicide, in view of the potential for traumatisation.

As so little is currently known about self-help groups for suicide survivors, groups should be encouraged to monitor and evaluate their activities and add to the body of knowledge and experience on the limits and benefits of self-help groups for survivors.

Models of Service Provision (Chapter 5)

After a span of over 20 years of research into interventions for the suicide bereaved, there is still no conclusive evidence that one technique or therapy is more efficacious than another. Therefore a range of services may be appropriate.

[1] This should be a dedicated phone number: personal mobile phone numbers should not be used.

Many first response services have been developed and have flourished throughout America, Europe, Australia and New Zealand, and represent the latest development in suicide postvention.

One potential concern is the level of training of those responding to the event. If the training and education of the volunteers on first response teams is not sufficient, the initial contact made with the families could be harmful as opposed to beneficial. Another potential concern involves support for the volunteers themselves.

Sufficient support is essential for those responding to traumatic events.

Current trends in good practice are leaning towards developing educated and trained first response teams to a specific standard.

First response suicide postvention programmes provide an outreach service for those bereaved by suicide. The programmes vary in their initial approach to the family but all provide immediate practical and listening support to the bereaved, and refer on to local services should they be necessary.

The New Zealand model for suicide postvention services is still at an early stage of development but could indicate the approach to be followed in Ireland (Appendix vii)

Training, Qualifications and Standards (Chapter 6)

All organisations and individuals offering support in this area need at least a minimum standard of training.

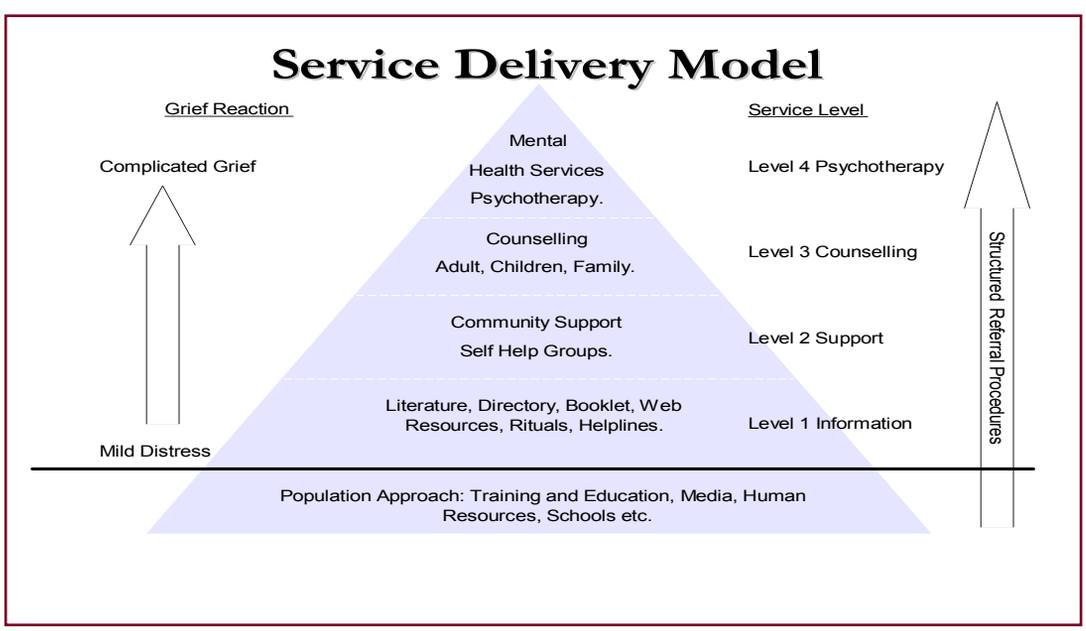
First responders should have a referral process and sufficient training to recognise when the next level of intervention is required. They should also ensure that they have personal support facilities in place, in order to ensure that they themselves do not become traumatised.

Service providers should have mandatory supervision, and training should be available for those providing the supervision.

Training should recognise that there is a risk of overlooking certain groups, such as, friends outside the immediate family circle, in the grieving process and ensure that such groups are identified.

The NOSP should await the outcome of the research on risk assessment being undertaken in the HSE South and ensure that any lessons learned are incorporated in the provision of training.

The diagram below sets out a service deliverey model based on the National Institute of Clinical Excellence Guidelines. The diagram distinguishes between various levels of intervention ranging from the provision of information and support to psychotherapy sevices. A full description is included in section 6.7.



At levels 4 and 3 in the Service Delivery Model above, we recommend that all support providers are qualified in a clinical capacity and complete 60 hours of bereavement support training. This training should be augmented on a yearly basis by an additional twelve hours of training, some of which should be in the area of personal development.

We recommend that all support personnel at levels 1 and 2 also achieve the sixty-hour minimum, though it would be envisaged that this would be spread over time, possibly over a three year period.

A standardised national qualification in bereavement support should be developed in partnership between existing training providers and should be accredited to a HETAC/NUI college. Such a qualification would not be a professional counselling course, but rather a standardised national programme for voluntary staff who provide bereavement support but not professional counselling or psychotherapy. Such a course should be developed incorporating the training needs identified by organisations as set out elsewhere in this report (Chapter 7).

Staff and volunteers from agencies providing bereavement support to children and adolescents should receive specialist skills based training in order to deal with their capacity to understand, their internal reaction, and their ability to self-care. Such training should be accredited and delivered by suitably qualified personnel.

Training programmes for volunteers and professionals working with the bereaved should include at a minimum the following modules:

- Active listening
- Bereavement support and mourning
- Theories and models of grief
- Counselling skills
- Self-care and caring for carers
- Identifying trauma
- Practical issues for the bereaved.

Further specialist training on a modularised basis is required for those working with children, adolescents and marginalised groups.

Training and development should be ongoing in all categories, with additional modules and seminars to be attended each year.

Profile of Service Providers (Chapter 7)

This chapter sets out the profile of service providers in Ireland. It identifies the arrangements regarding financing, staffing, services provided, supervision and referral, activity levels, training received, and required and future requirements and development needs.

Future Service Delivery (Chapter 8)

The research examined is inconclusive as to whether suicide bereavement support is different in nature to other kinds of bereavement.

No clear and compelling evidence-based justification has been identified that suggests that suicide bereavement support is sufficiently different so as to require a standalone, dedicated response.

Professional caregivers working solely in the area of suicide bereavement support may suffer from higher levels of stress and grief than those working with a mixture of those bereaved by natural deaths and suicide survivors.

A bereavement support service should not necessarily put an emphasis on the type of death, but rather concentrate on the bereaved person and the consequences of their loss, and screen for complicated grief.

In the absence of evidence to support the need for, and efficacy of, a dedicated suicide-specific bereavement support service, we recommend that the appropriate development path is to enhance and strengthen existing general bereavement support structures. This means that a separate, stand alone suicide-specific bereavement support service should not be established at this time. Existing suicide bereavement support services should continue to be supported for identified needs and in accordance with normal funding criteria.

The NOSP, in conjunction with the key service providers, should continue to monitor and review national and international research and service development in the area of suicide bereavement support services.

Services for those bereaved by suicide should be integrated, from a structural perspective, with general bereavement support services. This will mean enhancing and developing general bereavement support services in those parts of the country that do not have a service or where the service is not fully or adequately resourced and ensuring that the needs of those bereaved by suicide are catered for within these structures while recognising their special requirements.

Costing of Service Delivery (Chapter 9)
The main cost headings related to the development of suicide bereavement support services are set out below and are detailed in Chapter 9.

Summary of Additional Costs.

Summary	2008 Budget Provision €	Recurring Annual Budget Provision €
Training - Initial and Ongoing - Gross Cost	107,000	62,000
Risk Assessment Guidelines	70,000	25,000
Directory Update and Web Based Version	50,000	25,000
“You Are Not Alone” Reprint and Development	50,000	50,000
Website Support	15,000	5,000
Resource Manual and Training	190,000	50,000
Monitoring and Evaluation	50,000	50,000
Total Gross Cost	**532,000**	**267,000**
Assumed Training Cost Recovery	**104,000**	**58,000**
Total Net Cost	**428,000**	**209,000**

The initiatives and related costs shown above are dependent on the necessary funding and resources being made available to the HSE NOSP for both existing projects and for new initiatives.

2 Introduction

2.1 Background

The National Office for Suicide Prevention (NOSP) selected Petrus Consulting to examine and report on general bereavement support services and specific services available following suicide bereavement. The terms of reference for the review are included as Appendix iii and can be summarised as the guidlines for carrying out a comprehensive data gathering and analysis of all the services available in Ireland following bereavement. The emphasis of the review is on the services available to those bereaved following a suicide.

The key questions that this report sets out to answer are as follows:

- What level of (suicide) bereavement information is available and what is it like?
- What level of (suicide) bereavement support is available and what is it like?
- What level of (suicide) bereavement counselling and/or other treatments are available, and what are they like?
- What kind of training is received by those working in bereavement support and/or counselling and is the training suitable?
- Are we better focusing on suicide-specific supports and if so in what areas, e.g. just information or should counselling be 'suicide-specific'?
- How do we best develop a national suicide bereavement care plan and what are the likely resource implications?

The work was carried out by Petrus Consulting in association with a team from St Vincent's University Hospital and Blackrock Hospice during late 2006 and early 2007.

A key part of the methodology was the development of a detailed questionnaire that was circulated to individuals, bodies and organisations with an involvement in the area. A summary of the methodology is included as Appendix iv. The questionnaire served two purposes:

- to act as the source document for populating a database in order to create a directory, and
- to provide the review team with quantitative and qualitative data on the provision of bereavement support services throughout the country.

We also undertook an extensive literature review and the methodology for this is also described in Appendix IV.

We did not, for reasons of client confidentiality, make contact with any clients of the organisations providing services.

The output from our work comprises this report along with a Directory of Services for the Bereaved and an updated version of the booklet "You Are Not Alone" which are published separately by the NOSP. In addition, a number of presentations were made at interim stages to the Steering Group, the Resource Officers for Suicide Prevention and to both the National Advisory Group and the National Forum of the NOSP.

In preparing this report, we have drawn on published sources, as well as our own knowledge, research and experience. Among the main sources used in the preparation of this report are:

- A postal survey and detailed questionnaire to individuals and bodies directly or indirectly involved in the provision of bereavement support services
- Meetings and semi-structured interviews with key service providers

- Extensive literature review
- Interviews and meetings with Resource Officers for Suicide Prevention (ROSPs)
- Review of international literature and good practice.

2.2 Steering Group, Advisory Team and Work Team

Mr. Geoff Day, National Office for Suicide Prevention, Steering Group Member

Mr. Derek Chambers, National Office for Suicide Prevention, Steering Group Member

Ms. Susan Kenny, National Office for Suicide Prevention, Steering Group Member

Ms. Anne Callanan, National Office for Suicide Prevention, Steering Group Member

Ms. Rita Kelly, Suicide Resource Officer, H.S.E. Dublin Mid Leinster - Midlands Region, Steering Group Member

Ms. Ursula Bates, B.A., M.A., Principal Clinical Psychologist, Advisory Team

Prof. Kevin Malone, M.D., M.R.C.P.I., F.R.C. Psych. Professor of Psychiatry, Advisory Team

Dr. Eoin Tiernan, M.D., F.R.C.P.I., M.I.C.G.P., Consultant in Palliative Care, Advisory Team

Mr. Michael Griffin, B. Comm., F.C.A., M.B.A., Petrus Consulting

Ms. Liz Monahan, B.A., Dip. Psych., M.Sc. Psychotherapy, Petrus Consulting

Ms. Norah Jordan, B.A. Applied Psychology, Researcher

Ms. Suzanne O'Connor, B.A., M.A. Clinical Psychology, Researcher

Acknowledgements

We are extremely grateful to all the organisations that assisted us in our work. In particular, we are indebted to the many organisations that took the time to complete the detailed questionnaire and that met us to discuss their particular circumstances.

The work would not have been possible without the assistance of the team from St Vincent's Hospital and the Blackrock Hospice. Our particular thanks to Ms. Ursula Bates, Professor Kevin Malone and Dr. Eoin Tiernan for their expertise in mental health, bereavement and loss which was invaluable in analysing the data.

Our thanks also to Ms. Norah Jordan and Ms. Suzanne O'Connor who were key members of the team and who put in extreme efforts to process and analyse the questionnaire returns and to research and summarise the academic literature.

3 Information Available to the Bereaved

3.1 Terms of Reference

Report on the availability, accuracy and suitability of information about death, dying and bereavement, including practical and educational information and information specific to suicide.

Examine the suitability of such information for various populations across lifespan, including children and older people.

3.2 Practical Information Guides

Many countries now provide a practical guide to help the bereaved through the initial crisis. Such booklets are typically made available in garda stations, the offices of general practitioner's, libraries, community centres, counselling centres, funeral homes and on the internet. Australia, New Zealand, Canada, the USA, England, Ireland, Scotland and others have published such information guides. From a review of these guides the following content and themes were common to all publications:

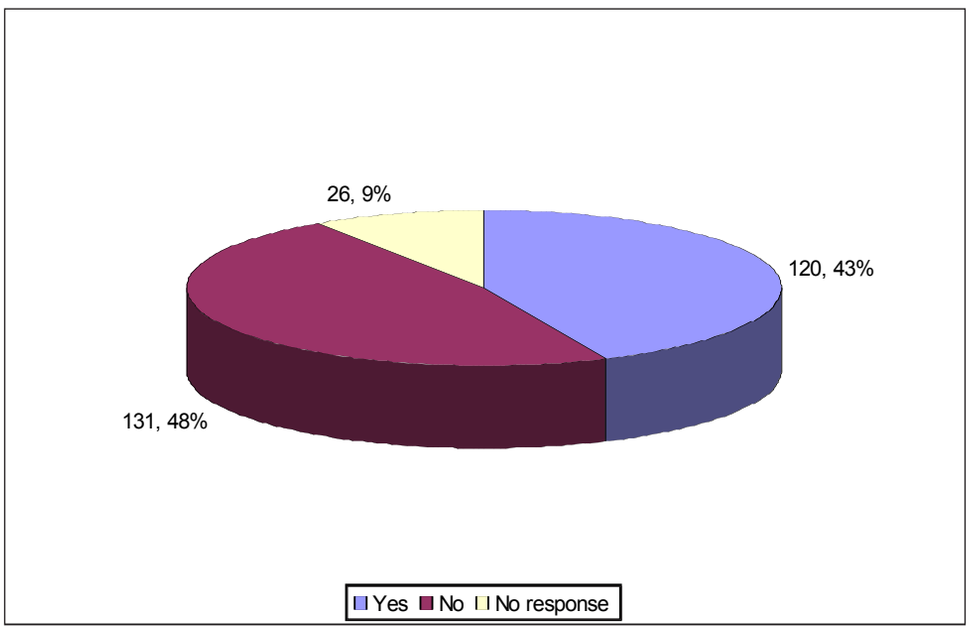
- Immediate reactions/natural responses to the bereavement
- The nature of grief and common emotions during the grief process
- How to approach children, neighbours, family and friends
- Practical matters to include:
  - Dealing with the police
  - Dealing with the media
  - Death certificate
  - Funeral arrangements
  - Coroner's inquest
  - Wills
  - Banking/insurance/entitlements
  - Getting help/sources of support: local, national and international support including various websites specifically pertaining to loss by suicide.

As part of this review, the earlier publication "You Are Not Alone: A Guide for Survivors in Managing the Aftermath of a Suicide" (Health Service Executive, 2001) was reviewed and updated in several respects. It was republished in July 2007 entitled, "You Are Not Alone - Help and Advice on Coping with the Death of Someone Close" (National Office for Suicide Prevention2, Online) together with a "Directory of Bereavement Support Services" (National Office for Suicide Prevention3, Online). Both publications are available to download from the website of the National Office for Suicide Prevention (National Office for Suicide Prevention1, Online) and in hard copy format from the Resource Officers for Suicide Prevention.

3.3 Range of Information Resources

The questionnaire that was sent out to investigate bereavement support services in Ireland included a request for copies of any literature such as leaflets, booklets and information resources that each organisation produces on death, dying and bereavement, or information specific to suicide bereavement. Overall, out of the 277 responses, 43% of organisations stated that they provide literature, 48% do not and 9% did not respond to the question.

Figure 1. Provision of Literature to Assist the Bereaved (n = 277)



We sought copies of the literature produced and this request yielded approximately 57 different relevant leaflets and booklets. The literature was reviewed on a consistent basis against defined criteria and was found to vary considerably in terms of, for example, theoretical background, style, accuracy and, in particular, the suitability of the information for various populations across the age span.

3.4 Theory

The majority of the information resources draw on the five stages of grief theory (Kübler-Ross, 1969), with a strong emphasis on venting emotion and working towards acceptance. Kübler-Ross pioneered methods in the support and counselling of personal trauma and grieving associated with death and dying. Her five stages of grief model involves denial, anger, bargaining, depression and acceptance. Current research questions the use of the stage model as a normative guide and notes that acceptance is a variable outcome. Furthermore, the concepts of inhibited grief and delayed grief are not supported by reviews of current research (Stroebe & Schut, 2004, p. 356). It is now accepted that each person grieves in their own way, even if it is not obvious to observers. The concepts of an ongoing search for meaning and continuing bonds should be integrated into any description of efforts towards resolution of grief. The Irish Hospice Foundation leaflets are a good example of theoretically up-to-date sources of information.

Most organisations should review the theory behind their information resources in the light of recent developments in the field of bereavement theory and research. Written material should state the approach and theory that lies behind the recommended strategy.

3.5 Practical Advice

Many of the resources contain practical advice on how to cope in the aftermath of bereavement. The advice generally related to daily routine (e.g. eating, sleeping and exercise), emotions (seeking emotional support, emotions you might expect or feel) and legal and financial advice (tax, death certificates etc.).

Some of the information resources target friends, acquaintances and co-workers of those recently bereaved and provide examples of how to help. This should be encouraged because the bereaved person may not want to read tips themselves, but can still receive appropriate guidance and emotional support from their community.

3.6 Style

The majority of the leaflets were two pages long (front and back of an A4 page). Some were much longer, including the Barnardos' 'Someone to talk to: A handbook on childhood bereavement', (Donnelly, 2001) which is 120 pages long and the original Health Service Executive's 'You are not alone: A guide for survivors in managing the aftermath of suicide' (Health Service Executive, 2001), which was originally 50 pages long.

In striving for information that can best help the bereaved, it may be useful to publish a different leaflet on each different aspect of bereavement, so as to avoid a potentially large and daunting booklet. Some of the leaflets received had large blocks of writing in small fonts. For the benefit of the bereaved, sub-headings and larger fonts should be used where possible to make the text more user-friendly.

Organisations that are publishing information literature should be careful about putting emotive quotes on the cover, as was often the case. A more constructive, 'coping' quote is more useful. Some consideration should also be given to the photographs contained in the leaflets and should avoid using photographs of people who are crying, distressed or grieving. Furthermore, photographs in children's literature should show the parent/adult supporting the child, rather than the child on their own.

Literature should be carefully reviewed prior to publication and, where possible, tested with a sample of the target audience, to assess the impact of quotes and images, readability and length. A generic leaflet with a brief summary of grief and local contact information, with a selection of specific resources addressing practical, emotional and coping strategies may best meet the range of needs.

3.7 Population Focus

The information resources were almost exclusively aimed at adults, and, although some of them contained advice on how to deal with children, family members and teenagers, the advice was aimed at adults rather than direct guidelines for children or teenagers. Some specific populations are addressed by dedicated organisations however, such as parents whose babies have died, (e.g. ISANDS), widows, or those who have been bereaved by meningitis or suicide. None of the literature addressed the needs of older adults, who have specific difficulties and often live with unresolved loss and diminished resources. Some literature is available from the HSE South that is appropriate to different age groups. However this information is not available on a national basis.

Age-specific literature should be made available on a national basis.

3.8 Diversity

'Care of the Muslim Patient' from Our Lady of Lourdes Hospital in Drogheda was the only leaflet we received that targeted ethnic minorities or specific religions and has a section on death and dying and a very brief section on suicide. No other literature was received that specifically addresses bereaved members of other ethnic or cultural groups, including the travelling community.

There is a lack of literature for diverse orientations, whether religious, cultural, linguistic, sexual or ethnic in origin. Such groups need to be actively consulted in the development of supports and services.

3.9 Suicide

Forty-six of the information resources had no information on suicide bereavement.

The recently published "You Are Not Alone - Help and Advice on Coping with the Death of Someone Close", (National Office for Suicide Prevention2, Online) is an excellent resource for those bereaved by suicide and should be maintained and updated as necessary.

Information resources dealing with traumatic loss, such as the loss of a child, loss by road traffic accidents and loss through natural disasters should incorporate or reference information for those bereaved by suicide.

3.10 Complicated Grief

Interestingly, we received no material about 'complicated' grief, a concept that is gaining recognition amongst researchers on bereavement. Arguably, the population most in need of information and sources of further help are those who may be suffering from complicated grief.

Leaflets need some brief guidance on when and where to seek professional help in the event of intense or unusual bereavement reactions, which may indicate complicated grief.

3.11 Accuracy and Relevance

In terms of accuracy, a few problems were noted. Firstly, only 23 of the information resources contained a date of publication. Therefore, we recommend that material should be dated when published and reviewed regularly. Leaflets that contain practical information should be accurate and updated frequently. Leaflets should be peer-reviewed and user-reviewed prior to publication.

Further, we found that some of the information resources had a named person as a contact. If an individual is named as a contact, problems can arise if that person leaves the job or organisation. Therefore, it is recommended that individuals are not named, rather that the name of the organisation and the main contact number of the organisation are used to ensure that there is continuity of service. In addition, personal mobile phone numbers should never be used. Providing a service of this nature requires a dedicated number and should be carefully managed to ensure that callers receive a professional response to their needs. A dedicated number also minimises any risk of confusion between the personal life of the service provider and the needs of the caller.

Leaflets should have a publication date and a contact phone number along with an internet address where possible. Legal and financial information would be best published centrally.

3.12 Use of Technology

Many of the information resources did not have website links and some contained no e-mail address. A few had no contact telephone number. A direct, user-friendly web address should be used in order that those with minimal experience with computers can still access information. Leaflets should always include the name of the organisation, the address, a phone number and an internet link.

Every leaflet should contain a reference to an internet address for the Citizens Information Board.

The Citizens Information Board is the national agency responsible for supporting the provision of information, advice and advocacy on social services. It supports the provision of information to the public, through the nationwide network of Citizens Information Centres, the Citizens Information Phone Service and through the Citizens Information Website. It provides information on bereavement, which is regularly updated through this network and through its website (Citizens Information Board, Online).

If other services are cited, then it is important that the information given on the services is accurate.

3.13 Technology and Younger Populations

For many young people, the primary source of information is the internet. Therefore it is likely that instead of, or in addition to, using information leaflets to provide young people with information about bereavement, the internet will be one of the first places that young bereaved people will look for information. However, at present, search engines such as Google, Yahoo and Altavista do not generate appropriate responses for children and teenagers with regard to information on bereavement.

SpunOut (SpunOut, Online) is an Irish website that is designed and run by young people, for young people. It has sections on leisure activities, young people's rights, legal issues, and education, as well as a large 'Mind, Body, Soul' section, which gives information, advice and stories about emotional, physical and spiritual health. It has a discussion forum, where young people can ask questions, place comments and discuss various issues as well as sections on other pertinent topics for young people. Young people can also log on and write poems or essays.

The website also contains a comprehensive section on suicide that provides helpful resources for young people including sections on 'Asking for Help', 'Finding Help' and 'Helping Others'. The page entitled 'Suicide Bereavement' contains six concise points about how to cope in the aftermath of a suicide and has two up-to-date links to the Samaritans and the National Suicide Bereavement Support Network (NSBSN).

The Citizens Information Board also has information available for those bereaved by suicide and is regularly updated.

Any organisation with a website that is providing bereavement support and information should ensure that they have a link to the website of the Citizens Information Board and perhaps a subsection that is aimed specifically at young people.

Guidance for Developing Literature on Suicide Bereavement Support

1	Identify the subgroup of the bereaved or bereaved by suicide population for which the literature is being written, e.g. children, teenagers, siblings, adults, parents or friends.
2	Consider referencing, using or adapting other material published by reliable sources such as the National Office for Suicide Prevention.
3	Use a brief and concise approach.
4	Ensure that the information is accessible by everyone, including print and internet resources.
5	Test to ensure that the information can be used safely by the bereaved and ensure that referral systems exist for those who may need professional assistance.
6	Consider whether the literature provides practical, skill-based strategies and information to assist the bereaved to manage their own wellbeing.
7	Include links to further support, including a section that encourages links to local support.
8	Ensure that the focus of the literature considers a family systems approach, rather than an exclusively individual understanding of loss and bereavement.
9	Check the style of the text to ensure a balance between an evidence-based approach and a voice with which the reader can identify.
10	Aim to achieve a desired outcome including increased understanding, provision of practical information, encouragement to reach out and to seek appropriate help.
11	Test the literature prior to publication by obtaining inputs from the target group.
12	Review the literature on an annual basis or when reprinting to ensure that it is still appropriate.
13	Include the date of publication on information resources.
14	Review the theoretical orientation of the material in the light of recent developments in the field of bereavement theory and research and state the approach and theory that lies behind the recommended strategy.

4 Role of Self-Help Groups

4.1 Terms of Reference

Examine the role of bereavement self-help groups in providing bereavement support services, especially in the area of suicide bereavement.

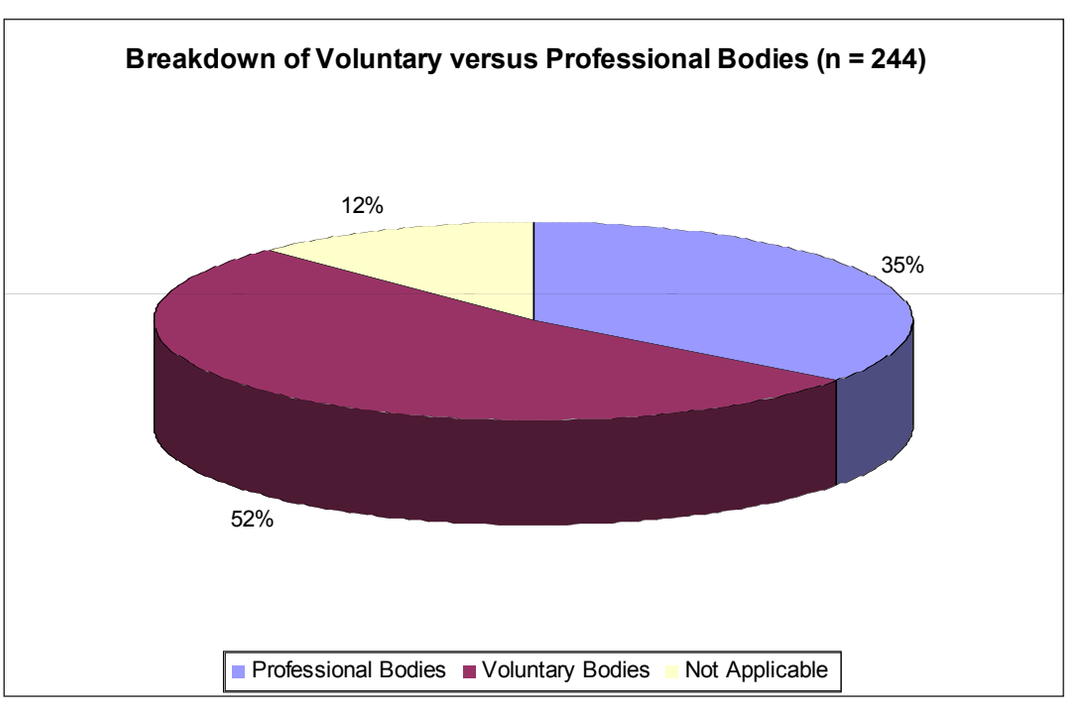
4.2 Introduction

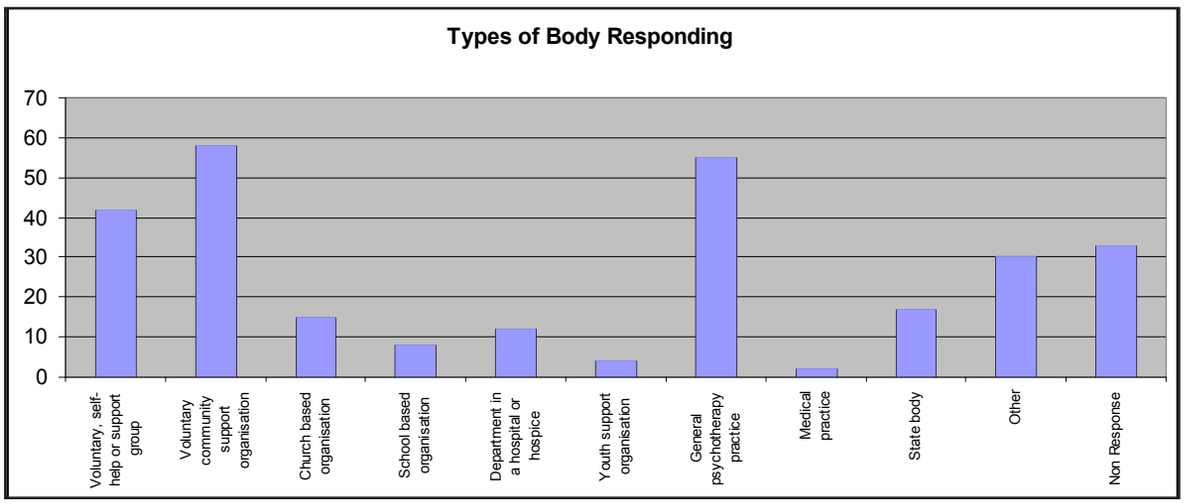
In western society, where communal rituals have lost some of their support, bereavement self-help groups may now actually serve as a link between the individual suffering and a communal narrative of remembrance for the deceased (Petty, 2000, as cited in Pietilä, 2002). Self-help groups, as a concept, are generally poorly defined (Lieberman, 2003). A working definition includes:

- The members share a common core experience
- The group is self-governing and self-regulating
- Self-help groups are accessible without charge and share common values
- Self-help groups are community based
- Leadership is provided by trained lay people.

Currently, self-help groups are the most common form of intervention for a wide variety of physical and emotional problems. They have the advantage of galvanising local energy and initiating responses that are specific to particular problems. From the responses to the questionnaire it is clear that a large number of self-help groups are in operation throughout the country. Although the definition of a self-help group is not exact, it is clear from the table below that voluntary groups, church and school-based organisations and youth support organisations make up an large proportion of all the groups active in the area of bereavement support.

Some 244 services surveyed identified the type of service that best described them, 52% were voluntary, church-based or school-based groups and 35% were located in professional settings.





4.3 Benefits and Features of Self-Help Groups

The reported benefits arising from self-help groups include:

- A focus on a common core problem
- Reduced isolation
- Normalisation of responses and
- Modelling on those more advanced in recovery from grief.

Further benefits of self-help groups may include the provision of support, hope and understanding. Participants are supported in expressing emotions, relating experiences and engaging in cognitive restructuring via problem-solving and working towards new meanings and identity.

Robust empirical research into the usefulness of self-help groups is limited. The field is restricted by many of the difficulties faced by counselling and psychotherapy research generally, including subjectivity and the suitability of measures and tests. It is also difficult to measure improvement due to possibly unaccounted for complex social and psychological variables. The most frequently reported finding is improvement over time, regardless of the type of group, which suggests that there is a developmental progression as people adjust to loss.

The most consistent evidence suggests that spousally bereaved people benefit from attending self-help groups (Lieberman, 1983). Results from efficacy studies, though very variable, provide some basis for concluding that a large number of bereaved people could have their social and psychological needs met in such settings while they are grieving.

Self-help groups are inexpensive to run and are frequently supported by local faith groups and organisations. The most common reason reported by attendees for satisfaction with groups is that it eases their concern about burdening family members with their continued grief.

4.4 Suicide Bereavement and Self-Help Groups

Although the literature is far from conclusive with respect to differences and similarities between 'normal' bereavement and suicide bereavement, there are some who claim that one of the defining aspects of suicide bereavement is the stigma experienced by survivors (Cvinar, 2005). Arguments have been made that reactions to suicidal deaths are more extreme and generally last longer than natural deaths (Cain, 1972; Demi, 1978). However, this has not been supported in more rigorous research that controlled for socio-demographic differences between samples (Farberow et al., 1987). More recent research has again challenged this idea and reports that, when followed longitudinally, suicide survivors continue to experience distress with a more variable pattern of change over time (Zisook & Schuchter, 1986).

In their study of suicide survivors, Wrobliski and McIntosh (1987) noted three problems unique to suicide survivors: isolation within and outside the family; rumination on the death scene and difficulty in reconstructing events before the death. This suggests that the bereaved have considerable difficulties that may need several types of intervention.

It is frequently reported that the suicide bereaved consider that only people who have had a similar experience can fully empathise with the distress of the loss, hence the immediate appeal of a self-help group. This is especially true given the qualities of self-help groups outlined above, such as support, hope, understanding and 'universalization'. However, self-help groups are unlikely to meet all their needs and there is the risk of vicarious traumatisation as many traumatic stories are shared among vulnerable people.

Pietilä (2002) reports that half of the families she interviewed had attended a group for suicide survivors and had appreciated becoming a member of a relevant group.

While there is little research into suicide bereavement self-help groups, it is feasible that, given a possibility of stigma and isolation suffered by the suicide-bereaved person, and as their grief may continue longer than in the case of 'normal' bereavement, an appropriately structured and constituted self-help group may be useful.

Self-help groups should be appropriately constituted and should ensure that the possibility of re-traumatisation for members is minimised.

Principles[2] to underpin the establishment of community suicide postvention initiatives should include:

- Establishing values
- Recognising culture
- Links to services, information and support
- Making use of research
- Becoming learning organisations
- Promoting safe practice
- Having detailed referral procedures.

Suicide self-help groups should ensure that all members are appropriately trained and that there are detailed supervision and referral arrangements in place. Critically, those wishing to establish or join a group should be carefully assessed for suitability, particularly where they themselves have been bereaved by suicide, in view of the potential for traumatisation.

As so little is currently known about self-help groups for suicide survivors, groups should be encouraged to monitor and evaluate their activities and add to the body of knowledge and experience on the limits and benefits of self-help groups for survivors.

[2] Appendix vi - Principles for Community Suicide Postvention Initiatives - provides further information and explanation on the principles set out above. The appendix is based on a New Zealand publication from the Ministry of Youth Development concerning guidance for community organisations involved in suicide postvention.

5. Models of Service Provision

5.1 Terms of Reference

To examine outreach support for those bereaved by suicide in Ireland, especially in relation to the services offered by Living Links but also with a view to other models internationally such as those offered by the Baton Rouge Crisis Intervention Service

5.2 What is Suicide Postvention?

Anticipated losses that are supported within a community tend to reach an adapted level of functioning over approximately two years with considerable variation depending on individual circumstances and relationships. A cognitive, behavioural and emotional restructuring takes place within the individual, enabling the person to fully integrate the loss. For the suicide bereaved, the path and journey to acceptance, understanding and adaptation can seem utterly unimaginable. Research has indicated that following a suicide, grief may encompass a longer period of time (Beautrais, 2004).

Formal support for those bereaved by suicide, or "postvention", originated in the 1970s with a pioneer in the field of suicidology, Edwin Schneidman (Beautrais, 2004). Postvention can be defined as follows:

> "[The] interventions after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers). The aim is to support and debrief those affected and [to] reduce the possibility of suicide contagion. Interventions recognise that those bereaved by suicide may be vulnerable to suicidal behaviour themselves and may develop complicated grief reactions." (New Zealand Health Strategy, 2001, p. 42).

Schneidman, the founder of the American Association of Suicidology, drew attention to the apparent differences between the needs of those generally bereaved and the needs of those who were bereaved suddenly or traumatically, including the suicide bereaved. Those who are suicide bereaved suffer a loss that may be filled with stigma, shame, responsibility and enormous confusion.

According to Schneidman, "[postvention's] purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise" (Schneidman, 1981, as cited in Beautrais, 2004, p. 4).

In a study by Ness and Pfeffer (1990, p. 281) it was concluded that:

> "In summary, reports about the grieving process after suicide associate it with certain apparently special experiences, including a sense of shock, a need to search for an explanation, and difficulty in sharing one's feelings about the suicide. Feelings of guilt may be strong and may persist. Such impressions, although based on reports of uncontrolled studies, are consistent, and their face validity is supported by numerous articles in the media and in current literature as well as in professional journals."

5.3 Objectives of Suicide Postvention

Most postvention programmes agree on the following goals:

- The relief of the suffering and related effects of the suicide loss
- The prevention of the onset of adverse grief reactions and complications
- The minimisation of the risk of suicidal behaviour in the suicide bereaved
- Encouragement of resilience and coping in the suicide survivor.

According to Beautrais (2004) the suicide bereaved require:

- Help and advice about practical matters
- Information - with an awareness that individuals may be cognitively disorganised in the immediate aftermath of the death and may require the information again at a later time or from a different source
- Support (particularly assistance or therapy from mental health professionals)
- Opportunities to talk with others who are bereaved by suicide.
(Beautrais, 2004, pp. 14-15, Beautrais, 2006).

5.4 Efficacy of Postvention Models

Many studies have attempted to establish the superiority of one evidence based model over another. According to King et al. (2004) there have been thirteen studies cited in eighteen journals evaluating an intervention for those bereaved by suicide. Research from the USA comprises nine of the thirteen studies while Canada is represented by two studies and Finland and Norway by one. The studies evaluated interventions for families, peers, spouses, parents, those who were generally bereaved and the local community.

Recently, de Groot et al. (2007) carried out research that examined the effectiveness of a family-based grief counselling programme to prevent complicated grief among first degree relatives and spouses of someone who had died by suicide. The programme consisted of a family-based, cognitive behaviour counselling programme of four sessions with a trained psychiatric nurse counsellor, between three to six months after the suicide.

The study concluded that a cognitive behaviour grief counselling programme, for families bereaved by suicide, did not reduce the risk of complicated grief or suicidal ideation or the level of depression 13 months after the event. However, the programme may help to prevent maladaptive grief reactions and perceptions of blame among first degree relatives and spouses.

The mental health community relies on current trends and the opinions and current research of those professionals in the field who work with the suicide bereaved. Good practice in postvention, according to the National Alliance for the Mentally Ill, New Hampshire (NAMI-NH) (National Alliance for the Mentally Ill, Online), is based on what those in the field generally agree are the most effective interventions at the time.

Also, "In the context of bereavement care, best practice is usually linked to standards derived from a combination of empirical research and expert opinion from leaders in the field… in bereavement support services, best practice not only refers to direct involvement with bereaved people, but also policy development, program infrastructure and the sequencing of care". (Renzenbrink, 2002, p. 6)

After a span of over 20 years of research into interventions for the suicide bereaved, there is still no conclusive evidence that one technique or therapy is more efficacious than another. Therefore a range of services may be appropriate.

5.5 Current International Trends in Survivor Support Groups

There are different support options for suicide survivors depending upon the resources available in their community. According to Andriessen (2004, Online), some suicide survivor groups exist on their own, while some have made links with other bereavement groups both locally and nationally. The ultimate goal of suicide survivor groups would include developing a national network with strong ties to the local community and connecting with groups in other countries.

Many countries worldwide have established at least one suicide bereavement support group and several countries have numerous such groups in existence, including Ireland, England and Norway. Other countries including Belgium, Sweden, the USA, Canada, Australia, and New Zealand have established a strong network of groups for suicide survivors.

Survivor groups have taken on the additional role of advocate in some countries, particularly in the USA and in Belgium where the group "Further On" developed the Rights of Suicide Survivors (World Health Organisation, 2005). The group aimed to increase the survivor network, raise awareness of the issue of suicide bereavement, and to "promote empowerment for support and for the social position of suicide survivors" (Andriessen, 2004, Online, p.3).

In general, those who have utilised survivor support groups reported that the experience was very positive. In a study by the Calgary Health Region (Davis & Hinger, 2005), the participants had been bereaved by suicide and were asked their opinion of the support group. The researchers reported that the participants felt "it was very helpful…The shared experience of suicide bereavement was important and they felt their grief was validated and… no judgments were made and thus the stigma of a loss to suicide was not present" (Davis & Hinger, 2005, p.11).

5.6 Outreach Services in Ireland

Outreach consists primarily of face-to-face contact with survivors in their natural environments in order to provide counselling services or support. It is the means by which counselling services or support are made available to people[3].

In the context of suicide bereavement support services, some organisations providing an outreach service will only respond at the direct invitation of the bereaved party whereas other service providers will respond at the invitation or recommendation of third parties.

As part of this review, we gathered information on general bereavement and suicide bereavement support services, including outreach services, available in Ireland. The results of this are provided in Chapter 7 of this report. We profile below one organisation, Living Links, which has a well developed and structured outreach service. It should be noted that Living Links has a strict protocol that it will only intervene at the personal invitation of the suicide bereaved and works closely with the individual's GP.

Profile - Living Links - Ireland

In 2002, a small community in Ireland reacted to a local suicide, and out of their actions the organisation Living Links was created (Living Links2, Online paragraph 1). The group initially set out to help friends and family in the aftermath of a suicide. There were existing support groups within the community but the group considered that such groups were not being utilised for fear of stigma and shame. Living Links has developed into a suicide outreach support programme available to anyone in the community who has experienced a loss due to suicide. Volunteers are trained in suicide bereavement and meeting the immediate needs of the suicide bereaved by providing practical information on the funeral, inquest, the pattern of grief reactions and connecting the bereaved to support services in their area. Living Links has branched out into nine different locations around Ireland. They are currently in counties Tipperary, Cork, Meath, Clare, Limerick, Kerry, Galway, Wicklow and Kildare.

Living Links' Objectives (Living Links1, Online, paragraph 2) are:

- To provide support and outreach to those bereaved by suicide
- To increase awareness and understanding of suicide and its effects on individuals, families and communities
- To liaise and exchange information with similar support groups nationally and internationally
- To support and encourage relevant research
- To produce leaflets and associated literature to be provided to survivors

[3] Adapted from the Iowa Department of Human Services. Online - http:// www.dhs.state.ia.us/mhdd

- To liaise and provide families with information on health services available in the region, and the referral pathways to such services should they be required
- To provide and facilitate a group healing programme, on a needs basis, for the suicide bereaved
- To encourage the suicide bereaved and/or suicide impacted to establish and foster an ongoing support group among themselves (Living Links1, Online, paragraph 2).

Living Links works by invitation only with the bereaved individual or family. They do not offer counselling and their protocol supports referral procedures to local GPs.

5.7 First Response Suicide Postvention Programmes

First response programmes grew out of the outreach concept of going beyond existing services to meet the specific needs of a population; in this case, the suicide bereaved. First response outreach programmes have grown in popularity over the past 10 years despite lacking hard evidence and replicated research studies to support them.

Many communities across various countries are implementing first response programmes. Trained volunteers from the community as well as medical and mental health professionals respond to the practical and emotional needs of the suicide bereaved.

Three international programmes from Australia, New Zealand and the USA are described in the following profiles:

Profile - StandBy Response Service - Noosa, Australia (StandBy Response Service, Online, pp. 1-2)

In Noosa (a cluster of suburbs in Queensland, Australia), the StandBy Response Service sends out trained suicide bereavement professionals to families, friends and associates of the bereaved. The StandBy service provides a 24-hour crisis intervention line with further face to face outreach and pathways to services in the local community. StandBy utilises "local community support mechanisms such as the police, ambulance, coronial
services, community groups and health services" (StandBy Response Service, Online, p. 1). In October 2006, the StandBy response service was awarded funds by the Australian government as part of the Living is for Everyone (LIFE) national suicide prevention plan. The funds will extend the StandBy service beyond the Noosa area into the areas of North Brisbane, Cairns and the Australian Capital Territory.

StandBy responds to people in the immediate aftermath of a bereavement by suicide or those for whom an earlier suicide bereavement has since become a significant issue. StandBy also responds to school settings, work places, community groups and other types of multiple bereavement experiences.

StandBy incorporates a Coordinated Community Response plan that provides people with access to timely support and clear pathways of care from a reliable, single-point contact. Working in conjunction with other services, StandBy aims to reduce potentially adverse health outcomes.

Bereaved people have found that the support provided reduced their sense of helplessness, gave them room to grieve and provided them with a sense of relief that other matters were being handled.

Profile - Victim Support - New Zealand (Victim Support Online, paragraphs 2-11)

In 1990, New Zealand created a national first response team, Victim Support, for all victims of crime and trauma, including suicide. Victim Support services include 24 hour emotional support, personal advocacy and information for all those who have been the victim of a crime or trauma. Currently, Victim Support has over 1,500 trained volunteers from all over New Zealand. Potential volunteers are interviewed, screened and undergo a mandatory 50-hour training programme. Training includes self-awareness, listening and communication skills, coping with grief, death, dying, trauma and loss and understanding legal, court, hospital and police procedures. Training is also available in specialist areas on a monthly basis.

Victim Support has two objectives:

- To provide information, support and assistance to individual victims, witnesses and their families and friends
- To raise public awareness and recognition of the effects of crime and promote victim's rights.

Profile - New Zealand Suicide Postvention Support Initiative (Clinical Advisory Services Aotearoa, Online)

A suicide postvention service commenced on 1st June 2007 and up to the end of August had dealt with 53 deaths, with 122 affected people receiving the service. A gradual roll out over a two to three year period is planned and at the moment the services are available in four of the 13 police districts in New Zealand.

There are varying levels of service offered. Everyone receives a set information pack about bereavement, the coroners court, how to discuss suicide with children, local support groups and counsellors.

Different service levels are offered with one group who receive this information, along with basic support (e.g. one visit, and telephone contact), another group who engage in a follow-up service only (set contact points post-bereavement at 3, 6 and 12 months), and another group who receive the full service (receive ongoing face to face visits from a support worker, have a basic needs assessment completed, have an individual plan for what support is required, receive a suicide screen, get given assistance with practical matters (e.g. how to access financial support), and are guaranteed one year of service provision. Because the service is new it is also changing rapidly in response to what is being learned.

A database system carefully monitors the volunteer's work (e.g. type of contact with the families, how often, for how long, what they say).

Training consists of a two day training workshop for workers with competency based assessment around factual knowledge about suicide, bereavement processes, and practical skills around suicide screening. Workers all have to learn about cultural perspectives on suicide and working cross-culturally. They are in specialist teams and training occurs after they have already completed the basic training offered by Victim Support (the service provider for whom these people are working).

There is tight supervision, and ongoing small group training over specific issues (e.g. moving from a trauma approach to a bereavement approach) and set one day refresher training each year which will start after they have been working for six to eight months. See Appendix viii for more details.

Profile - Baton Rouge Crisis Intervention Center - USA (Baton Rouge Crisis Center1, Online)

The Baton Rouge Crisis Intervention Center in Louisiana, USA has been developing programmes in prevention and postvention since 1970. It is an internationally recognised centre that offers services across the lifespan for the bereaved.

The Crisis Center began as a phone line at Louisiana State University in response to six student suicides. The phone line has since grown into a 24-hour service, operated by counsellors, called The Phone. The counsellors undergo an extensive mandatory 60 hour training program in crisis intervention and suicide prevention.

The Crisis Center offers another phone service, United Way 2-1-1. This is an information and referral phone service run by trained counsellors who are connected to hundreds of agencies and services in the Baton Rouge area. The counsellors direct the caller to a local service in the community that best fits their needs. The Survivors of Suicide support group (SOS) and Survivors Supporting Survivors (SSS) are both groups aiming to ease the pain of those bereaved by suicide. The SOS group is a place for the bereaved to discuss their loss in the safe presence of those who have shared the same experience. Survivors Supporting Survivor's aim is to encourage those who have lost a loved one by suicide to get involved in prevention and awareness in their community and to help educate others concerning suicide.

Baton Rouge Crisis Intervention Centre offers Applied Suicide Intervention Skills Training (ASIST) workshops, and currently works with the Baton Rouge school system to train educators, law enforcement, mental health professionals, administrators, volunteers and anyone interested in developing suicide intervention skills.

Established in 1998, one of the key programmes developed is the Local Outreach to Suicide Survivors (LOSS) programme. The team of trained volunteers and staff from the Crisis Center respond to calls from the Medical Examiner. They visit the home of the bereaved as close to the time of death notification as possible. While at the home, the team listens supportively to the family, provides practical information, discusses the grief process and makes referrals to other services in the community. In their own words, "LOSS team members are there to offer resources, support and sources of hope to the newly bereaved" (Baton Rouge Crisis Intervention Center2, Online, paragraph 1).

The Crisis Center also provides a nine-week bereavement support group for children using the creative arts, an eight-week peer group for teens supporting other teens and short term individual adolescent counselling.

5.8 Referrals Protocols

Every bereavement support organisation should have an onward referral procedure. For example, Living Links has a very clear onward referral protocol. Here, the supporters will only become involved if invited by the individual seeking support (not on the suggestion of a friend or other family member). If at any stage the supporter involved feels that a higher level of intervention is required, they automatically refer back to a local GP, and never to any other group or organisation. While different organisations will have different operating procedures and referral pathways, a strict protocol for when to get involved, when to refer onwards and to whom should be in place.

5.9 Assessment of First Response Suicide Postvention Programmes

The Calgary Health Region published a needs assessment article on survivors of suicide. They conclude that "reactions by first responders, such as police, EMS, Fire and Medical Examiner personnel, have a lasting impact and can vastly influence the course of recovery" (Davis & Hinger, 2005, p. 4).

Several countries around the world have implemented first response services that are researched and evaluated for efficacy on an ongoing basis. Currently, research has been inconclusive as to whether first response teams are effective or whether they could potentially be damaging.

According to Beautrais's research (2004), the USA and Australia have committed to funding research projects on different postvention models. Belgium, New Zealand and the United Kingdom have taken a slightly different approach. Their primary focus is on strengthening existing bereavement support services within their respective countries.

Many first response services have been developed and have flourished throughout America, Europe, Australia and New Zealand, and represent the latest development in suicide postvention.

One potential concern is the level of training of those responding to the event. If the training and education of the volunteers on first response teams is not sufficient, the initial contact made with the families could be harmful as opposed to beneficial. Another potential concern involves support for the volunteers.

Sufficient support is essential for those responding to traumatic events.

5.10 Summary

In time, current research will identify good practice models and more countries will establish national postvention plans. Until that time, the approach taken by the Baton Rouge Crisis Center, the Noosa StandBy Response Service and New Zealand's Victim Support seems to represent international good practice services in suicide postvention.

Research in postvention has yet to determine a technique or therapy that is more effective than another.

Current trends in good practice are leaning towards developing educated and trained first response teams to a specific standard.

First response suicide postvention programmes provide an outreach service for those bereaved by suicide. The programmes vary in their initial approach to the family but all provide immediate practical and listening support to the bereaved, and refer on to local services should they be necessary.

The New Zealand model for suicide postvention services is still at an early stage of development but could indicate the approach to be followed in Ireland.

6 Training and Development for Bereavement Support Staff

6.1 Terms of Reference

To examine and make recommendations in relation to the training needs of the service providers and the development of bereavement care protocols (covering for example risk assessment) - identifying the relevant training programmes where possible.

To examine current standards and qualifications for people involved in bereavement support services, including de-briefing and supervision arrangements, and if necessary establish a set of standards and qualification requirements.

To examine and make recommendations in relation to the appropriate standards and qualifications for people involved in bereavement counselling, including professional and clinical supervision arrangements and accreditation to the appropriate professional bodies.

6.2 Introduction

The objective of the NOSP in the context of developing responses to suicide is "to minimise the distress felt among families, friends and in a community following a death by suicide and to ensure that individuals are not isolated or left vulnerable so that the risk of any related suicide behaviour is reduced" (National Office for Suicide Prevention, 2005, p. 45). The strategy also identifies the need to develop services for those who are bereaved, ensuring the registration, training, supervision and support of bereavement counsellors.(p.67)

6.3 Support Needs of the Bereaved

The Irish Hospice Foundation (Renzenbrink, 2002) recommends the following:

- Bereavement support should be available to all
- It should begin early in the process (i.e. before the death, where possible)
- Trained personnel should provide it
- Assessment of need should be routine in all palliative care services.

All organisation and individuals offering support in this area need at least a minimum standard of training.

It is accepted internationally that grief following bereavement (from any cause of death) largely follows a typical, non-pathological process (Bonanno & Kaltman, 2001). However, for those who need intervention, it follows that they may react with recognised symptoms such as depression, anxiety, post-traumatic stress disorder or they may be categorised as suffering from the more recently proposed concept of complicated grief.

One of the primary concerns is that the provision of bereavement support may lead to the initial trauma being re-triggered. This is a concern of The Daughters of Charity (Personal Communication, 2007), and is referred to in the Canterbury Suicide Project: "relevant evidence from randomised control trials suggests that debriefing after trauma may not be helpful and may in fact be harmful" (Beautrais & Gibbs, 2006, p. 6). Consequently, it is necessary to ensure that all those working in the field of bereavement support, and particularly suicide bereavement support, are appropriately trained.

The current limited evidence about the effectiveness of existing support services suggests that we need to encourage the scrutiny of existing services, and the evaluation of all new services that may be developed.

Traumatic deaths (including suicide) may also differ thematically and may involve a stronger need to find meaning in the death, higher levels of guilt, blame and responsibility, greater feelings of rejection and abandonment, stronger feelings of stigmatization and social isolation; a particular impact on family systems (including interaction and communication), and a higher risk of suicidal ideation and behaviour (Jordan, 2001). This implies that in bereavement by suicide, the issues may be more complicated, though the research on the process of grief is inconclusive as to whether it is different or not. To quote the National Suicide Bereavement Support Network: "All bereavement creates its own brand of suffering, especially sudden death, but because of the inability to understand the 'why', suicide bereavement is more intense" (Personal Communication, 2007).

6.4 The Need for and the Effectiveness of Bereavement Support Providers

It has also been reported that (60-80 percent of the time) the bereaved require no intervention, regardless of the cause of the bereavement (Prigerson et al., 1995). However, where there are reactions to a death that may be classified as severe or complicated (where the bereaved are traumatised), intervention may be useful. In these cases intervention or postvention can be offered at a number of levels. The first responders in these cases (in many cases on the recommendation of a medical physician or a member of the emergency services) are usually voluntary organisations.

Definition of Bereavement Support First Responders: Based on a review of the literature and emerging best practice, First Responders are typically defined as emergency personnel called to the scene of a crisis or responding to emergency calls for assistance. First responders could include emergency medical technicians, police, hotline/crisis line personnel, fire and rescue service personnel, child protective services and others. In the context of bereavement support we define first responders as those called to assist a bereaved person who have a specific brief and training to support those who are bereaved. This could include a specially trained member of the emergency services, or more likely in Ireland it could be someone from a local bereavement support agency whose contact details are given to the family by the emergency services. In the New Zealand postvention service described previousely in this document, the first responders are specially trained members of Victim Support.

As a working definition, we categorise a certified first responder as a person who has completed 40 to 60 hours of training in providing care for bereaved individuals or families. They would have more skill than someone who is trained in first aid but are not necessarily emergency medical personnel or trained counsellors or psychotherapists. First responders in bereavement support need not be medical personnel, trained counsellors or psychotherapists, or mental health professionals. However, they should have the basic knowledge and skills to refer and signpost individuals to professionals services should they be required or simply to provide brief, non-counselling based, support.

First responders should have a referral process and sufficient training to recognise when the next level of intervention is required. They should also ensure that they have personal support facilities in place, in order to ensure that they themselves do not become traumatised.

6.5 Training Needs of Service Providers

The questionnaire and the interviews carried out as part of this research sought to establish the level of training of those involved in the provision of bereavement support services in order to establish what protocols, if any, are in place and to ascertain the views of the Irish service providers on further training requirements.

The belief in Ireland (and supported internationally) amongst the main service providers is that training is absolutely necessary, even when what is being offered is simply the support of a peer sufferer as part of a bereavement self-help group. At a minimum, all those involved in service provision at all levels should be assessed at the outset by a professional in the area of bereavement as much for their own sake as for the sake of potential clients.

Service providers in this review identified the following areas as critical components of training programmes for their staff/volunteers:

- Active listening
- Bereavement and mourning
- Theories and models of grief
- Counselling skills
- Self-care and caring for carers
- Identifying trauma.

Training is also required for practical issues such as the identification of trauma in children, the coroner's court and the legal processes, and their organisation's referral pathways. All the organisations interviewed for this study have this training in place, including Living Links, The Daughters of Charity, Bethany and Console.

Due to the risk of volunteers who have themselves been bereaved being re-traumatised while dealing with another bereaved person, all service providers who work with the bereaved, whether on a voluntary or professional basis, should have appropriate debriefing and supervision arrangements in place.

The postvention required by families or individuals following a suicide is potentially complicated, as there is a danger of re-traumatising the supporter if they have previously been bereaved themselves. Furthermore, work with the bereaved can be potentially traumatic, or taxing, even for those who have not been bereaved. Monitoring of service providers providing suicide postvention is therefore crucial.

Service providers should have mandatory supervision, and training should be available for those providing the supervision.

An Irish paper (Carroll, 2005) highlights the need for training in order to deal with sudden traumatic deaths, multiple deaths, families post-suicide, children and adolescents post-suicide, as well as training in risk assessment so that clients can access the appropriate level of support. The paper also recommends standardisation of training and practices within the services offered and group facilitation training so that group support can be offered. Carroll notes that "there was a strong request from many clergy for training in working with the trauma resulting from deaths by suicide and road traffic accidents" (Carroll, 2005, p. 27).

The requirement for group training, especially in dealing with adolescents following a death by suicide, has been identified by the Daughters of Charity. They are currently working with and assessing such a group, which was requested by the adolescents themselves and is currently being run in conjunction with Trinity College, Dublin (Personal Communication, 2006).

Irish services providers feel that stigma surrounds death by suicide, and that this can cause complications in the support that would normally be offered by the community and extended families.

Training is required to identify a 'suicide survivor'. While most research has focussed on the spouses and parents of the person who died, many others such as siblings, friends and colleagues may also be affected by a suicide death. Due to their circumstances, certain groups are at risk of becoming overlooked in the grieving process and need recognition.

Training should recognise that there is a risk of overlooking certain groups, such as friends outside the immediate family circle in the grieving process and to ensure that such groups are identified.

6.6 Bereavement Care Protocols - Risk Assessment

Our review of current literature has not identified a definitive set of guidelines or care protocols for the bereaved or suicide bereaved. Similarly, risk assessment guidelines do not appear to be used. The feedback that we received from the major service providers is that such protocols would be very useful.

Currently, the second phase of a Review of Bereavement Care Services (Carroll, 2005) is empirically reviewing a bereavement risk index using the Adult Attitude to Grief Scale (Machin, 2001). This research is being undertaken in the HSE South East, and is being tested in an acute hospital setting with a hospice home care team, a voluntary agency and a counselling service. This work is likely to be completed in 2007 and will provide an empirical study on the uses of a risk index within the bereavement support arena.

The NOSP should await the outcome of the research being undertaken in the HSE South East and ensure that any lessons learned are incorporated in the provision of training.

6.7 Identifying Training Needs

The National Institute of Clinical Excellence (NICE) is an independent organisation based in the UK that is responsible for providing national guidance on promoting good health and preventing and treating ill health. We have adapted the three-component model set out in the NICE guidelines (National Institute for Clinical Excellence, 2004, pp. 160-161) for the provision of support to the bereaved.

- In the model proposed here, by us **Level 1** represents a normal or mild level of distress, and the requirement is for access to information through the community, information resources, the internet and from rituals that surround bereavement (e.g. funerals etc.).

- **Level 2** indicates a moderate reaction to the death and at this level community support and self-help groups can provide assistance.

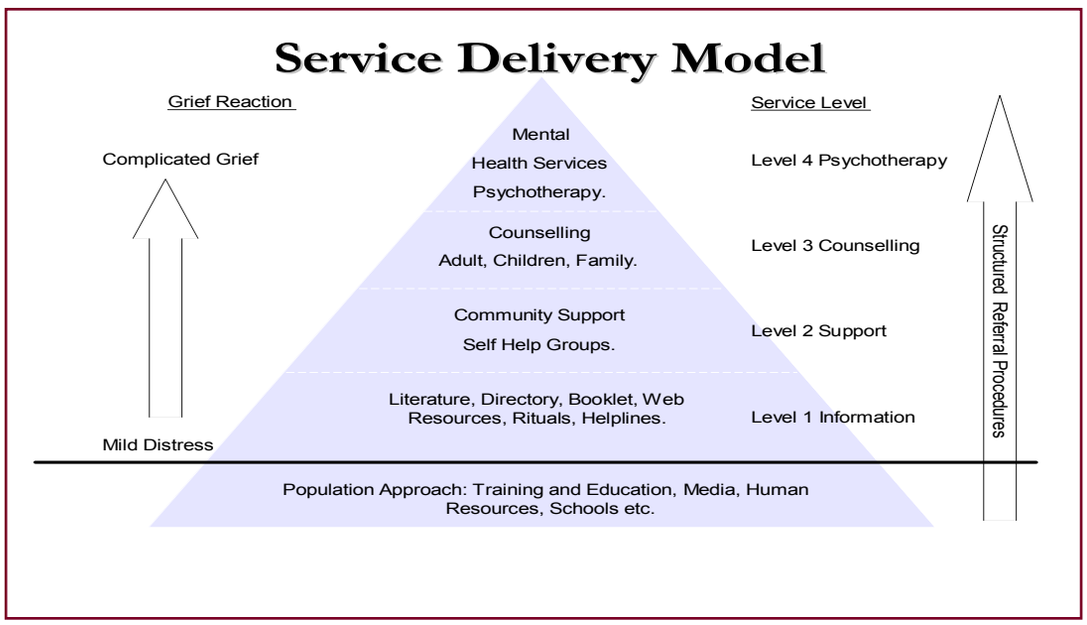
- **Level 3** represents a severe reaction to the bereavement and may require counselling, either individually, in a group setting, or for families.

- **Level 4** represents a complicated reaction to the bereavement, possibly arising co-morbidly with a psychiatric condition, or other psychological problems. Here, the needs of the individual or family should be met by intensive psychotherapy, provided by the mental health services or by groups offering qualified psychotherapists or psychiatrists.

It should be noted that the levels set out above are not exact and in practice there may be an overlap between the levels. For this reason, it may also be helpful to consider the various levels of grief as a continuum moving from normal or mild distress to complicated grief.

Most bereaved people's needs are met with the support provided in the community from friends, family and colleagues. This is represented in the service delivery model below (Figure 4) as level 1. Here, support comes from religious or spiritual rituals, literature, helplines and websites offering information. The role of voluntary organisations starts here, and moves into the second tier of the pyramid where, as well as providing literature, web sites and helplines, they will offer emotional and practical support to the bereaved. Training is needed at this point and upwards. If the reaction to the death is severe rather than moderate, counselling for adults, children or families may be required, and in some small percentage of cases psychotherapy or the mental health services may be required to intervene in a complicated bereavement.

Figure 4: Service Delivery Model



Those who are at risk of suffering from complicated grief, and who will therefore require more intensive care, could potentially initially access services at any of the levels shown above. This means that it is vital that those providing services are trained to recognise instances that lie outside their level of training and that they have structured referral procedures in place.

At levels 4 and 3 we recommend that all support providers are qualified in a clinical capacity and complete 60 hours of bereavement support training (e.g. training offered by Cruse Bereavement Care[4]). This training should be augmented on a yearly basis by an additional twelve hours of training, some of which should be in the area of personal development.

All the groups we interviewed who were providing services at this level had staff or volunteers who were trained to post-graduate level in a relevant clinical discipline (i.e. psychology, psychotherapy or clinical nursing augmented with counselling courses) with additional bereavement training. Thus, these groups of service providers have already attained the recommended level of training.

At levels one and two, many voluntary organisations, self-help groups and private practices offer support. Here the actual level of training is less clear and less uniform. Many of the larger voluntary organisations have training courses in place although the length of time required and the vetting procedure for the volunteers varies. Currently, there is no process by which this training is standardised and quality assured.

We recommend that all support personnel at levels 1 and 2 also achieve the sixty-hour minimum - though it is envisaged that this would be spread over time, possibly over a three year period.

6.8 Current Standards and Qualifications.

Current standards and qualifications are very mixed. Some organisations are very clear that they do not provide counselling and that they are just a support facility. For example, Rainbows has a formal training programme, is following tried and tested methods and provides an extremely useful service. In terms of the service delivery model above, Rainbows fits between Level 1 and Level 2, i.e. the border between the information and the voluntary bereavement support groups. There is then every level of qualification up to professional clinical counselling standard working in the area. This is good news for prospective users of support services as a variety of tiered treatment and intervention options are appropriate.

However, service providers are not obliged to undergo training and even when they do so, the training and the qualifications that they receive are not generally recognised and accredited by an independent body.

4 Cruse is a UK based organisation that provides training in bereavement support to organisations across the public, private and voluntary sectors. See website http://www.crusebreeavementcare.org.uk/ for further information

6.9 Setting Standards

All organisations offering training should endeavour to have their courses accredited. Zinner (1992) explains why certification is a step forward: it is a formal procedure, which certifies the experience and knowledge base of a practitioner, it affirms their identity and attests to competency.

In Ireland, HETAC (Higher Education and Training Awards Council) is the qualifications awarding body for third-level educational and training institutions outside the university sector. HETAC may delegate authority to make awards to recognised institutions. Recognised institutions currently comprise various Institutes of Technology. HETAC is also charged with ensuring that student assessment procedures within institutions are fair and consistent, and ensuring academic and financial protection for students in commercial educational institutions providing programmes validated by HETAC.

A system that insists on, for example, 30 hours[5] in core training modules, and then allows credits to be accumulated, would help to bring about a way of incorporating many of the existing training courses run by volunteer support groups into the system. Where existing core training does not meet the required minimum hours, it is possible to set up a module-credit system so that personnel can achieve the additional hours, within a specified time-limit, from other courses. This could be achieved in the same way as UCD (University College Dublin) in Ireland have set up their "Horizons" programme. This is a programme where each course is defined as a module or a self-contained entity, comprising a defined volume of learning and awarded with a credit value.

Many Irish groups run their own training programmes, e.g. Bethany, Living Links, Samaritans, and Console. The larger groups also avail of additional courses or invite guest speakers from the Health Service Executive, the Irish Hospice Foundation or from each other. All organisations should be encouraged to get their internal training accredited, so that it can be augmented by relevant external courses leading to certificates, diplomas, higher diplomas etc. in bereavement support care.

A standardised national qualification in bereavement support should be developed in partnership between existing training providers and should be accredited to a HETAC/NUI college. Such a qualification would not be a professional counselling course but rather a standardised national programme for voluntary staff who provide bereavement support but not professional counselling or psychotherapy. Such a course should be developed incorporating the training needs identified by organisations as set out elsewhere in this report (Chapter 7).

6.10 Special Training Requirements for Dealing with Bereaved Children and Adolescents

The Daughters of Charity, who have a specific focus on children, highlight the need for special training requirements for those dealing with bereaved children. The stigma attached to a death by suicide often results in lack of support from normal sources in the family or community. The family may decide not to accept support especially if they are trying to protect young children. Children may not have been told the truth (or the whole truth) about the death. The family may then shun intervention, as they may be afraid that a visitor will reveal the true story. Teenagers also feel that they would benefit from, and have requested, a peer support group in the case of suicide bereavement. The Daughters of Charity suggest that a group of teenagers requires two qualified facilitators at each meeting. Thus, group facilitation skills, as well as bereavement support skills, are required in this area.

Carroll (2005) found mixed concerns among this younger group of children and adolescents, mainly about roles of carers overlapping, for example teachers operating as facilitators.

Staff and volunteers from agencies providing bereavement support to children and adolescents should receive specialist skills based training in order to deal with their capacity to understand, their internal reaction, and their ability to self-care. Such training should be accredited and delivered by suitably qualified personnel.

[5] The specific needs of various groups or organisations differ. Thirty hours is a starting point and one which the main servise providers in Ireland felt could be coped with as a minimum. The suggested duration also assumes continuous development, especially in areas such as children, teenagers, personal development, minority groups, etc.

6.11 Minority Groups and Training Requirements

There are many minority groups living in Ireland, including foreign people living in Ireland, Travellers and gay, lesbian and bisexual groups. Each has its own challenges with regards to suicide and bereavement support services. Foreign nationals living in Ireland may be away from the supporting network of their families and culture and thus may be vulnerable.

Pavee Point, an Irish organisation that is intent on encouraging Travellers and settled people to work together to improve the lives of Irish Travellers, state the following: "There is a general acknowledgement that, in common with the settled community, it is mainly young Traveller men who commit suicide and that it is a growing phenomenon within the Traveller community. There continues to be a stigma in Ireland around suicide and this stigma resonates also for Travellers. Travellers could be described as a 'high risk' or 'vulnerable group' in so far as they fare poorly on every indicator used to measure socio economic status, health, accommodation, education and employment" (Pavee Point, Online, p.3). Carroll's research (2005) supported this view: "there are significantly higher neo-natal deaths and deaths due to suicide in the traveller community" (p. 32).

Gay, lesbian and bisexual individuals are also at risk. In a survey based in England and Wales, "361 (31%) [out of the whole sample of gay men, lesbians and bisexual men and women] had attempted suicide. This was associated with markers of discrimination such as recent physical attack" (Warner at al., 2004, p. 479). Gay, lesbian and bisexual friends of a suicide victim may be marginalised or excluded from the familial rituals, making their grieving process more complicated.

All practitioners should be aware of the specific requirements of minority groups such as the travelling community and the gay, lesbian and bisexual community.

6.12 Conclusion

A standardised national qualification in bereavement support should be developed in partnership between existing training providers. Such a qualification would not be a professional counselling course, but rather a programme for voluntary staff who provide bereavement support but not professional counselling or psychotherapy.

The national qualification in bereavement support should be accredited to a HETAC/NUI college.

All those working with the bereaved should undertake the national qualification with appropriate allowance for core modules previously undertaken.

Services providing counselling and psychotherapy should ensure that their staff are registered with a professional body and undergo regular professional supervision.

Training programmes for volunteers and professionals working with the bereaved should include at a minimum the following modules:

- Active listening
- Bereavement and mourning
- Theories and models of grief
- Counselling skills
- Self-care and caring for carers
- Identifying trauma
- Practical issues for the bereaved.

Further specialist training on a modularised basis is required for those working with children, adolescents and marginalised groups. Training and development should be ongoing in all categories, with additional modules and seminars to be attended each year.

7 Current Profile of Service Delivery in Ireland

7.1 Terms of Reference

Review general bereavement counselling in Ireland, including counselling offered by statutory and non-statutory services. Review suicide bereavement counselling services in Ireland, including those offered by the organisation Console.

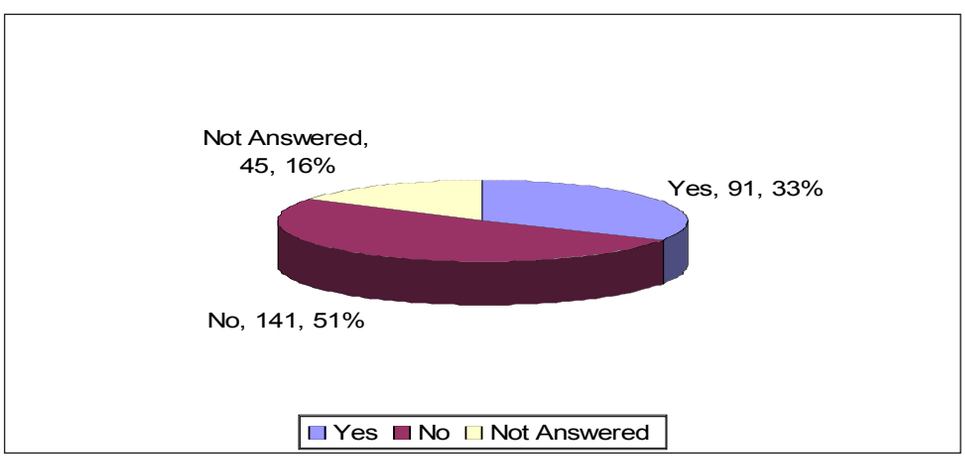
7.2 Introduction

This section provides a profile of the organisations providing general bereavement and suicide-specific bereavement support services. It is based on the 277 returned questionnaires, although not all respondents answered all questions. Where relevant we have identified the number of responses received in each category.

7.3 Incidence of Charging

Overall, 61% of the bodies that responded to this question do not charge for their services. This is shown in the chart below, which identifies that the majority of organisations do not charge for their services. Amongst those organisations that are categorised as charging for their services are a number of bodies (n = 39) that welcome donations (although this is up to the individual). Also included within the bodies that charge for services are sole practitioners, institutes and clinics that operate on a commercial basis. In addition, many bodies that charge for their services operate a sliding scale in order to improve affordability.

Figure 5. Incidence of Charging for Services



7.4 Organisation Types

We asked respondents to identify their organisation type and the results are shown below. Overall, it can be seen that voluntary self-help and community support groups are the most numerous grouping accounting for 52% of responses. Professional bodies accounted for 35% of those responding.

Figure 6. Breakdown of Voluntary versus Professional Bodies (n = 244)

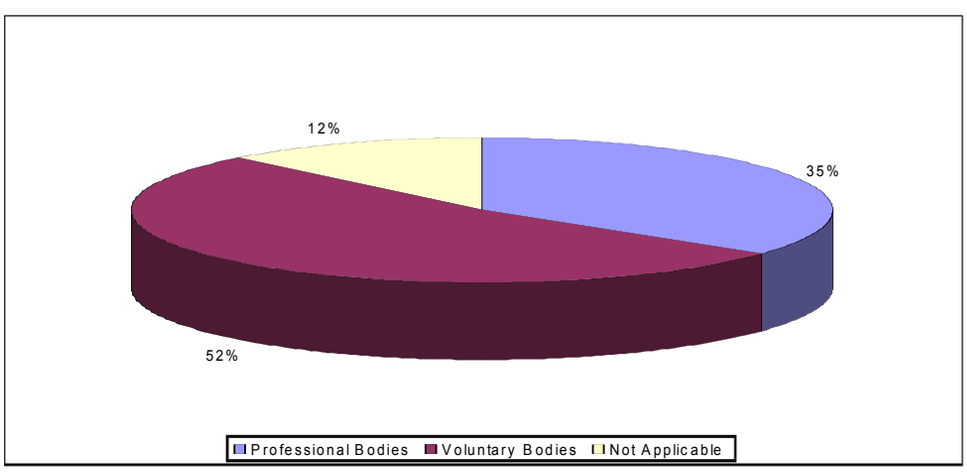
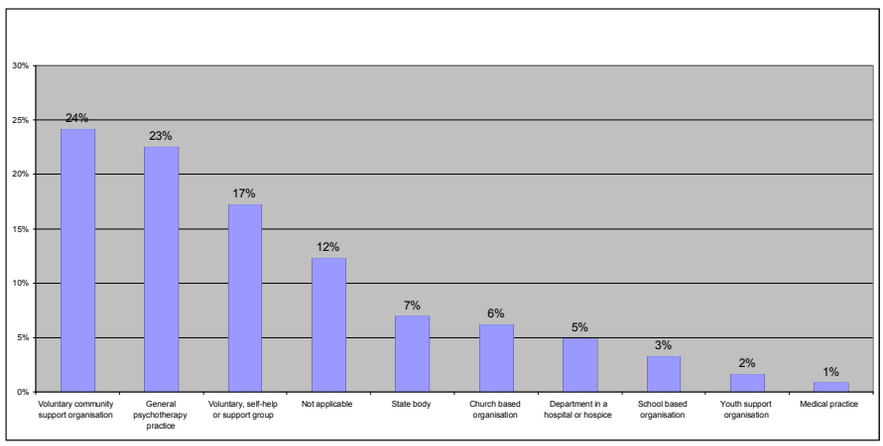


Figure 7. Type of Body (n = 244)



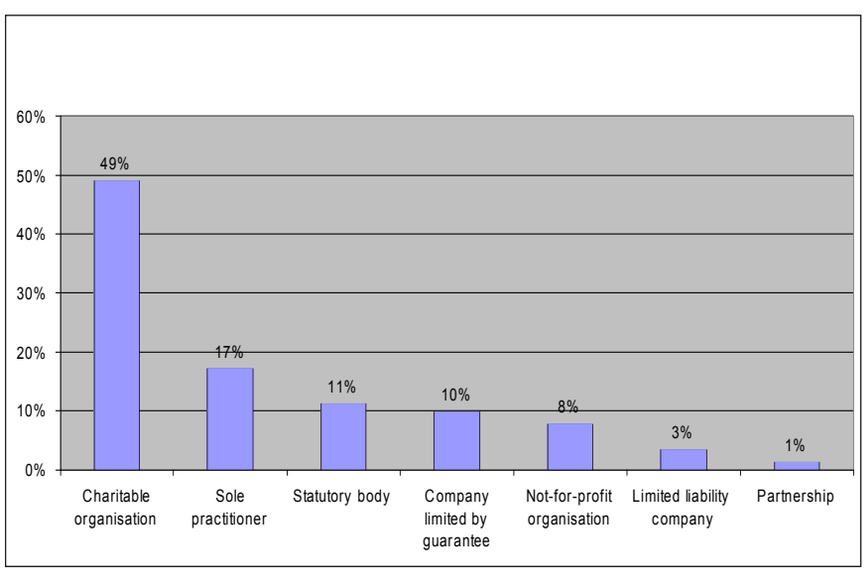
7.5 Type of Body

The graph above shows that the most numerous type of organisation is a community based voluntary support organisation which, together with voluntary self-help or support groups, account for 41% of all organisations. General psychotherapy practices account for 23% of all organisations that responded to the question.

7.6 Legal Structures

Almost 50% of those responding categorised themselves as Charitable Organisations. Sole practitioners, statutory bodies and companies limited by guarantee are also evident, while limited liability companies are quite uncommon.

Figure 8. Legal Structure (n = 204)



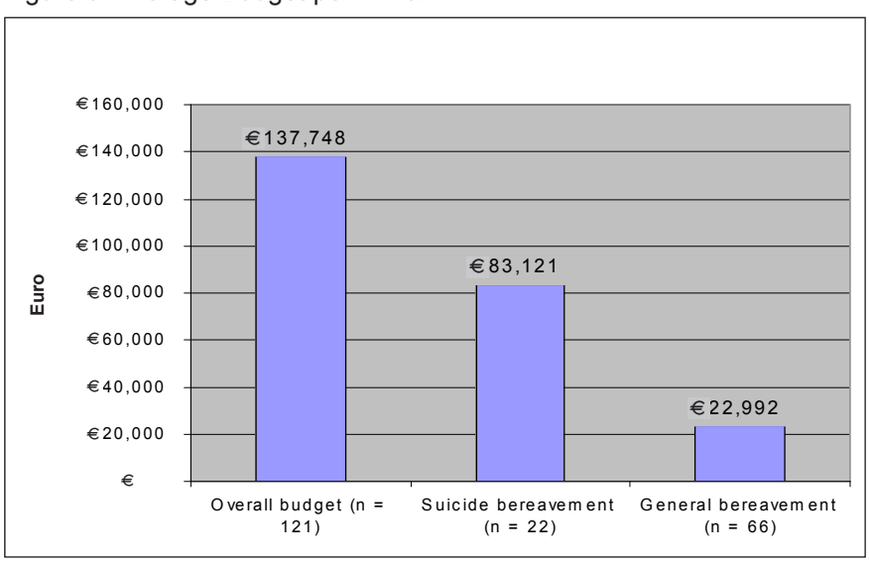
7.7 Funding and Financing

We received responses regarding their annual budget from 121 bodies in total. The total budget for these organisations amounted to €16.67 million or an average of €137, 748 per organisation. We also asked for the breakdown of this budget between suicide bereavement support and general bereavement support.

Table 1. Budget Available by Type of Group

Budget Information	All Bodies Responding	Suicide Bereavement	General Bereavement
Total Budget €	16,667,591	1,828,675	1,517,462
Average Budget €	137,748	83,121	22,992
Bodies with budget greater than €25,000	46	5	11
Bodies with budget greater than €15,000 and less than €25,000	6	4	10
Bodies with budget greater than €10,000 and less than €15,000	10	2	5
Bodies with budget less than €10,000	59	11	40
Number of bodies responding	121	22	66

Figure 9. Average Budget per Annum



The average budget for suicide bereavement support services is €83,121 per annum, whereas the average budget for general bereavement support services is €22,992. Very few bodies have budgets greater than €25,000, with only five bodies having a budget for suicide bereavement support services greater than €25,000 and eleven bodies having a budget for general bereavement support services above €25,000.

Eleven of the twenty two bodies with budgets for suicide and forty of the sixty-six bodies with general bereavement budgets have budgets lower than €10,000. Several bodies have budgets below €1,000.

The figures above are heavily influenced by a single organisation with a relatively large budget. Adjusting for this organisation by excluding its budget, the total budget available for suicide bereavement support was €328,675 spread over the 21 bodies. This indicates a budget for suicide specific bereavement support services of €15,651 on average. This is lower than the average budget available for general bereavement support services. On a standalone basis these organisations would not have the financial resources to employ full-time staff and severely limited resources to undertake research, carry out staff training, rent premises and promote their service quite apart from delivering the service itself.

Table 2. Adjusted Budget Information

Adjusted Budget Informatiuon	All Bodies Responding	Suicide Bereavement	General Bereavement
Total Budget €	15,167,592	328,675	1,517,462
Average Budget €	126,397	15,651	22,992

7.8 Sources of Funding

Bodies generate their funding from a range of sources as shown in the table below. While some bodies receive their entire funding from a single source, it is more common for bodies to receive funding from a range of sources. Grants and public funding is the most common source while donations and fees are also a source of funding.

Table 3. Sources of Funding

Sources of Funding	Number of Responses Yes	Number of Responses No	Bodies with Percentage Funding =100%	Bodies with Percentage Funding >50% <100%	Bodies with Percentage Funding <50%
Grants/Public Funding	132	6	41	34	18
Donations	55	8	0	2	39
Fees	55	12	12	5	13
Fund-raising	26	11	1	7	12

Among the sources listed within the Grants/Public Funding category were the Family Support Agency (74), the HSE (32), the Church (5), the National Lottery (2), the Dept of Education and Science (2) and the ESB (2). Among the sources listed for donations were clients including individuals, families and students, the Gardai, the Church, the Lions Club, the Department of Social and Family Affairs, local businesses, hospices, NUI Maynooth and the Dominican Priory.

Where organisations charged fees, these were generated from the individuals directly and also from health insurers (VHI, BUPA, VIVAS), through the HSE and school and community groups. Some examples of fund-raising given, included church gate collections, public appeals and organising a mini marathon.

7.9 Networking and Integration

Bodies were asked to identify if they were affiliated, accredited or a member of any national network and specifically if they were part of the National Suicide Bereavement Support Network.

Figure 10. Network Participation

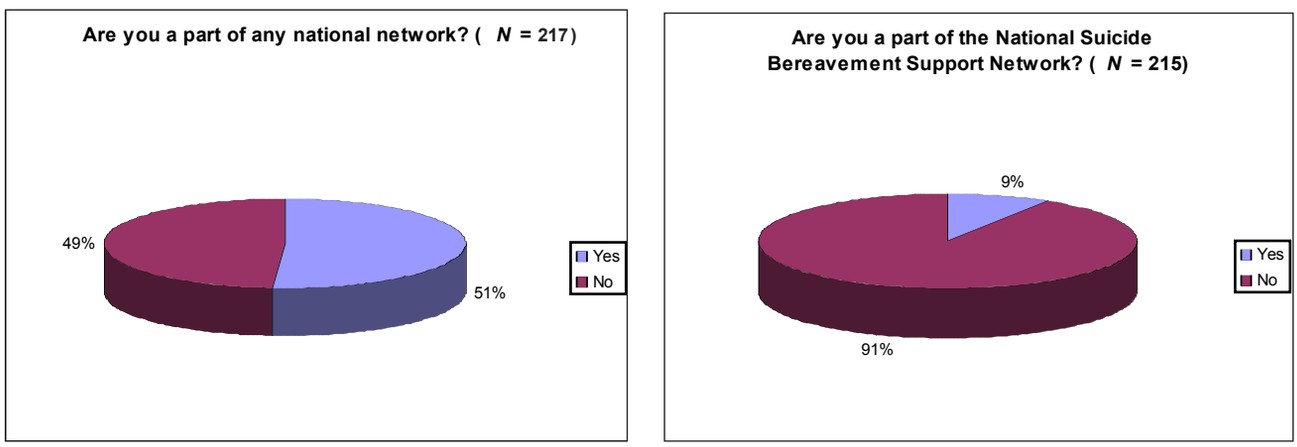


Table 4. Part of a National Network

National Networks	Yes	No
Part of a National Network?	111	106
Part of the National Suicide Bereavement Support Network?	19	196
Part of Other Network	11	

Among the affiliations listed within the "Other Networks" category were the Irish Association of University and College Counsellors, Inclusion Ireland, the National Womens Council, Console and Family Resource Centres.

7.10 Staffing

We obtained responses from 169 bodies on the profile of their staffing arrangements. From these responses we identified over 3,600 individuals involved in the provision of services in this area. A number of caveats need to be applied to this number. Firstly it represents the response from 169 organisations and it is not possible to estimate the numbers employed by the remaining organisations responding to the questionnaire. In addition, other organisations that did not respond to the survey will employ further staff.

One national organisation, Samaritans, employs almost 2,000 volunteers on a part-time basis. The staffing profile for the average organisation, excluding Samaritans, is shown in the table below. This shows that the average service provider has just over 10 staff with 3 of these full-time staff and the balance made up of part-time staff mostly working on a voluntary basis.

For the organisations responding, we found that there is a heavy reliance on voluntary staff. Of the total staff of over 3,600 covered by the responses, just over 82% were volunteers and 18% were paid. Equally, just over 86% of staff were involved on a part-time basis with the balance having a full-time involvement.

When volunteers from Samaritans are excluded and the remaining 1,708 individuals are examined, just over 62% were volunteers and 38% were paid. Again, when analysing the 1,708 staff, 70% of staff were involved on a part time basis with the balance having a full time involvement.

Table 5. Profile of Staff within Organisations

Staffing Profile (excluding Samaritans) n = 169					
Staffing Levels	Full Time Voluntary	Full Time Paid	Part Time Voluntary	Part Time Paid	Total
Administrators	46	42	50	31	169
Support Staff	76	17	397	26	516
Counsellors	36	66	317	114	533
Psychotherapists	24	90	11	166	291
Doctor and Nurse Practitioners	1	14	4	7	26
Other	47	51	63	12	173
Total	230	280	842	356	1,708
Average Staff Involved	1.4	1.6	5.0	2.1	10.1

From the table above, the staffing profile by activity level for the roles performed shows that 10% of staff are in administrative positions while supporters and counsellors account for 30% and 31% of positions respectively. Psychotherapists represent 17% of positions. Among the "Other" category are psychologists and social workers. Overall, it is clear that there is a very high emphasis on service delivery, with almost 90% of those involved providing services to clients.

7.11 Experience and Training Level of Staff

The results for the level of expertise or relevant educational attainment are shown in the table below. This highlights the large number of individuals with "Life Experience" or what the respondents themselves identified as a "Relevant Course". These categories accounted for 72% of the responses. While there is some overlap and duplication evident from the responses, whereby those responding gave each of their expertise levels rather than their highest attainment level, it is clear that "Relevant Courses" make up a very significant portion of the overall provision of expertise. The "Other" category includes psychologists and those pursuing or having attained a Doctoral qualification.

Table 6. Level of Staff Experience and Training

Level of Staff Experience and Training	Number of Staff	%
Life Experience	807	18
Relevant Course	2,494	54
Certificate Course	292	6
Diploma Course	379	8
Degree Course	174	4
Masters Course	248	5
Other	203	4
Total	4,597	100

Some of the relevant courses, as cited by the respondents, are set out below.

Table 7. Relevant Courses as self-reported by the Respondents

Relevant Courses	No of Responses
Bethany Basic Training	8
Bereavement Courses (various)	6
ASIST	3
General/Basic Counselling Course	2
Children and Loss	2
Samaritans Training	2
LivingLinks Training Programme	2
Suicide Prevention Course	2
Rainbows	2
Gestalt Therapy	1
BCS Training Course	1
Cert in Suicide Support	1
PCI	1
Console	1
Workshop on Bereavement Issue	1
Seasons for Growth	1
Courses at Milford Care Centre	1
Workshops	1
Child/Adolescent Psychotherapy	1
Listening Skills	1

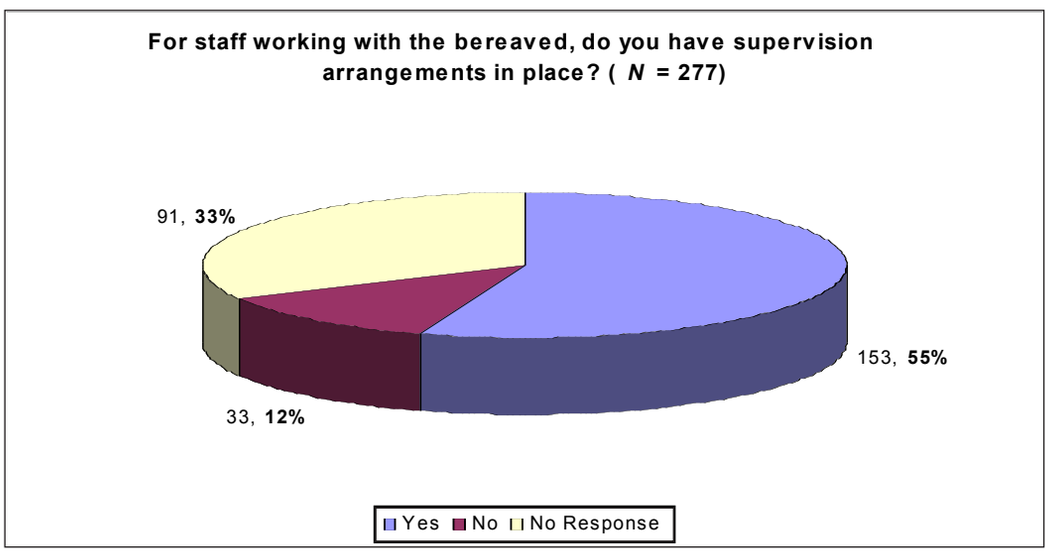
7.12 Supervision

For those bodies with staff working with the bereaved, we asked whether they had supervision arrangements in place. Of the overall two hundred and seventy-seven bodies, thirty-three did not have such supervision in place, representing approximately 12% of all bodies. However, as a percentage of those who responded to this question, the percentage without supervision is almost 18% or 1 in 5.

Table 8. Supervision Arrangements

Supervision	Number	%
Supervision in Place	153	55%
No Supervision in Place	33	12%
No Response	91	33%
Total	277	100%

Figure 11. Supervision Arrangements



The larger the group and the more highly qualified the providers, the better the arrangements. However, in many of the groups, debriefing or supervision is not mandatory.

Supervision or debriefing should be mandatory after ten hours client contact. This measure would serve to protect the supporter as well as the clients.

7.13 Services Provided

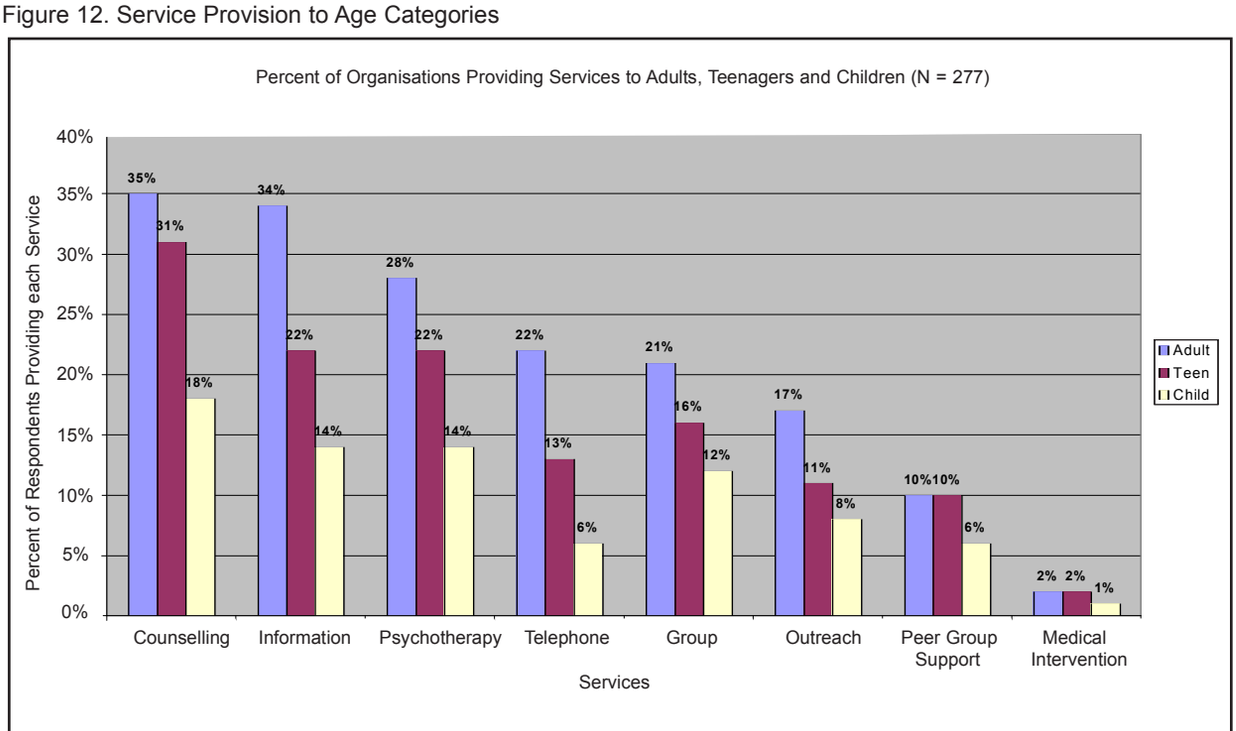
The table below sets out the number of bodies that indicated providing or not providing specific support services to the suicide bereaved and to those generally bereaved along with the age groups catered for. Overall, it appears that there is a comprehensive range of services available. The overall picture may mask some geographic gaps in service provision but it is not possible to identify these from the data. In addition, the level of service provision to teenagers and to children is in almost all cases lower than the service availability to adults, reflecting the fact that there are fewer agencies providing services for young people.

Table 9. Bereavement Counselling and Support and Suicide Bereavement Support
(Number of Organisations providing or not providing the Service Indicated.)

	Nature of Service Provided				Age Group Catered For					
Type of Bereavement Support	**Support**		**Counselling**		**Adult**		**Teenager**		**Child**	
	YES	NO	**YES**	NO	**YES**	NO	**YES**	NO	**YES**	NO
Information	**116**	4			**93**	0	**60**	11	**39**	27
Telephone Intervention	**82**	11	**29**	23	**62**	3	**37**	10	**18**	25
Outreach	**65**	15	**25**	24	**47**	9	**31**	12	**22**	18
Counselling			**117**	7	**97**	6	**85**	13	**50**	31
Psychotherapy			**96**	12	**78**	9	**62**	17	**36**	36
Medical Intervention*	**11**	24	**5**	14	**5**	11	**5**	11	**3**	12
Family	**85**	6	**60**	8	**62**	3	**55**	5	**40**	12
Group	**79**	7	**44**	9	**57**	3	**44**	4	**33**	12
Peer group	**46**	11	**20**	12	**29**	8	**29**	6	**18**	13
Schools	**43**	12	**28**	12			**38**	5	**25**	9
Colleges	**29**	13	**20**	10	**20**	7	**17**	8		
Play-Therapy	**12**	19	**14**	8					**12**	7
Legal and or Financial Advice*	**10**	19	**4**	11	**6**	8				
Other -	Small numbers in this category and not significant									

* The population of bodies surveyed did not include a wide sample of medical and legal practitioners and this explains the apparently low level of service provision. However, these services are available from GPs, solicitors and accountants throughout the country.

Figure 12. Service Provision to Age Categories



7.14 Telephone Support Services

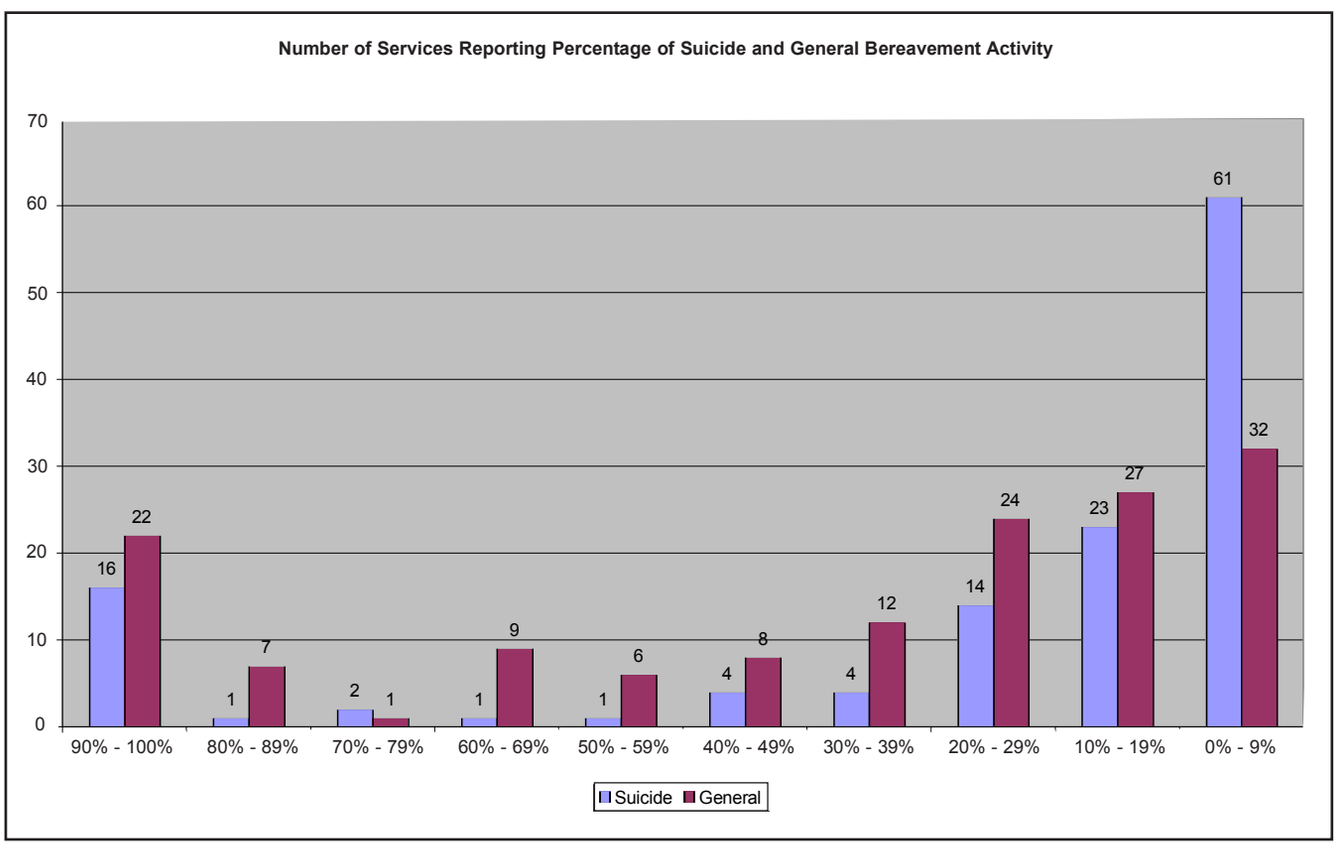
Some organisations provide a telephone helpline for a limited time each week whereas a small number provide a 7-day, 24-hour service. Overall there were 31 services providing a telephone helpline and the average number of calls dealt with by each organisation on a monthly basis was 1,008. These results are strongly influenced by two organisations, one of which deals with 32,000 calls each month and the other that deals with 1,200 calls each month. Excluding these organisations, the average number of calls handled drops to just over 90 calls per month or approximately three per day per organisation. In total, the number of calls handled on an annual basis is estimated to amount to over 431,000. Samaritans are estimated to handle 90% of these calls.

These numbers do not indicate the number of unique callers and do not allow for situations where callers may contact more than one service. However, it is clear that the volume of contacts is very high and that Samaritans are the primary organisation dealing with such calls. In 2006, Samaritans in the Republic of Ireland provided 149,856 hours of listening and, according to Samaritans, 12% of callers in the Republic of Ireland in 2006 were suicidal (Samaritans, Online).

7.15 Bereavement Support Activities

The picture that emerges from examining the activities of the organisations is one whereby there are a small number of organisations that are dedicated solely or predominantly to suicide bereavement support services. From the survey, we identified 16 bodies that are dedicated predominantly to suicide bereavement support.

Figure 13. Proportion of Activities Represented by Suicide and General Bereavement Support



Many organisations provide suicide bereavement support or general bereavement support, or both, but most commonly these organisations also provide a wider range of services. For the bodies involved in this area and who responded to the questionnaire, the typical profile is that 23% of their activities relate to suicide bereavement support, 35% of activities relate to general bereavement support and 42% of activities relate to other services.

7.16 Level of Activity

We asked respondents to provide their best estimates of the level of activity in a typical year. The results are shown illustrated as a table below for both general bereavement support services and suicide specific support services. Two tables are provided as a result of the significant effects of Console's figures. Table 10 includes data from Console, while Table 11 provides the corresponding information, but without the Console data.

Table 10. Activity Levels (With Console Data)

	Suicide Bereaved					Bereavement Counselling and Support				
	Male	Female	Child <18	Family Units	Total*	Male	Female	Child <18	Family Units	Total*
Number Assisted	1,547	2,661	319	520	5,219	5,380	8,588	1,046	3,335	19,095
Contact Hours	8,371	14,330	2,158	1,952	29,451	10,767	16,599	5,887	7,157	44.164
Average Contact Hours	5.41	5.38	6.76	3.75	5.64	2.00	1.93	5.62	2.14	2.31
Average No. Helped	18	33	11	15	55	60	92	26	76	161
Responses	84	81	29	35	94	90	93	39	44	118

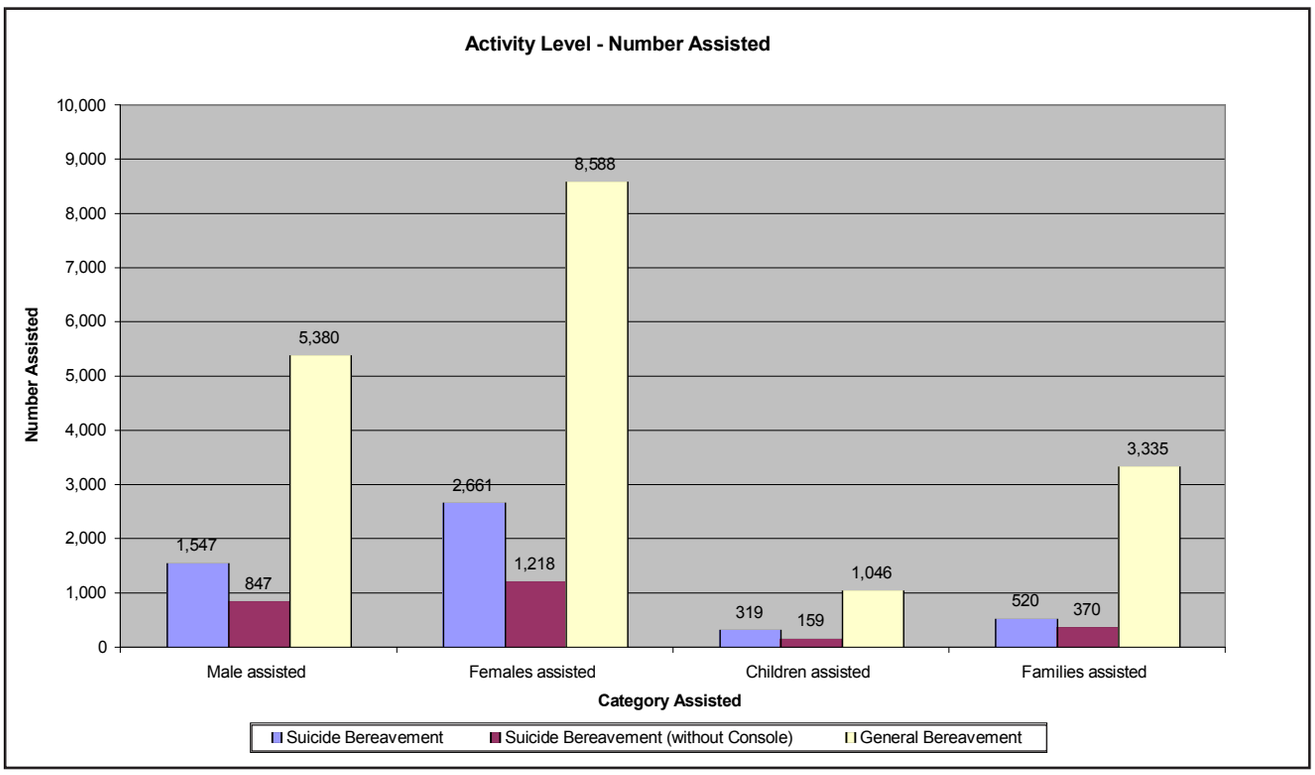
***Note the Total column in each case also includes those responses where a breakdown was not provided and for this reason does not represent the addition of the individual sub-categories.**

Table 11 Activity Levels (Without Console Data)

	Suicide Bereaved				
	Male	Female	Child <18	Family Units	Total*
Number Assisted	847	1,218	159	370	2,766
Contact Hours	4,171	5,672	1,198	1,052	14,733
Average Contact Hrs	4.92	4.65	7.53	2.84	5.32
Average No. Helped	10	15	6	10	30
Responses	83	80	28	34	93

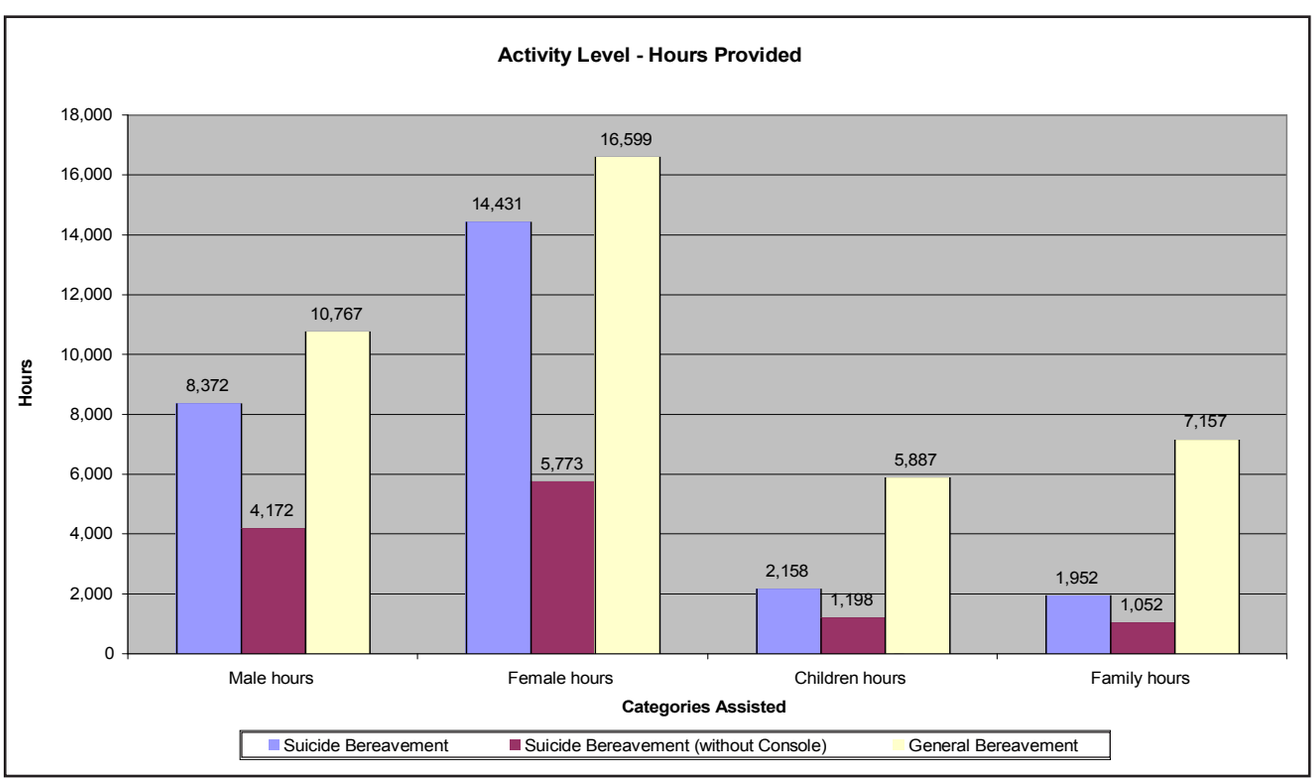
The organisations that responded reported that over 5,000 individuals and family groups were assisted by suicide-specific services, and 19,095 individuals and family groups were assisted by general bereavement support services.

Figure 14. Activity Level - Number Assisted



The number of contact hours amounted to 29,451 and 44,164 for suicide bereavement support and general bereavement support respectively.

Figure 15. Activity Level - Hours Provided



The average number of hours during which each individual engages with each type of service is less than six hours for suicide bereavement support and about two hours for general bereavement support. Since counselling sessions generally last one hour it can be seen that a service can be delivered in a small number of sessions although the information is not available to indicate the elapsed time over which such sessions generally take place. This reported level of involvement was supported by our discussions with key service providers. In some cases, individuals may only need one or two visits or sessions and to be made aware that there is a service there, should they subsequently need it.

The average number of contact hours is longer for suicide bereavement, at 5.64 hours on average, whereas general bereavement contact hours averaged 2.31 hours. This may be an indication that suicide survivors need a longer period of engagement compared to those generally bereaved.

For both suicide bereavement support services and general bereavement support services, the number of hours required to deal with children was longer. General bereavement support services for children take almost as long as suicide bereavement support services for children. This indicates that general bereavement support services for children should recognise the special needs of children and the possibly complicated nature of their grief.

The average number of individuals assisted by each body is relatively small. Most people find assistance for suicide bereavement from organisations that typically deal with about 30 individuals each year. The average number dealt with by general bereavement support services is larger, at approximately 161 each year.

Console is the major provider of suicide bereavement support services, and provides almost 14,000 contact hours of service per annum. The average length of engagement is six one-hour sessions. Services are provided to almost 2,500 individuals and family groups annually.

7.17 Referral Procedures

Many of the bodies have onward referral procedures. Out of the 277 responses, 166 bodies (60%) had referral procedures in place even if some of these referral procedures appeared to be relatively informal. More importantly, 110 bodies (40%) did not identify any form of referral procedure.

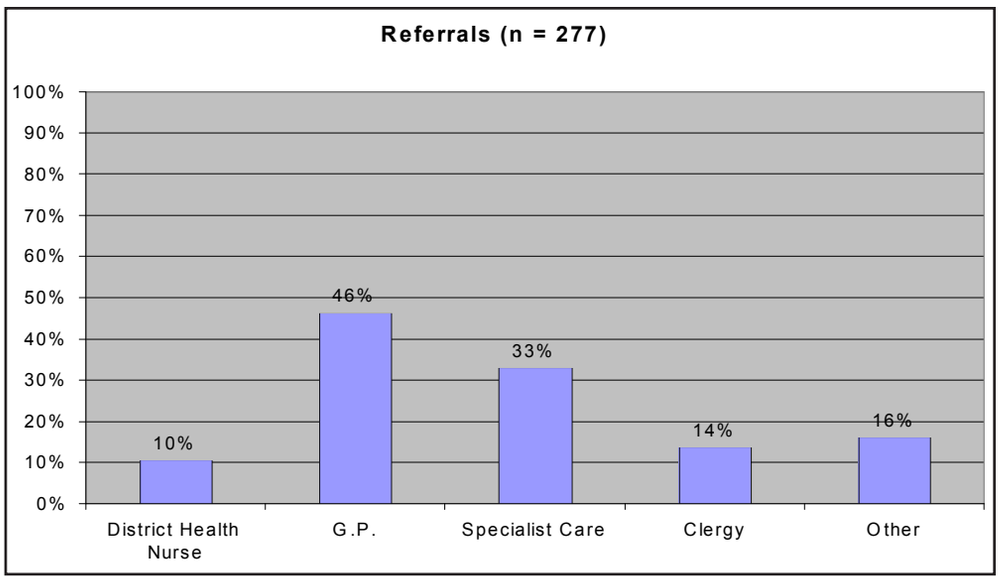
The bodies responding to the questionnaire that do have referral procedures tend to refer to GPs or to specialist care. They also reported the use of a wide range of other bodies, or people, including Family Life Centres, the Department of Social and Family Affairs, social workers, community supports and the HSE. Several of the larger organisations such as Console, Aware and Barnardos are also used by these bodies as referral points.

Table 12. Onward Points of Referral

Referral Points	Refer	Do Not Refer	Number Responding
District Health Nurse	29	11	40
GPs	128	6	134
Specialist Care	91	5	96
Clergy	38	8	46
Other*.	30	N/A	30

*Includes Aware, Console, Barnardos, HSE, counselling.

Figure 16. Onward Points of Referral



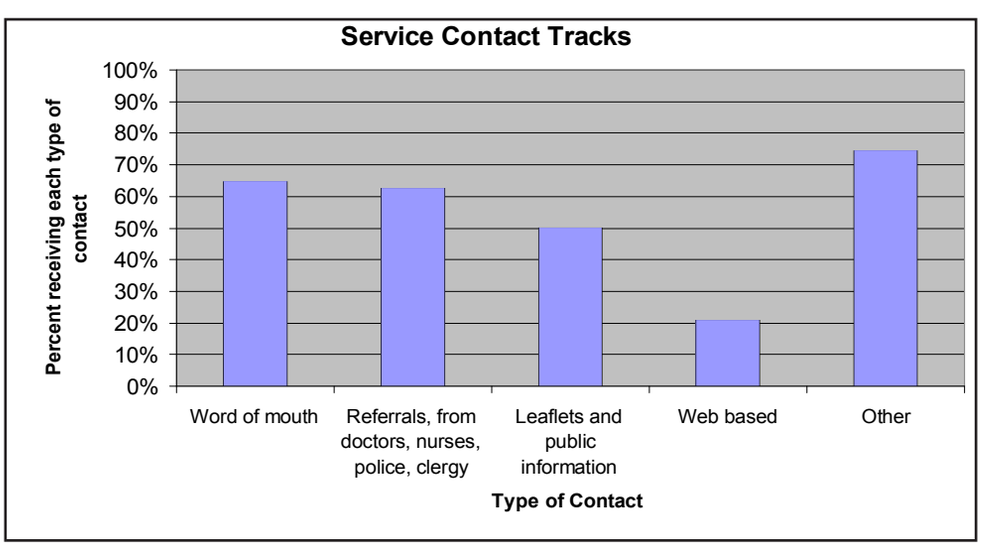
7.18 Identifying Those in Need

The table below sets out the ways in which service providers become involved with those in need. These range from passive methods such as word of mouth to more active methods including the development of literature and advertising. Most bodies use more than one approach. The table highlights the need for bodies to communicate their services in an effective manner.

Table 13. Sources for Inward Referrals

Initial Contact	Number of Bodies
Word of Mouth	180
Leaflets and Public Information	139
Referrals from Doctors, Nurses, Police, Clergy	174
Web-Based	58
Total Responses	210

Figure 17. Sources for Inward Referrals



Among the other approaches used were school presentations, social workers, probation service, FÁS and HSE Resource Officers for Suicide Prevention.

7.19 Research Conducted

We asked each body to provide us with a list of key research or relevant publications that they had prepared in the last five years. A sample of the topics covered is shown below, excluding items such as leaflets and internal policy or strategy documents.

- Review of bereavement care services in HSE South East region in 2005 (Carroll, 2005)
- Book Chapter-The Death Drive, ed R. Weatherhill: Encyclopedia of Psychoanalysis, Rebus Press
- Suicide research among the travelling community
- The mental health initiative: A resource manual for mental health promotion and suicide prevention in third level colleges
- Policy on responses to challenging behaviour in mental handicap
- Psychological distress and change among the college population
- Report on suicide in Ireland
- Thesis - How adults forget about the needs of children during bereavement
- Suicide in Ireland; Where we are now?
- Focus Group Study - Understanding how effective suicide bereavement support groups have been for participants
- Therapeutic communities and adolescents
- Bereavement risk assessment project
- Bereavement theory in context
- Evaluation of women awake groupwork progress
- World of widowhood
- Strategies for the prevention of suicide
- Older people working for older people
- Developing a dedicated service for children affected by domestic abuse
- Bullying in youth projects
- Working with clients in psychiatric care policy
- The Traveller experience of death.

7.20 Training Received in the Last Two Years

Many of the bodies did not identify any training that they had received in the last two years. In total, 137 bodies listed various training courses, conferences, seminars and networking events that they had attended in the previous two years while 140 bodies did not identify any training. Many of the events attended were also of very short duration with most lasting one or two days.

Training courses given multiple mentions were courses based on ASIST (Applied Suicide Intervention Training), the Irish Hospice Foundation courses and Bethany training courses. These accounted for almost 40% of all training courses mentioned. Conferences organised by the IAS (Irish Association of Suicidology) and by Console together accounted for 18% of courses mentioned.

From the responses provided, it appears that a large number of organisations have not undertaken any formal training in the past two years. In addition, many of the events that were attended, while being very beneficial as a networking and communications forum, are not structured as training events.

Table 14. Training Courses Attended

Course	Responses	Location
After Suicide	1	Church - D'Olier Street
ASIST	23	Various
Assessment of suicide risk in Adolescents and Adults	1	Tralee
Basic bereavement training courses ongoing	1	Clonliffe/Monkstown/Knocklyon
Bereavement and Intellectual Ability	1	Dublin
Bereavement Counselling	1	People's College, Dublin
Bereavement courses	17	Irish Hospice Foundation
Bereavement led by Brid Carroll	1	Waterford
Bethany Training	13	Dublin
Brief Group therapy	2	
Child art psychotherapy	1	Mater
Complicated Grief/Pastoral appraoch to suicide	1	Knock
Console conference	12	Dublin
Coping with Loss/Facing up to Suicide	1	Milltown/Rathmines
Counselling Skill	1	NUI, Dublin
Cruse Conference	1	England
Cruse Bereavement Training	1	Cavan
Cultural awareness in the context of the bereaved	1	Merlin Park Hospital
Diploma in counselling	1	Target
Diploma in Pastoral Counselling	1	Scotland
FSA	2	
Good Grief	1	Australia
Grief and loss	1	Dun Laoghaire
HSE Training	4	Clondalkin
IAS Conference	13	
Jean Casey Seminar/Facilitation Skills	1	Wexford/New Ross/ Waterford
Journey of Grief and Grief support		Kells
Living Links	5	Milford
Meath Suicide Awarness	1	Meath
MSc Grad Diploma in Bereavement Studies	1	IHF
Multicultural differences in bereavement	1	
Oncology and Palliative Care courses	1	
Rainbows	3	
School bereavement/Diploma in bereavement counselling	1	Galway
SE Suicide Forum	1	Dublin
Seasons for growth	2	Scotland
Seedlings	1	Cork
Shattered Dreams/Suicide Conference	1	Wexford
Storm	2	Dublin
Stress management	1	Cork
Suicide and Adult/Child Mental Health	1	
Suicide and Schizophrenia/Peer Support Group/RAMAS	1	Cork
Suicide Awareness	2	Crumlin
Suicide awareness training	1	Sligo
Suicide Bereavement	1	St Mary's, Rathmines
Suicide Bereavement Counselling	1	Tramore
Suicide Intervention Skills	1	Ardee Education Centre
Suicide Prevention	1	Bank of Ireland
Suicide Prevention Course	1	Waterford
Turning the tide of suicide	3	Dublin
Working with suicide bereaved	1	Limerick
Working with Teens	1	Trinity College
Workshop on bereavement issue/suicide prevention	1	Mayo

7.21 Future Training Requirements

The tables below list the training courses that those responding to the questionnaire identified as the specific training requirements for their body. The tables are based on 108 organisations. A total of 169 organisations did not specify a future training requirement. The number of staff expected to attend the training is also identified.

Table 15. Named Courses

Named Courses	Number To Attend
ASIST training	130
IAS conference	17
LivingLinks training	15
Irish Hospice Foundation	13
STORM	12
Bethany bereavement course	8
Console training	5
Seasons for growth	5
Emor conference	2
Samaritans initial training	1
Ongoing CPD day courses	1
Total	**209**

Table 16. Generic Courses

Generic Courses	Number To Attend
Bereavement counselling / support	422
Total	**422**

Table 17. Courses Relating to Children and Adolescents

Children and Adolescent Courses	Number To Attend
Certificate on children and loss	5
Children and trauma	2
Specific training for adolescents	2
Ongoing training and intervention re young people	1
Total	**10**

Table 18. Suicide Specific Courses

Suicide Specific Courses	Number To Attend
Suicide Bereavement	79
Suicide prevention and intervention	45
Helping suicidal people	37
Process of grieving for those who are bereaved by suicide	29
Working with young people bereaved by suicide	8
Dealing with suicide in those with an intellectual disability	3
Skills in working with suicide and trauma	2
Suicide risk assessment	1
	Total 204

Table 19. Miscellaneous Courses

Miscellaneous Courses	Number To Attend
Current research on suicide and general bereavement	33
Groupwork training	29
Critical incident defusing	24
Supervision training	7
Counselling for widows	6
Telephone training	6
Outreach training	5
Trauma and loss	5
Facilitation skills	3
Healing depression	2
How to get those in need of services in for help	2
Reference courses for those offering up to date research	1
Self-care	1
Seminars on various aspects of grief	1
Update on certificate course at hospice	1
	Total 126

Table 20. Summary: Training Requirement by Type of Course

Type of Courses	Number To Attend
Named Courses	209
Generic Courses	422
Children Specific Courses	10
Suicide Specific Courses	204
Miscellaneous Courses	126
Total	**971**

In total, the responses above identify 971 individuals that require training from the 109 bodies replying. Some of the courses requested are already available and would be relatively low cost and of short duration.

7.22 Future Requirements

The table below sets out the ranking of areas likely to improve the service provided as ranked by the respondents. The results are not weighted according to the size of body. Training, additional finance and connections to other services all scored highly and represent priority areas for the bodies responding. Publicity and literature/information leaflets also scored relatively highly. Areas that scored relatively low include language skills, access to medical and social workers, outreach facilities and services and supervision.

The results of this question support the responses to the earlier questions on training.

Table 21. Future Requirements Identified by Respondents*

Area	Average Score	Number Responding
Training	7.92	152
Additional finances	7.49	132
Connections to other services	7.13	142
Publicity	6.64	134
Literature, information leaflets	6.60	136
Access to research	6.36	122
Teen or children specific skills	6.30	114
Outreach Service	6.29	107
Networking capabilities	6.28	127
Supervision	6.12	132
Outreach facilities	5.93	103
Access to medical teams	5.86	103
Access to social workers	5.77	113
Language skills	3.76	94

*** Scored for level of importance on a scale of 1 to 10**

Table 21. Future Requirements Identified by Respondents

Area	No of Mentions
Volunteers/staff	17
Funding	16
Group work	10
Networking/communication	10
Training	10
Education/public awareness	9
Standards/coordination	7
Children and teens' needs	6
Facilities	5
Suicide intervention	5
Advertising	4
Outreach	4
Follow-up service	3
Literature	3
Directory of services	3
More clients	2
Liaison psychiatry	2
Suicide postvention	2
Supervision	2
Intellectual difficulties	1
Rural groups	1

8 Future Service Delivery

8.1 Comparing and Contrasting Suicide Bereavement and Other Types of Bereavement

It may seem like common sense to think of bereavement following the suicide of a loved one as more traumatic and complicated than bereavement following a natural death, for example, from an illness.

From our discussions and interviews with those who provide services to the suicide bereaved, there is a clear belief among all those interviewed that those bereaved by suicide believe themselves to be different and that there is a need for a specialised response. Anecdotally, they are not comfortable in groups that include others who are bereaved for reasons other than suicide and they consider that their grief requires a specialised response.

However, as we have seen earlier, the research literature on this topic is not conclusive. There has been support for both differences and similarities between suicide-related bereavement and grief following other types of losses.

Initially, the literature seems to indicate a notable difference between suicide bereavement and other types of bereavement (e.g. Knieper, 1999; Rando, 1993; Range, 1998; Sprang & McNeil, 1995). However, after reviewing the literature, it becomes clear that others dispute the difference. For example, Cleiren and Diekstra (1995) asserted that it is doubtful that the symptoms and problematic adaptation related to suicide bereavement are different from that of other types of bereavement. They also comment that the symptoms that arise following bereavement from suicide are similar to other sudden, traumatic deaths, such as those from fatal accidents and terrorist acts. This gives rise to the question of whether suicide should be grouped separately from normal bereavement and whether it should be included with traumatic death.

McIntosh (1993) carried out a review of studies involving suicide survivors, looking closely at some of the methodological problems outlined above and came to a similar conclusion to Cleiren and Diekstra (1995). However, he made some observations about the research and highlighted some differences: (a) there appear to be more similarities than differences between suicide and other types of survivors (particularly sudden death survivors), (b) there may be a small number of grief reactions that are different for survivors, but these are not yet clearly established, (c) the course of suicide bereavement may differ over time, but (d) after the second year, the reactions observed in suicide bereavement seem to show few differences from the mourning trajectory for other types of losses (McIntosh, 1993, as cited by Jordan, 2001).

Jordan (2001) also came to three main conclusions after his reassessment of the literature. He believes that suicide bereavement is distinct in three ways:

- the thematic content of the grief
- the social processes surrounding the survivor
- the impact that suicide has on family systems.

Jordan (2001) also asserts that the research that finds no distinction between the two types of bereavement is often quantitative. Furthermore, he suggests that the standardized tests and questionnaires used in these studies may fail to capture the true nature of the experience of any type of bereavement. In addition, Jordan feels that the qualitative research on this issue is more adept at providing us with a more practically useful idea of the differences in the experiences of the bereaved.

Hawton and Simkin (2003) observed that, while bereavement by suicide may not be necessarily more severe than bereavement by other cause, it often involves factors that make the death particularity particularly difficult to process and bear. The three factors they identify as most common are: experiences of stigmatisation, feelings of shame and guilt especially in cases of the loss of a son or daughter, and feelings of being rejected. Hardwood et al. (2002) found that half of his sample of the relatives of older people who had died by suicide had problems dealing with the coroner's office and were distressed by media reports.

The research summarised above illustrates the problems that arise when attempting to draw conclusions from the literature, partly because studies may be looking at a different aspect of bereavement, or because they are comparing results from studies that did not use an equivalent population. Some of the methodological issues that can adversely affect the accurate summarising of the literature on this subject include:

- the robustness of each individual piece of research (e.g. sample size, reliability and validity of standard tests/questionnaires)
- whether the research is qualitative or quantitative
- the duration of the research (short duration [i.e. cross-sectional versus long-term i.e. longitudinal])
- the exact nature of the bereavement (e.g. suicide, traumatic death, death following an illness)
- the relationship of the bereaved person to the person who has died and the age/stage of life of the bereaved person
- the cultural and contextual environment.

The research examined is inconclusive as to whether suicide bereavement is different in nature to other forms of bereavement.

No clear and compelling evidence-based justification has been identified that suggests that suicide bereavement is sufficiently different so as to require a standalone, dedicated response.

8.2 Is There a Need for a Separate National Organisation for Those Bereaved by Suicide?

Given that the research into the differences between suicide bereavement and other types of bereavement is inconclusive, the necessity for a separate national organization dedicated to suicide survivors remains unsubstantiated. On a practical level, Jordan (2001) believes that the conclusions from his literature review may suggest that there is a need for suicide-specific support groups, psycho-educational services and family and social network interventions. However, what is not clearly stated in the literature is whether such services would need to be carried out in a separate centre, dedicated specifically to suicide survivors, or as a sub-group within a larger bereavement service. Rolls and Payne (2004) carried out a research project on UK childhood bereavement support service provisions. They found that "all [bereavement] services… recognized the needs of those children who had been bereaved through murder or suicide, and, in some cases, special groups were organized for these families, or individual work was undertaken with them prior to their joining a group" (Rolls & Payne, 2004, p. 318). In addition, a literature review and recommendations for support services for families and significant others following suicide was carried out in New Zealand, which suggested that:

> From a practical point of view, individuals and families…who are bereaved by suicide require responses that attend directly to both the grief and the suicide. Positioning the loss, and bereavement experiences, in the context of common grief reactions is important to facilitate mourning and avoid escalating anxiety. At the same time, however, there is a critical need to attend directly to the fact that the death was by suicide and that there is a need to address issues of shame, guilt, stigma and isolation associated with suicide deaths.
>
> (Beautrais, 2004).

Both Rolls and Payne (2004) and Beautrais (2004) highlight the need for a suicide-specific subsection within normal bereavement support services. However, neither comments on theoretical reasons that would support this viewpoint.

Profile - Suicide Bereavement Support Service Integrated with General Bereavement Support Service - HSE/W Bereavement Therapy Service in County Donegal

Services Provided

- Information and consultation services in bereavement and the grief process to HSE staff, GPs, community groups, and the public.
- Training on bereavement issues and in bereavement support to staff and community groups.
- Counselling/psychotherapy to individuals and families in cases of difficult or traumatic grief, such as bereavement by suicide, bereavement of a child, and accidental or traumatic deaths.
- A counselling/psychotherapy input to palliative care and hospice services; that is to those who are terminally ill and/or their families.
- Individual counselling to HSE staff in Donegal who experience stress arising from bereavement issues. Referral Systems: Referrals can be made by GPs, HSE staff, etc; and by self-referral.
- The service requires that there are at least two months interlude between the death and provision of therapy services.
- The person being referred should want some therapy input.
- The therapy service is not intended in situations of "normal" grieving; but useful written information on bereavement is available by post in such cases.
- Referrers can discuss and consult on any case by phone with the service.
- A total of 121 referrals post-suicide were made to the HSEW Bereavement Counselling Service in Donegal over the seven-year period since this service was instigated.
- The length of time between the suicide and referral varies between several weeks to 18 years. In 2006, a higher proportion of referrals came in the earlier period post-suicide, which is a varying trend from previous years.
- The period of bereavement immediately following a suicide is not the time during which a therapeutic intervention of this nature (i.e. counselling/psychotherapy) is most needed/appropriate.

Bereavement Referral by Type, 2006

	CA	SU	DR	RTA	SD	CG	Sb/Mc	TI	AD	Misc	Total	Actual refs
TOTAL	25	15	2	13	11	66	6	10	3	21	129	102

CA	Cancer	**SU**	Suicide
CG	Complicated Grief	**DR**	Drowning
Sb/Mc	Still Birth/Miscarriage	**RTA**	Road Traffic Accident
AD	Accidental Death	**SD**	Sudden Death
TI	Terminal Illness	**Misc**	Miscellaneous

The HSE/W Bereavement Therapy Service is responding to demand from those affected by complicated grief and suicide in the Donegal Local Health Office catchment area, where there is an average of 1,300 deaths per annum, with an average of 14 deaths recorded as suicide. Arising from the complexity of clinical presentations, increasingly the service is working in the area of suicide prevention as well as post-suicide issues/postvention.

The service has a positive professional track record, evidenced by the ongoing robust demand, the strong referral rate by GPs, and increasing self-referral rates. It is a vital and significant part of the HSEW response to suicide prevention and bereavement in Donegal.

In addition, a study carried out by Papadatou (2001) suggested that high levels of stress and grief are associated with professional caregivers. This may be even more pertinent in caregivers dealing solely with suicide bereavement, rather than a mixture of those bereaved by natural deaths and suicide survivors.

Professional caregivers working solely in the area of suicide bereavement support may suffer from higher levels of stress and grief than those working with a mixture of those bereaved by natural deaths and suicide survivors.

"..it may be useful to conceptualize suicide as one example of the more general class of traumatic deaths that are likely to be associated with complicated mourning. Accordingly, our research efforts may need to be concentrated on the common characteristics of bereavement after all traumatic death, as well as the unique characteristics of suicide bereavement." (Jordan, 2001).

Furthermore "there was no evidence of suicide survivors having greater difficulties in adapting to the death compared with survivors of SIDS or accidents" (Dyregrov, Nordanger & Dyregrov, 2003; as cited in Kristjanson, Lobb, Aoun & Monterosso, 2006).

Lastly, there is also an argument for the unimportance of the type of death when it comes to providing bereavement support services. Rolls and Payne (2004) make a pertinent point regarding the development of children, in relation to bereavement. Developmental psychology often presumes a concrete, linear sequence of events for the development of a child. This is also often presumed with adults (for example in Kübler-Ross' 'stages of grief', 1969). However, this ignores the constructive nature of humans, who '[appropriate] information from [their] environment to use in organizing and constructing [their] own interpretations of the world" (Corsaro, 1997; as cited in Rolls & Payne, 2004). Rolls and Payne (2004) also argue that "the notion of 'childhood' obscures the plurality of the individual experiences of childhood". The same could be said for bereavement. The notion of specific reactions to suicide as different from reactions to natural death may also do a disservice to the individual experience of bereavement.

A bereavement support service should not necessarily put an emphasis on the type of death, but rather concentrate on the bereaved person and the consequences of their loss, and screen for complicated grief.

Further research into the efficacy of a standalone suicide bereavement support organisation in comparison to a suicide-specific service within a general bereavement support service will be required in the future. For now, however, the research is inconclusive, both in regards to the differences/similarities between suicide bereavement and normal bereavement and with respect to providing optimal bereavement support services to those bereaved by suicide.

8.3 Overall Approach

In the absence of evidence to support the need for, and efficacy of, a dedicated suicide-specific bereavement support service, we recommend that the appropriate development path is to enhance and strengthen existing general bereavement support structures. This means that a separate, standalone suicide-specific bereavement support service should not be established at this time. Existing suicide bereavement support services should continue to be supported for identified needs and in accordance with normal funding criteria.

The NOSP, in conjunction with the key service providers, should continue to monitor and review national and international research and service development in the area of suicide bereavement services.

Services for those bereaved by suicide should be integrated, from a structural perspective, with services for the bereaved generally. This will mean enhancing and developing general bereavement support services in those parts of the country that do not have a service or where the service is not fully or adequately resourced and ensuring that the needs of those bereaved by suicide are catered for within these structures while recognising their special requirements.

Suicide bereavement support should be dealt with as part of overall general bereavement support services while recognising the specific characteristics of suicide bereavement. In practical terms this means, for example, that those bereaved by suicide may prefer to participate in groups drawn from similar individuals rather than the general bereaved.

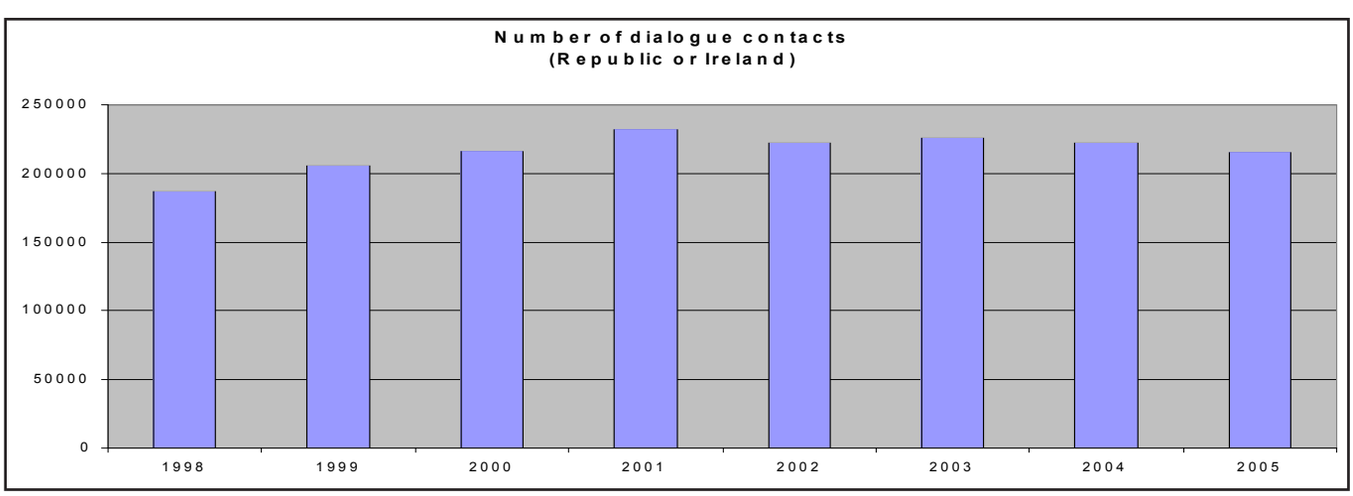
Suicide bereavement support and general bereavement support share many features in common from both an organisational and a service delivery perspective:

- The basic training that staff require is common to both with some additional training to deal with suicide bereavement support
- The infrastructure required for the provision of both services is similar
- Most organisations working in this area already provide both services
- The burn-out level for staff dealing solely with suicide bereavement support is believed to be higher than for staff dealing with a combination of requirements
- Console is the largest organisation in this area and was originally established as a dedicated suicide bereavement support service but its most recent expansion in Limerick will provide general bereavement support services alongside suicide bereavement support services. "Console Limerick has recently decided to expand the service to provide general bereavement counselling which complements the Seasons for Growth programme. Console also provides a Child Psychotherapy Service for children and young people bereaved as well as those bereaved through suicide. Console is developing a drop-in Library facility which is available to the public providing information and resources for people bereaved" (Console Press Release)
- There may be less of a stigma for those seeking assistance to approach a service that provides both services.

As can be seen from the profile described earlier the vast majority of community and self-help groups are very small and localised. They provide an essential service in their local community and have mainly developed in order to meet a specific need. They are primarily focused on direct service delivery. This strength is also a weakness in that they have low levels of funding, do not charge for their services and cannot afford to carry an administrative overhead. Training, supervision and referral procedures vary widely.

Within the existing range of services are organisations that play, and can continue to play, a key role in service delivery. Included here are organisations such as the Samaritans, The Irish Hospice Foundation, Console and Living Links. For example, the Samaritans have 13 branches in Republic of Ireland and dealt with over 200,000 contacts in 2005. Console dealt directly with almost 2,500 individuals and family units in 2006 and provided almost 14,000 hours of intervention. At the time of writing, Living Links is active in nine counties.

Figure 18. Number of Contacts with Samaritans in Ireland 1998 - 2005



Source: Samaritans (Online)

8.4 General Bereavement and Suicide Bereavement Care Development

In Table 23 we set out a summary of the generic progression pathway for the development of a service from a community level of capacity building to a sustainable integrated service. We have mapped the current provision of general bereavement support services in Ireland onto this framework (Table 24) and separately mapped the current provision of suicide bereavement support services (Table 25). It can be seen that many of the elements have been or are being addressed, albeit by many different organisations working on a localised basis and with different priorities. We comment later on those areas where further attention is required.

Table 23. Development of Bereavement Support Services

Capacity Building	Localised Provision	Sustainable Integrated Service
Sensitised personnel.	Critical mass of providers in one or more locations	Critical mass of activists countrywide.
Links established (international) with service providers.	Services established.	Regular campaigning- Broad awareness of service availability.
Conference participation.	Local awareness/support.	Clear referral and supervision arrangements in place.
Education and training available and undertaken.	Sources of funding established.	Mainstream integration of service provision.
Preparation of a strategy for service development.	Tiers of service provision available.	Established education centres.
Lobbying of policymakers/health ministries.	Risk assessment in place.	Policy feedback loop.
		Research activity.
		Academic links.
		Core curriculum for undergraduate and postgraduate health service training.
		National network.

Adapted from Hospice and Palliative Care in Africa: A Review of Developments and Challenges (Wright & Clark, 2006)

Table 24. What Should be Done: General Bereavement Support Services

Area	Status	Requirements and Recommendations
Links Established (international) with service providers.	Limited links currently established.	Support development of international links.
Conference Participation.	Poorly developed.	National Biannual General Bereavement Support Conference drawing on expertise in palliative services, Rainbows and HSE services.
Education and training available and undertaken.	Training at the entry and mid-levels is primarily non-standardised, brief workshops and in-house training.	Recognised certification is needed in line with HETAC levels, with particular focus on entry-level training.
Lobbying of policymakers/health ministries.	Bereavement is recognised in policy documents as an area of need.	Needs a national champion organisation.
Critical mass of providers countrywide.	Geographic distribution is mixed.	Encourage needs-based and policy-driven capacity-building. Encourage and support the development of a whole-island availability of and access to services.
Services established.	Services are available. E.g. Irish Hospice Foundation, Family Support Agency Directory.	Directory to aid identification and access.
Local awareness/support.	The National Bereavement Directory.	Circulate the directory widely, including an on-line version.
Sources of funding established.	Funding is available but not predictable.	Long term funding commitments required.
Tiers of service provision available.	Tiers of service are available but are inadequate, poorly developed and not linked.	Links should be agreed and developed (see section on referral procedures for recommendations about links between levels).

What should be Done: General Bereavement Support Services - continued

Area	Status	Requirements and Recommendations
Risk assessment in place.	Not in place.	Should be developed and researched.
Regular campaigning - Broad awareness of service availability.	Poor public awareness of general bereavement issues.	Increased visibility for service providers and national body.
Clear referral and supervision arrangements in place.	Varies by organisation.	Should be core part of training.
Mainstream integration of service provision.	Rarely integrated in mainstream health service provision.	Look to good practice models.
Established education centres.	Irish Hospice Foundation provides a range of training courses. Some organisations have well-developed in-house training.	Develop links with Irish Hospice Foundation and other training organisations. Develop outreach certification courses in local areas.
Academic links.	Limited academic links.	Promote academic linkages and support.
Policy feedback loop.	Limited service audit and annual reports.	Encourage monitoring and evaluation.
Research activity.	Research activity uncoordinated.	Review efficacy of service models nationally and compare with international models
Core module for undergraduate and postgraduate health service training.	In place in some training courses.	A core module on bereavement support should be included in courses for undergraduate and postgraduate health service training.

Table 25. What should be Done: Suicide Bereavement Support Services

Area	Status	Requirements and Recommendations
Links established (international) with service providers.	NOSP and e.g. NSBSN have well established links internationally.	Continue to support development of international links.
Conference participation.	The National Office for Suicide Prevention already supports and participates in several conferences, workshops and seminars both in Ireland and abroad. Console arranges an annual conference.	For many, training is sourced from attendance at conferences. Conferences should have a training focus and where feasible allow training credits for attendance The NOSP should co-host an annual conference with another national organisation to encourage national links and feedback mechanisms.
Education and training available and undertaken.	Training at the mid levels is not standardised or accredited. NOSP is developing a national training strategy to incorporate, inter alia, the recommendations of this review.	Recognised certification is needed in line with HETAC levels, with particular focus on the establishment of a basic skills based certificate in bereavement support and suicide bereavement support for volunteers and non professionals.
Critical mass of providers countrywide.	Geographic distribution is fragmented.	Encourage needs-based and policy-driven capacity-building. Encourage and support the development of a whole-island availability of and access to services.
Services established.	Services are available throughout the country but vary widely in terms of scope and resources.	Develop postvention support services nationally in association with general bereavement services.
Local awareness/support.	“You Are Not Alone” booklets produced and circulated.	Circulate the Directory widely, including an on-line version. Investigate the inclusion of a basic bereavement support information section in the resource officer's awareness pack.

What should be Done: Suicide Bereavement Support Services - continued

Area	Status	Requirements and Recommendations
Sources of funding established.	For the most part, funding appears to be established albeit through many different channels.	Consider longer term funding for key service providers subject to a service development plan and annual review.
Tiers of service provision available.	Tiers of service are available.	Links should be agreed and developed (see section on referral procedures for recommendations about links between levels).
Risk assessment in place.	Not in place.	Should be developed, including academic links to training institutions.
Regular campaigning. Broad awareness of service availability.	3Ts, NOSP and local organisations are all carrying this out.	Continue to maintain and improve.
Clear referral and supervision arrangements in place	Varies by organisation	Should be core part of training and service development. Mandatory supervision for all service providers.
Mainstream integration of service provision.	Rarely integrated in mainstream service provision.	When research identifies the preferred service model, provide core service as part of mainstream HSE bereavement support services that should be enhanced and developed.
Established education centres. Academic links	NOSP is developing a national training strategy but currently there are no links with academic institutions.	Develop links with Irish Hospice Foundation and academic institutions and training bodies.
Policy feedback loop.	NOSP commissions research.	Review efficacy of service models nationally and compare with international models.
Research activity.	Some limited research performed.	Develop/localise a toolkit/handbook for those dealing with people who are bereaved by suicide.
Core module for undergraduate and postgraduate service training.	Not currently in place.	Suicide bereavement support should form part of a core module on bereavement support studies for undergraduate and postgraduate health service training.

9 Costing of Service Delivery

9.1 Terms of Reference

To prepare a costing of a national suicide bereavement support care plan.

9.2 How Many People Need Assistance?

Various studies carried out in this area have reached widely different conclusions regarding the total number impacted and the number likely to have a complicated, severe, moderate or base level of impact.

Table 26 below quantifies the number of people in the population impacted by a suicide at various levels of impact and is based on several assumptions.

Table 26. Number Impacted by a Suicide.

Impact Level[6]	Number Impacted for Each Suicide	Total Number Arising Annually	Total Number In Population
4 Complicated	4	2,000	10,000
3 Severe	6	3,000	15,000
2 Moderate	10	5,000	25,000
1 Base Level	50	25,000	125,000

The table identifies that there may be up to 125,000 people in the population who have been exposed to a suicide in any five year period

The table is based on using an estimate of 500 deaths from suicide annually in Ireland. We have used an estimate of 50 individuals who are impacted to any extent by each such death in order to calculate the total number impacted in a year. This indicates that there would be 25,000 individuals impacted each year in the country. (The estimate of 50 is open to debate and will vary widely according to factors such as the age and occupation of the individual dying by suicide.)

We also assume that, within the total of 50 individuals, there will be 10 individuals who will require at least a level of support from community or self help voluntary groups. We assume that there will be 6 from this group of 10 who will require counselling. Finally, we assume that 4 out of this 6 will require professional counselling and assistance. Thus, the 10 individuals will require up to 20 interventions at the various levels.

In order to estimate the number in the population who may still require assistance and to reflect the potentially long time lag between the incidence of the suicide and the need for assistance we have assumed a period of 5 years during which the impacted individual may present for the first time as requiring assistance. Again, this is open to debate but we are aware of examples where individuals whose grief has been triggered by some recent event and who have sought assistance many years after the original suicide. Our assumption is that there are individuals affected by suicide bereavement in the population as a result of suicides in earlier years and that this backlog would be seen over a 5 year period. The effect of this assumption is to double the number that need support each year over a five year period.

[6] Mild impact refers to the widest range of individuals who are exposed to a suicide. Moderate impact refers to those individuals who are exposed to a suicide and who experience a moderate impact. Severe refers to those individuals from within the moderate category who require some form of assistance beyond the family network in order to deal with the bereavement. Complicated Bereavement refers to those who suffer the most traumatic bereavement and who may require professional assistance.

Our model estimates that there could be up to 125,000 individuals in the population who have been impacted by a suicide over the last 5 years. Our model further assumes that the majority (80%) of these individuals are able to deal with their bereavement within their own social network and support for such individuals means having information available in a readily accessible format and ensuring availability and access to services should they be required.

Within the overall population of 125,000 who are impacted, there are estimated to be 25,000 individuals who require at least a higher level of response. In such cases there may be a need for trained counsellors working in partnership with Primary Community and Continuing Care (PCCC) and the voluntary and community organisations along with clear risk assessment methodologies and referral procedures.

9.3 Estimated Resource Implications

The table below sets out the estimated resources required to deal with those impacted each year and to deal with the backlog for each of the first five years of the service.

Table 27. Resources Required.

Resources	Impact No. per Suicide	Number Annually	Required Support Hours	Total Support Hours	Resource Hours Available	Resource Number Required	Nature
Psychotherapy	4	4,000	7	28,000	16	38	Mental Health Professional
Counselling	6	6,000	5	30,000	8	82	Counsellor
Support	10	10,000	3	30,000	2	326	Volunteer/ Support
				88,000		446	

Assuming that there are 46 working weeks annually and on the basis that there are 4,000 individuals who will require the services of a mental health professional and that each such professional can handle 16 sessions each week, a team of 38 professionals would be sufficient to handle the total requirement. Similarly for those severely impacted, with counsellors providing 8 hours each week, there would be a need for approximately 82 counsellors. For those moderately impacted, with each volunteer providing 2 hours each week, there would be a need for 326 volunteers.

9.4 Capacity Available

From the responses to the questionnaire we identified approximately 3,600 individuals working in this and related areas. As referred to previously, most organisations do not specialise solely in general bereavement support or suicide bereavement support activities. Overall, we estimated that 23% or approximately a quarter of the activities of those responding related to suicide bereavement. Applying this proportion to the total staff involved from our responses suggests that over 800 individuals are involved in the area of suicide bereavement support to a greater or lesser extent. These individuals are mostly part time volunteers and few are full time employees.

9.5 Assumptions

The calculations above relating to demand and to capacity are based on several assumptions but appear to indicate that there is sufficient availability of individuals to deal with the estimated numbers arising.

- The response rate to the questionnaire was approximately 32% by number of organisations. The staff of those organisations that did not respond would increase the available pool of staff to provide services
- Some organisations did report difficulties engaging volunteers and staff but we found no evidence that there were large numbers of bereaved without access to services
- One large voluntary organisation has over 20 professionally trained staff
- We have assumed a weekly input of just 2 hours per week for volunteers from the voluntary and community sector
- The proportion of activities that relate to general bereavement support (35%) could be altered according to requirements and prioritisation. Combined with suicide bereavement support activities (23%) this would mean that almost 60% or over 2,000 individuals were available to provide services.
- In our model, the support hours we have assumed to be required are somewhat higher than the average support hours actually provided by volunteers and counsellors as identified in the responses to the questionnaire. The above analysis suggests that there is likely to be a sufficient number of professional staff and voluntary staff at a national level to deal with the suicide bereaved.

9.6 Cost of Training Requirements

We have assumed that those dealing with the suicide bereaved at Levels 4 and 3 are already well qualified to carry out their role and that their membership of professional organisations requires them to undertake ongoing professional development. Our recommendation that all staff working with the suicide bereaved attain at least 60 hours of training can be, or is already, met by these individuals as part of their professional training.

At Level 2 the training undertaken is not as uniform with some organisations ensuring that their volunteers undertake initial training, whereas others attend training or gain experience through less formal mechanisms. This is where we believe that training should be directed with a particular emphasis on risk assessment and referral pathways. At this level the emphasis should be on helping volunteers to recognise when problems are outside the scope of their expertise and to refer such individuals to the appropriate next level of intervention, working closely with the individual's GP's.

Initial training in Year 1 of 24 hours would be followed by further annual training of 12 hours in each of the following three years so that by the end of the fourth year all would have achieved the 60 hour recommended level.

The tables below shows the initial and ongoing training cost to provide training to the number of volunteers and supporters identified above. Using a group size of 15, there would be a need for 22 separate groups to be given 4 days training (not necessarily consecutively) at a total estimated cost of c€107,000. If the trainees paid €80 per person per day this would cover much of the training costs including such other costs as room hire and trainee packs.

Table 28. Initial Training Requirement

Training Hours Required	Cost per Day per person	Revenues (if charging)	Training Days	Group Size	Number of Courses	Trainer Cost € per day	Cost €
0	80	-	-	15	3.0	600	
0	80	-	-	15	5.0	600	
24	80	104,320	1,304	15	22.0	600	
Room Hire per day		500					44,000
Trainee Packs per trainee	30						9,780
		104,320	1,304				106,580

For ongoing training, a small number of training sessions should be provided to update those professionally qualified and counsellors. This could be done in a half day session. Voluntary and support staff should make up the balance of the 60 hour minimum and over a three year period this would mean an average of 12 hours per annum. The indicative costings, based on the assumptions set out, would be that this could be delivered at a cost of c€62,000 per annum to cover the direct training cost, room hire and trainee packs. Again, if participants paid €80 per training day this would cover the majority of the cost.

Table 29. Ongoing Training Requirement.

Training Hours Required	Cost per Day per person	Revenues (if charging)	Training Days	Group Size	Number of Courses	Trainer Cost € per day	Cost €
4	80	2,027	25	15	3.0	600	1,200
4	80	4,373	55	15	5.0	600	2,000
12	80	52,160	652	15	22.0	600	26,400
Room Hire per day	500						22,000
Trainee Packs per trainee	30						9,780
		58,560	732				61,380

9.7 Staffing Requirements Number and Cost

The number of professional and counselling staff required is also shown in the table above. This shows a need for 38 mental health professional staff and 82 counsellor staff. Using an estimated salary cost of €80,000 and €50,000 respectively, this indicates that the overall cost of staffing amounts to €7.1 million annually to meet suicide bereavement support needs.

One of the key assumptions underlying this calculation is the number of individuals in the population who may present in the future arising from a suicide bereavement in the past. We have assumed that such a backlog exists and that it would be dealt with over a five year period. Our assumption has the effect that dealing with this potential backlog doubles the number of staff required. For this reason, the number of staff should be considered as ranging from 60 to 120 at a salary cost range of €3.57m to €7.14m as shown below.

Table 30. Cost of Professional and Counsellor Support for Those Impacted by a Suicide

Category	Professional	Counsellor	Total
Annual Requirement - Number	19	41	60
Incl. Backlog Requirement - Number	38	82	120
Annual Requirement - Cost €Million	1.52	2.05	3.57
Incl Backlog Requirement - Cost €Million	3.04	4.1	7.14

The staff required are already working in the area as shown in the staffing profile analysis from the completed questionnaires. Some of these may be in private practice, health agencies and voluntary groups and are funded from a number of different sources. For this reason no additional or incremental cost is shown for these staff in the summary table of costs.

9.8 Develop and Train on Risk Assessment Guidelines

As part of the assessment of "What Should Be Done", (Table 25), set out earlier, we identified that risk assessment guidelines should be developed that can be used to identify where individuals should be referred to another level of service provision. Such a risk assessment methodology was identified in the survey as being of particular value, especially to those organisations that operate within the community and self-help group area of activity.

We have not carried out a detailed costing on the likely cost for the development of such guidelines and we are aware that work is already being carried out in the South East. We suggest that a budget of €70,000 be established to fund the development and testing of risk assessment guidelines. In addition, a budget of €25,000 should be provided for seminars and training events to familiarise and train non professional staff in applying the guidelines once developed.

9.9 Develop, Update and Distribute Directory of Bereavement Support Services, Make Available on Web.

As part of this review, a directory has been prepared and printed providing information for the bereaved. This directory should be be updated at regular intervals and also should be made available in a web accessible form. We recommend that a budget of €50,000 should be set aside in 2008 to provide for approximately 25,000 copies of the directory, to allow for updating and distribution of the directory and to make it available online. Assuming that the directory is updated every 2 years there should be an annual provision of €25,000 set aside.

9.10 Update and Distribute "You Are Not Alone" Booklet and Make Available on Web

Our work identified the ongoing need for a booklet providing practical and accessible information on bereavement and confirmed the suitability of the "You Are Not Alone" booklet. Arising from this and as part of this review the existing booklet, "You Are Not Alone", was updated and reprinted. We recommend that this booklet is distributed widely through the Resource Officers for Suicide Prevention to the Garda Síochána, community groups, undertakers etc.

On an annual basis there is likely to be a need for up to 50,000 copies of this booklet and we recommend an annual budget of €50,000 to cover printing, distribution and also to make it available online.

9.11 Web-based Access to Information

We have referred earlier to the need to make information available in an accessible manner both in hard copy format such as directories and booklets and also to the need to make the information available online through a suitable web presence. We recommend that the NOSP identifies a suitable website or websites that are used by young people and supports these websites to make suicide bereavement support and other related information available. An indicative budget for this would amount to €15,000 initially and €5,000 annually thereafter.

9.12 Develop and distribute guidelines for organisations dealing with suicide bereavement and bereavement generally

There is a clear need for practical guidelines to be followed by bodies and organisations providing assistance to those bereaved by suicide. Guidelines are also needed to assist the smaller organisations with issues such as establishment, operations and management.

Elsewhere we have recommended structured referral arrangements, the use of risk assessment guidelines and the provision of practical advice following a bereavement. Together with the directory of services and supplemented with additional information on administration, record keeping, training, management etc., such guidelines could form a resource manual for those smaller organisations already established or contemplating establishment.

We recommend that such a resource manual is prepared and that an initial budget of €190,000 be established to prepare the manual and carry out initial training and thereafter and annual budget of €50,000 for updating the manual and for further training.

9.13 Develop monitoring and evaluation capability

All service providers should be subject to monitoring and evaluation of the postvention services they provide. This work would be done by third parties on behalf of the NOSP and an annual budget of €50,000 should be provided.

Table 31. Summary of Additional Costs.

Summary	2008 Budget Provision €	Recurring Annual Budget Provision €
Training - Initial and Ongoing - Gross Cost	107,000	62,000
Risk Assessment Guidelines	70,000	25,000
Directory Update and Web Based Version	50,000	25,000
“You Are Not Alone” Reprint and Development	50,000	50,000
Website Support	15,000	5,000
Resource Manual and Training	190,000	50,000
Monitoring and Evaluation	50,000	50,000
Total Gross Cost	**532,000**	**267,000**
Assumed Training Cost Recovery	**104,000**	**58,000**
Total Net Cost	**428,000**	**209,000**

The initiatives and related costs shown above are dependent on the necessary funding and resources being made available to the NOSP and HSE for both existing projects and for new initiatives.

Appendix i References

Andriessen, K. [Online]. (2004). How to Increase Suicide Survivor Support? Experiences from the National Survivors Programme in Flanders, Belgium. Available: http://www.med.uio.no/isap/english/postvention [2006, November 11].

Arendt, M. & Elklit, A. (2001). Effectiveness of psychological debriefing. *Acta Psychiatrica Scandinavica, 104*, 423-437.

Baton Rouge Crisis Intervention Center1. [Online]. Homepage of Baton Rouge Crisis Intervention Centre. Available: http://www.brcic.org [2007, May 15].

Baton Rouge Crisis Intervention Centre2. [Online]. Programs: Local Outreach to Suicide Survivors. Available: http://www.brcic.org/pro_loss.html [2007, May 15].

Beautrais, A. L. (2006). Postvention: what we know and do not know. Presented at the 11th European Symposium on Suicidal Behaviour. Portoroz, Slovenia, September, 2006.

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.

Beautrais, A. L. & Gibbs, S. (2006). *Support Services For Those Bereaved by Suicide: What We Know and Do Not Know.* Christchurch: Canterbury Suicide Project.

Bonanno, G. A. & Kaltman, S. (2001). The varieties of grief experience. *Clinical Psychology Review, 21,* 705-734.

Carroll, B. (2005). *Investigation into Bereavement Care Services in the HSE/SE*. Unpublished.

Cain, A. (Ed.). (1972). *Survivors of Suicide*. Illinois: Charles C Thomas.

Cleiren, M. & Diekstra, R. (1995). After the loss: Bereavement after suicide and other types of death. In Mishara, B. L. (Ed.), *The Impact of Suicide* (pp. 7-39). New York: Springer.

Citizens Information Board. [Online]. Bereavement: Information for Those Affected by Bereavement. Available at: http://www.citizensinformationboard.ie/publica-tions/entitlements/downloads/Bereavment.pdf or http://www.citizensinfor-mationboard.ie/publications/entitlements/publications_entitlements_bereavement.html [2007, May 19]

Clinical Advisory Services Aotearoa. [Online]. Postvention Support Initiative. Available: http://www.casa.org.nz/news.php [2007, August 15].

Cvinar, J. G. (2005). Do suicide survivors suffer social stigma: A review of the literature. *Perspectives in Psychiatric Care, 41*(1), 14-21.

Davis, C. & Hinger, B. (2005). Assessing the Need of Suicide Survivors, [Online]. Available: http://www.calgaryhealthregion.ca/hecomm/mental/Suicide%20Postvention/AssessingNeedsofSurvivorsReport.pdf [2007, May 15].

de Groot, M., de Keijser, J., Neeleman, J., Kerkhof, A., Nolen, W. & Burger, H. (2007). Cognitive behaviour therapy to prevent complicated grief among relatives and spouses bereaved by suicide: cluster randomised controlled trial. *British Medical Journal, 334*, 1-6

Demi, A. S. (1978). *Adjustment of Widows After Sudden Death: Suicide and Non-Suicide Widows Compared*. San Francisco: San Francisco Medical Center.

Donnelly, P. (2001). *Someone to Talk to: A Handbook on Childhood Bereavement*. Dublin: National Children's Resource Centre, Barnardos.

Ehlers, A. & Clark, D. (2003). Early psychological interventions for adult survivors of trauma: A review. *Society of Biological Psychiatry, 53*, 817-826.

Farberow, N. L., Gallagher, D. E., Gilewski, M. J. & Thompson, L. W. (1987). An examination of the early impact of bereavement on psychological distress in survivors of suicide. *The Gerontologist*, 27, 592-598.

Grad, O., Clark, S., Dyregrov, K. & Andriessen, K. (2004). What helps and what hinders the process of surviving the suicide of somebody close? *Crisis, 25(3)*, 134-149.

Greenberg, N. (2001). A critical review of psychological debriefing: The management of psychological health after traumatic experiences. *Journal of the Royal Naval Medical Service, 87*, 158-161.

Harwood, D., Hawton, K., Hope, T. & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: a descriptive and case-control study. *Journal of Affect Disorders, 72*. 185-194.

Hawton, K. & Simkin, S. (2003). Helping people bereaved by suicide. *British Medical Journal, 327*, 177-178.

Health Service Executive. (2001). *You Are Not Alone: A Guide for Survivors in Managing the Aftermath of a Suicide*. Dublin, Ireland: HSE.

International Work Group on Death, Dying and Bereavement. (1991). A statement of assumptions and principles concerning education about death, dying, and bereavement. *Death Studies, 16*, 59-65.

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behaviour, 31(1)*, 91-103.

King, S., Khadjesari, Z., Golder, S., Eichler, K. & Snowden, A. (2004). *Interventions for Persons Bereaved by Suicide: a Scoping Review*. University of York: Centre for Reviews and Dissemination.

Knieper, A. (1999). The suicide survivor's grief and recovery. *Suicide and Life-Threatening Behavior, 29*, 353-364.

Kristjanson, L., Lobb, E., Aoun, S. & Monterosso, L. (2006). *A Systematic Review of the Literature on Complicated Grief*. Western Australia: Australian Government Department of Health and Aging.

Kübler-Ross, E. (1969). *On Death and Dying*. New York: Macmillan.

Lieberman, M. A. (2003). Bereavement self-help groups: A review of conceptual and methodological issues. In Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.), *Handbook of Bereavement: Theory, Research and Intervention* (pp. 411-426) (7th ed.). UK: Cambridge University Press.

Lieberman, M. A. (1983). Comparative analysis of change mechanisms in groups,. In Blumberg, H. H., Hare, A. P., Kent, V. & Davies, M. (Eds.), *Small Groups and Social Interaction* (pp. 239-252). London: Wiley.

Living Links1, [Online]. Homepage of Living Links. Available: http://www.living links.ie [2007, May 15].

Living Links2 [Online]. About Living Links. Available: http://www.livinglinks.ie [2007, January 20].

Machin, L. (2001). *Exploring a Framework for Understanding the Range of Response to Loss: A Study of Clients Receiving Bereavement Counselling*. Keele University, UK: Unpublished Ph.D. Thesis.

McIntosh, J. L. (1993). Control group studies of suicide survivors: A review and critique. *Suicide and Life-Threatening Behavior*, 23, 146-160.

Ministry of Youth Development. [Online]. Guidelines for Community Organisations Involved in Suicide Postvention. Wellington, NZ: Ministry of Youth Development. Available: http://www.moh.govt.nz/moh.nsf/0/B8454BE205475784CC25711A0080D41F/$File/guidance-for-community-organisations.pdf [2007, July 25]

National Alliance for the Mentally Ill - New Hampshire (NAMI-NH), [Online]. Frameworks: Youth Suicide Prevention Project. Available: http://naminh.org/documents/Frameworks2007Brochure.pdf [2006, October 25].

National Institute for Clinical Excellence. (2004). *Improving Supportive and Palliative Care for Adults with Cancer.* London: National Institute for Clinical Excellence.

National Office for Suicide Prevention. (2005). *Reach Out*. Ireland: Health Service Executive.

National Office for Suicide Prevention1. [Online]. Homepage. Available: http://www.nosp.ie [2007, July 29].

National Office for Suicide Prevention2. [Online]. You Are Not Alone - Help and Advice on Coping with the Death of Someone Close. Available: http://www.nosp.ie/ufiles/news0003/info-booklet-you-are-not-alone.pdf [2007, July 29].

National Office for Suicide Prevention3. [Online]. Directory of Bereavement Support Services. Available: http://www.nosp.ie/ufiles/news0003/directory-you-are-not-alone.pdf [2007, July 29].

Ness, D. E. & Pfeffer, C. R. (1990). Sequelae of bereavement resulting from suicide. A*merican Journal of Psychiatry, 147*, 279-285.

Papadatou, D. (2001). The grieving healthcare provider. *Bereavement Care, 20* (2), 26-29.

Pavee Point. [Online]. National Strategy for Action on Suicide: Submission by Pavee Point Travellers Centre. Available: http://www.paveepoint.ie/submissions/06-SuicideOffice.pdf [2007, September 18].

Pietilä, M. (2002). Support groups: A psychological or social device for suicide bereavement. *British Journal of Guidance and Counselling, 30* (4), 401-414.

Prigerson, H. G., Maciejewski, P. K., Reynolds, C. F., Bierhals, A. J., Newsom, J. T., Fasiczka, A., Frank, E., Doman, J. & Miller, M. (1995). Inventory of complicated grief: A scale to measure maladaptive symptoms of loss. *Psychiatry Research, 59*, 65-79.

Rando, T. A. (1993). *Treatment of Complicated Mourning*. Champaign, IL: Research Press.

Range, L. (1998). When a loss is due to suicide: Unique aspects of bereavement. In J. H. Harvey (Ed.). *Perspectives on Loss: A sourcebook*. Philadelphia, PA: Brunner/Mazel.

Renzenbrink, I. (2002). *Foundations in Bereavement Support in Hospice and Palliative Care*. Ireland: Irish Hospice Foundation Publication.

Rolls, L. & Payne, S. (2004). Childhood bereavement services: Issues in UK service provision. *Mortality, 9* (4), 300-328.

Samaritans. [Online]. Samaritans Information Resource Pack 2007.
Available: http:// www.samaritans.org/pdf/Samaritans-InfoResPack2007.pdf [2007, July 25].

Sprang, G. & McNeil, J. (1995). *The Many Faces of Bereavement: The Nature and Treatment of Natural, Traumatic, and Stigmatized Grief*. New York: Brunner/Mazel.

SpunOut. [Online]. Homepage. Available: http://www.spunout.ie [2007, February 15].

StandBy Response Service [Online]. Factsheet. Available: http://www.unitedsyner-gies.com.au /docs/StandBy.pdf [2007, May 15].

Stroebe, M. S., Hansson, R. O., Stroebe, W. & Schut, H. (Eds.) (2004). *Handbook of Bereavement Research: Consequences, Coping and Care* (4th ed.). Washington: American Psychological Association.

Stroebe, W. & Schut, H. (2004). Risk factors in bereavement outcome: a methodological and empirical review. In Stroebe, M. S., Hansson, R. O., Stroebe, W. & Schut, H. (Eds.). *Handbook of Bereavement Research: Consequences, Coping and Care* (4th ed.) (pp.349-371). Washington: American Psychological Association.

Stroebe, M. S., Stroebe, W. & Hansson, R. O. (Eds.) (2003). *Handbook of Bereavement: Theory, Research and Intervention.* (7th ed.). Cambridge: Cambridge University Press.

Victim Support. [Online]. About Us. Available: http://www.victimsupport.org.nz/ aboutus.htm [2006, November 20].

Warner, J., McKeown, E., Griffin, M., Johnson, K., Ramsey, A., Cort, C. & King, M. (2004). Rates and predictors of mental illness in gay men, lesbians and bisexual men and women: results from a survey based in England and Wales. *British Journal of Psychiatry*, 185, 479-485.

Worden, J. W. (2004). *Grief Counselling and Grief Therapy: A Handbook for the Mental Health Practitioner.* New York: Brunner-Routledge.

World Health Organisation. (2005). *Mental Health: Facing the Challenges, Building Solutions*. Helsinki, Finland: World Health Organisation.

Wright, M. & Clark, D.(2006). *Hospice and Palliative Care in Africa - a Review of Developments and Challenges. Oxford:* Oxford University Press.

Wrobleski, A. & McIntosh, J. L. (1987). Problems of suicide survivors: A survey report. *International Journal of Psychiatry and Related Sciences, 24*(1-2), 137-142.

Zinner, E. S. (1992). Setting standards: Certification efforts and considerations in the field of death and dying. *Death Studies, 16*(1), 67-77.

Zisook, S. & Shuchter, S. R. (1986). The first four years of widowhood. *Psychiatric Annals, 16*, 288-294.

Appendix ii Bibliography

American Association of Suicidology. (2003). *SOS: A handbook for survivors of suicide. After a Suicide: Recommendations for Religious Services and Other Public Memorials*. Newton, MA: Education Development Center Inc.

Andriessen, K. (2004). Suicide Survivor Activities: An International Perspective. *Suicidology,* 9(2), 26-31.

Australian Institute for Suicide Research and Prevention. (2003). *International Suicide Rates, Recent Trends and Implications for Australia*. Griffith University, Canberra: The Department of Health and Ageing.

Calgary Health Region. (2003). Hope and Healing: A practical guide for survivors of suicide. Available: http://www.calgaryhealth.ca/hecomm [2006, October 9].

Calgary Health Region. (2004). Suicide Response Initiative: Progress Report. Available: http://www.calgaryhealthregion.ca/hecomm/mental/Suicide%20-Postvention/Progress%20Report%202003-2004.pdf [2007, May 15].

Center for the Advancement of Health. (2003). *Report on Bereavement and Grief Research*. Washington D.C.: Center for the Advancement of Health.

Centre for Mental Health. (1999). *After Suicide: Information for Families and Friends*. New South Wales: Centre for Mental Health.

Centre for Suicide Prevention. [Online]. A Summary of National, State and Provincial Strategies for the Prevention of Suicide. Available: http://www.suicideinfo.ca/csp/assets/SummaryofNationalStateand ProvStrategies.pdf [2006, October 25].

Centre for Suicide Prevention. [Online]. National Suicide Prevention Strategies. Available: http://www.suicideinfo.ca/csp/assets/Alert55.pdf [2006, 20 November].

Children Bereaved by Suicide Project. (2002). *Supporting Children after Suicide*. New South Wales: Children Bereaved by Suicide Project.

Clark, S., Burgess, T. & Laven, G. (2004). Developing and evaluating the grieflink website: processes, protocols, dilemmas and lessons learned. *Death Studies, 28*, 955-970.

Clark, S. J. & Hillman, S. D. (2001). *Information and Support Pack for Those Bereaved by Suicide or Other Sudden Death*. Perth, Australia: Ministerial Council for Suicide Prevention.

Commonwealth of Australia. (2006). Reporting Suicide and Mental Illness: A Mindframe Resource for Media Professionals. Available: http://www.mind-frame-media.info (2006, September 15].

Cruse Bereavement Care. (2004). *After Someone Dies: A Leaflet about Death, Bereavement and Grief for Young People*. Surrey, UK: Cruse Bereavement Care.

Department of Health. (2006). *Help is at Hand: A Resource for People Bereaved by Suicide and other Sudden, Traumatic Deaths*. UK: Department of Health.

Dyregov, K. (2002). Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies, 26*, 647-668.

Edwards, L., Powney, J., & Dockrell, A. (2000). *Supporting Bereaved Young People*. UK: The Diana, Princess of Wales Memorial Fund.

European Commission. (2005). *Improving the Mental Health of the Population: Towards a Strategy on Mental Health for the European Unio*n. Brussels: Health and Consumer Protection Directorate-General.

Government of Canada. (2006). *The Human Face of Mental Health and Mental Illness in Canada*. Ottawa: Government of Canada.

Gjertsen, F. (2006). *Suicide Statistics in Norway, the Nordic and Baltic Countries*. Oslo: Norwegian Institute of Public Health.

Jane-Llopis, E. & Anderson, P. (2006). *Mental Health Promotion and Mental Disorder Prevention across European Member States: A Collection of Country Stories*. Luxembourg: European Communities.

Ministry of Youth Development. (2005). After a Suicide: Practical Information for People Bereaved by Suicide. Wellington: Ministry of Youth Development. Available: http://www.moh.govt.nz/moh.nsf/0/B8454BE205475784CC25711A0080D41F/$File/guidance-for-community-organisations.pdf [2006, Sep-tember 15].

Ministry of Youth Development. (2005). *Guidance for Community Organisations Involved in Suicide Postvention*. Wellington: Ministry of Youth Development. Available: http://www.moh.govt.nz/moh.nsf/0/B8454BE205475784CC25711A0080D41F/$File/guidance-for-community.organisations.pdf [2006, September 15].

Montgomery County Emergency Services. (2006). After a Suicide: A Postvention Primer for Providers. *Montgomery County Emergency Sercvices Inc. Quest, 5(2)*, 1-12. Available: http://lifeguard.tripod.com [2006, September 15].

Office for Youth: Department of Communities. (2005). Suicide and Self-Harm Prevention: Training and Professional Development Opportunities in Queensland. Available: http://www.communities.qld.gov.au/community/suicide_prevent-ion/resources/documents/suicide_manual.doc [2006, September 15].

Provini, C., Everett, J. R. & Pfeffer, C. (2000). Adults mourning suicide: self reported concerns about bereavement, needs for assistance and help-seeking behaviour. *Death Studies, 24*, 1-19.

Rose, S., Bisson, J. & Wessely, S. (2003). A systematic review of single-session psychological interventions ('debriefing') following trauma. *Psychotherapy & Psychosomatics, 72*, 176-184.

Rose, S., Bisson, J., Churchill, R. & Wessely, S. (2002). Psychological debriefing for preventing post traumatic stress disorder (PTSD). Online: The Cochrane Library.

Scottish Association for Mental Health. (2004). *After a Suicide*. Glasgow: SAMH.

Solace. (2006). The journey: A newsletter for survivors of suicide. *Solace, 8(1).*

The Nucleus Group. (2004). *Review of Specific Grief and Bereavement Services*. Victoria: Department of Human Services.

Wilson, A. & Clark, S. (2004). *South Australian Suicide Postvention Project*. University of Adelaide: Department of Health.

World Health Organisation. (2000). *Preventing Suicide: How to Start a Survivors Group*. Geneva: Department of Mental Health.

Appendix iii Terms of Reference

- To draft a report on the availability, accuracy and suitability of information about death, dying and bereavement, including practical and educational information and information specific to suicide
- To examine the suitability of such information for various populations across the lifespan, including children and older people
- To examine the role of mutual self-help bereavement support groups in providing bereavement support services, especially in the area of suicide bereavement
- To examine the potential for maintaining and developing the National Suicide Bereavement Support Network
- To examine outreach support for those bereaved by suicide in Ireland, especially in relation to the services offered by Living Links but also with a view to other models internationally, such as those offered by the Baton Rouge Crisis Intervention Service
- To review general bereavement counselling in Ireland, including counselling offered by statutory and non-statutory services
- To review suicide bereavement counselling services in Ireland, including those offered by the organisation Console
- To prepare a directory of bereavement support services available in Ireland, including basic information services through to counselling services
- To make recommendations for the future planning of the full range of bereavement support services in Ireland, including suicide bereavement support services
- To examine and make recommendations in relation to the training needs of service providers and the development of bereavement care protocols (covering, for example, risk assessment), identifying the relevant training programmes where possible
- To examine current standards and qualifications for people involved in bereavement support services, including debriefing and supervision arrangements, and if necessary establish a set of standards and qualification requirements
- To examine and make recommendations in relation to the appropriate standards and qualifications for people involved in bereavement counselling, including professional and clinical supervision arrangements and accreditation to the appropriate professional bodies
- To consider the organisational management structures at local, regional and national levels in relation to the full spectrum of bereavement support services
- To prepare a costing of a national suicide bereavement care plan.

Appendix iv Research Methodology

Questionnaire

A detailed questionnaire was developed to gather information on general bereavement support services and specific services available to support those bereaved following suicide. The questionnaire sought information on the range and availability of such services and future development requirements, along with basic information necessary in order to prepare a national directory of services.

The questionnaire sought information on a range of areas including

- The type of body e.g. voluntary, medical, state body
- Affiliations, networks and memberships
- Financing and funding
- Structure and staffing
- Experience and expertise
- Services offered
- Activity levels
- Referral pathways
- Research performed
- Training, qualifications and standards
- Future training requirements and development needs.

The population to be circulated to was identified from a wide ranging review of sources including the contact database from the NOSP and the database of organisations maintained by the Family Support Agency, which funds organisations providing bereavement support services and publicly available listings from a review of relevant websites.

This exercise identified almost 1,200 potential recipients for the questionnaire, which was subsequently reduced to 865 by eliminating duplicate individuals and by sending a single questionnaire to the head office of one organisation with multiple branches.

Completed questionnaires were returned by 277 bodies representing a response rate of 32%. The coverage level achieved is somewhat higher that the figure of 32% suggests for the following reasons:

- In some cases several individuals were circulated from the same or related organisations
- Some responses were received that covered several services in an area
- Some responses were received that amalgamated the responses of several individuals.

Literature Review - Inclusion criteria for source material used in this study

The aim of this report was to review general bereavement support services and services for the suicide bereaved in Ireland. All available evidence, published in peer-reviewed journals since the year 1996, on topics relevant to general bereavement and suicide bereavement support services, was considered. In addition, we referred to a wide variety of websites, and government and non-government documents.

Furthermore, evidence recommended by the members of our advisory group as significant or relevant to the research, that was published prior to the year 1995, was considered for inclusion in the report.

The following criteria were used to identify material that would be included for analysis in the current project:

- Evidence base
- Published in a peer-reviewed journal
- Published book chapters, government and non-government reports, standards of care, good practice, and other guidelines
- Published between 1995-2007
- Published in the English language
- Originating in a country with comparative health system to Ireland
- Originating in a country with social or cultural similarities to Ireland
- Articles or documents examining cultural aspects of complicated grief articles from the USA, Canada, New Zealand and Australia were included.

Also considered were the following:

- Year of study
- Country/countries involved
- Number of participants
- Average age of participants
- Longitudinal or cross-sectional study
- Bereavement or suicide bereavement
- Underlying theory
- Discipline approach of the article (e.g. psychiatry, counselling, psychotherapy etc.).

Databases and search terms used (1995 - 2007)

EBSCO (OLH database)

Bereavement + support	44
Bereavement + services	41
Audit + bereavement services	2
Review + bereavement services	5
Bereavement support + national	2
Bereavement + national	15
Complicated grief	21
Complicated grief + services	4
Complicated grief + support	9
Complicated grief + treatment	2
Pathological grief	4
Disabling grief	0
Traumatic grief	18
Chronic grief	2
Abnormal grief	2
Distorted grief	2
Maladapted grief	0
Truncated grief	0
Atypical grief	0
Intensified grief	0
Prolonged grief	7
Unresolved grief	2
Neurotic grief	0
Dysfunctional grief	0

Science Direct

Bereavement + services	377
Audit + bereavement services	3
Review + bereavement services	7
Bereavement support + national	5
Bereavement + national	70
Complicated grief	28
Complicated grief + services	1
Complicated grief + support	8
Complicated grief + treatment	8
Pathological grief	10
Disabling grief	0
Traumatic grief	28
Chronic grief	9
Abnormal grief	6
Distorted grief	0
Maladapted grief	0
Truncated grief	0
Atypical grief	1
Intensified grief	0
Prolonged grief	1
Unresolved grief	8
Neurotic grief	0
Dysfunctional grief	2

PsycInfo

Bereavement + services	1888
Bereavement + support	2790
Bereavement + support services	75
Suicide + bereavement + support	676
Suicide + bereavement + services	518
Suicide + bereavement + support services	18
Complicated grief	647
Complicated grief + services	206
Complicated grief + support	319
Complicated grief + treatment	252
Pathological grief	1257
Disabling grief	126
Traumatic grief	3376
Chronic grief	2359
Abnormal grief	1517
Distorted grief	177
Morbid grief	184
Maladapted grief	10
Truncated grief	25
Atypical grief	240
Intensified grief	123
Prolonged grief	580
Unresolved grief	1098
Neurotic grief	335
Dysfunctional grief	458

EBSCO (psychological and behavioural sciences collection)

Bereavement + services	73
Bereavement + support	127
Bereavement support	22
Suicide + bereavement + support	9
Suicide + bereavement + services	4
Complicated grief	53
Complicated grief + services	4
Complicated grief + support	8
Complicated grief + treatment	13
Pathological grief	6
Disabling grief	0
Traumatic grief	19
Chronic grief	6
Abnormal grief	4
Distorted grief	0
Morbid grief	1
Maladapted grief	0
Truncated grief	0
Atypical grief	0
Intensified grief	0
Prolonged grief	0
Unresolved grief	16
Neurotic grief	0
Dysfunctional grief	0

An extensive search of the Irish Hospice Foundation Library was also carried out.

Appendix v Definitions

Suicide is the act of deliberately causing one's own death.

Bereaved by suicide is the term used to refer to those who have had family or significant others die through suicide. Significant others is a wide ranging term that is intended to include, for example, partners, family, friends, colleagues, classmates and workmates.

Bereavement refers to the loss of a close relationship through death. Grief is an individual's emotional response to the death, and mourning is the social expression of that grief.

Postvention is the term given to activities and programmes that are intended to assist those who have been bereaved by suicide to cope with what has happened. Suicide prevention and postvention are closely related in that postvention might also prevent further deaths by suicide.

Self-Help Support Groups are groups made up of people who are directly and personally affected by a particular issue, condition or concern. Self-help groups are run by their members. While many self-help groups obtain resources and assistance from outside the group, e.g. from professionals or other groups, the members are the decision-makers.

Outreach consists primarily of face-to-face contact with survivors in their natural environments in order to provide counselling services or support. Outreach is the means by which counselling services or support are made available to people .

First Response Teams comprise trained volunteers from the community as well as medical and mental health professionals who respond to the practical and emotional needs of the suicide bereaved.

Appendix vi Principles for Community Suicide Postvention Initiatives

The following are principles from the Guidance for Community Organisations Involved in Suicide Postvention from the Ministry of Youth Development in New Zealand (Ministry of Youth Development, Online).

PRINCIPLE ONE: Establish appropriate values
Community postvention initiatives must develop appropriate shared values for the way that the organisation will work. The values will include respect for individuals and families who have been bereaved by suicide and the acceptance that people have the right to choose to engage or not engage with services. The values will also include the development of non-judgmental ways of working that support individuals and families without increasing the stigmatisation that they may feel.

PRINCIPLE TWO: Recognise culture
Community postvention service initiatives must have issues of culture woven through the way they operate. This means that the organisation honours cultural diversity; that different cultures are included in the group; and that cultural difference and cultural respect are reflected in the services that are available through the group. The weaving of culture through the organisation will also ensure that those who are being supported are able to choose the services that best meet their needs.

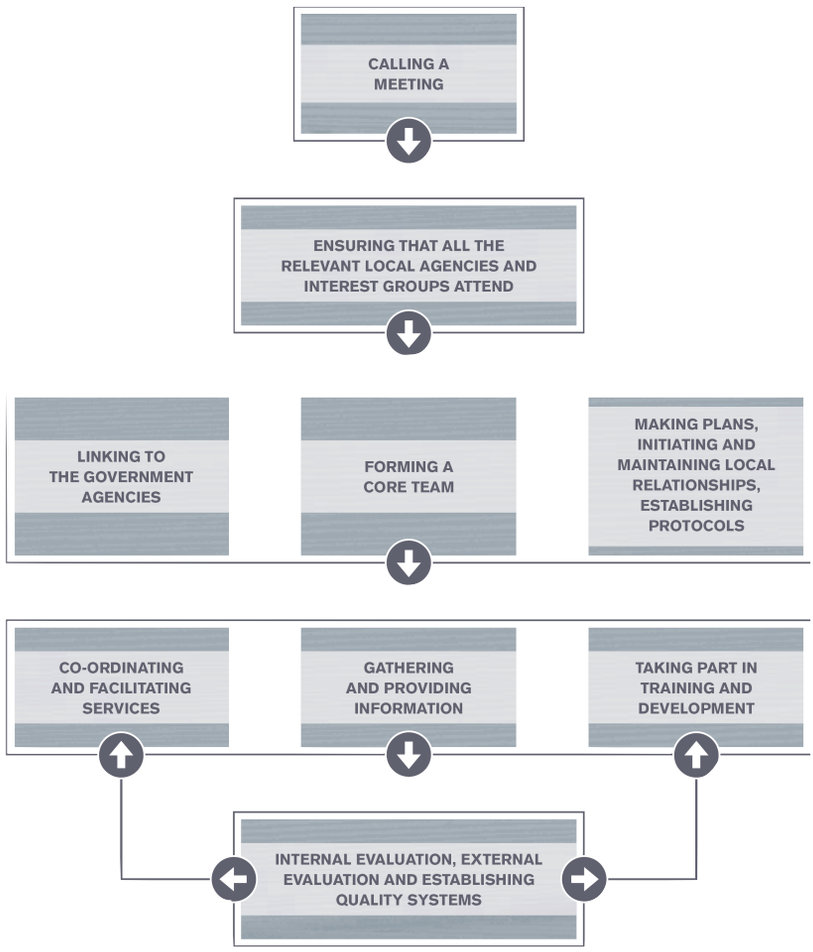
PRINCIPLE THREE: Link to services, information and support
Community postvention service initiatives must be linked to existing services and information sources. The existing services include both the locally-based government and non-government agencies that provide health, education, community development and social services. The information sources are available through websites. It is also important that the postvention service is linked, at a national level, to the government agencies responsible for the reduction of suicide deaths.

PRINCIPLE FOUR: Make use of the research
Community postvention service initiatives must base their work on mainstream research about suicide prevention, intervention and postvention. Although no one person has to be an expert, together the group must have a good practical knowledge of the research on suicide and they must know how to access this information.

PRINCIPLE FIVE: Become learning organisations
Community postvention groups must commit to being learning organisations. This means that the group (or members of the group) will regularly undertake training and development about suicide prevention, intervention and postvention. In addition the group will develop and implement internal and external evaluation strategies that will lead to quality improvements for the service that they offer.

PRINCIPLE SIX: Promote safe practice
This means that the group is confident that the services it encourages clients to use are provided in ways that are safe for the client and safe for the people who are providing the service. This includes knowing that the people who provide services are skilled at working with people bereaved by suicide. In addition safe practice requires a good understanding of role boundaries and role limitations. An illustration of role boundaries is that the provision of social support is different and distinct from the provision of counselling support. An example of role limitations is that individual people should not offer or provide services outside of those that they are qualified or accredited to provide.

Community Postvention



What can community postvention groups do?

- Make a list of agencies and interest groups that can provide safe services for those bereaved by suicide
- Facilitate protocols and agreements between services about referrals and service access
- Take part in training and development
- Facilitate training and development for others
- Find, collect and distribute information about suicide prevention, intervention and postvention
- Collate resource packs for the services that work with those bereaved by suicide
- Advocate for more services or resources for suicide prevention and postvention
- Evaluate the activities of the postvention group
- Share information and ensure that the initiative is maintained
- Take part in the New Zealand Suicide Prevention Strategy through participating in conferences and link with the appropriate government agencies
- Share the experience of establishing and operating a community-based postvention initiative with other communities who are starting out.

Agencies and interest groups that could be included in a community postvention initiative:

- Mental health services
- General practitioners
- Social and family affairs
- Local bereavement support groups
- Police
- Education
- Community-based social services
- Church-based social services
- Funeral directors.

Appendix vii Selected Training Courses

After Suicide, Amethyst Resource for Human Development. This group also run a three-year course in General Psychotherapy with an emphasis on pre and perinatal psychology. Prospective students should have completed a foundation course.

Applied Suicide Intervention Skills Training (ASIST), Canada. The two day ASIST workshop is designed for people already working as a care-giver and is largely an intervention, rather than postvention training course. It is used in many countries including in Canada, Australia, USA (by Baton Rouge), Norway and Ireland (by the HSE). ASIST is a unique program that teaches a concise, face-to-face suicide intervention model. Participants taking part in the training learn about their own attitudes concerning suicide, how to recognize and assess the risk of suicide, how to use an effective suicide intervention model and about available community resources. The major objective of ASIST is to offer a practical model of suicide intervention for all caregivers. The term "caregiver" is broad, thus the mission of ASIST is to provide a suicide intervention model that anyone can learn. Though this is not a postvention course it is highly regarded and widely cited in the responses to the questionnaire.

Diploma in Humanistic Counselling (IACP recognised), Base Resource Centre Fingal Counselling Services, The Base Resource Centre have run, and are running, a lot of training courses in suicide and suicide bereavement, because it is in demand in their area.

Bereavement Counselling, The Open University

Bethany Training Course

Console: Seasons for Growth (based on Australian Good Grief literature).

One Day Introductory Loss and Bereavement Workshop, Cruse, UK. This workshop is designed for individuals from all professions who would like to develop their knowledge and skills in the field of bereavement. This course is also available to be bought and is being used in Ireland.

Irish Hospice Foundation

The Irish Hospice Foundation provides a wide range of courses and workshops on loss and bereavement targeted at professionals and volunteers. Courses include:

- **Overview of Loss and Bereavement** - Explores the impact of a major loss through death, common reactions, and the factors that contribute to the uniqueness of each individual's response to loss
- **Finding Life after Suicide** - The impact on those closest to the suicide victim. The key steps to recovery, how to discuss it with children, suicide notes, depression, and the question 'Why?'.
- **Working with Bereaved Families** - As well as being an individual experience bereavement also affects families
- **Cultural Frameworks** - How to understand the impact of culture
- **Self-Care for the Person in a Caring Relationship** - The carer's own risk evaluation, self-care
- **Hidden Losses, Hidden Grief** - How to help those who feel there is a stigma, (adoption, abortion, suicide etc.)
- **An Introduction to Developing an Understanding of the Key Issues Arising from Exposure to Trauma** - This can arise in the face of a death that is violent, therefore understanding trauma is vital, as well as knowing when and how to intervene.

Living Links - Living Links run their own training programs. They train volunteers over three days. The first day is self-reflective and questions the helper's position in reaching out. The second day is about active listing and the third is practical upward referral paths, coroners, trauma and how to recognise it, etc. They also have a section on children, and every volunteer is vetted by a qualified psychotherapist.

Personal Counselling Institute, Clondalkin. Certificate in Suicide Support. Diploma/degree in Counselling Competence (IACP recognised), 30-hour module on loss and bereavement.

Samaritans - Samaritans run comprehensive training courses for their volunteers.

Appendix viii New Zealand - The Postvention Support Initiative

The postvention support initiative is a project funded by the Ministry of Health and jointly delivered by Victim Support and Clinical Advisory Services, Aotearoa. The aim of the initiative is to develop models of best practice for services for individuals, families, whanau (family groups of Maori society, including grandparents and great grandparents, and extended family through marriage) and communities who are affected by suicide or suicide attempts. A research and development model is being used to evaluate a set of services (see details below). The evaluation will be completed by mid year 2008, and this will contribute to the decision making around a national framework for service provision.

Suicide Bereavement Support Service

Victim Support will provide suicide bereavement postvention support to families, whanau and significant others bereaved by suicide. Trained Victim Support workers will provide a 24-hour, 7 day a week crisis response and ongoing service. This service will include practical and emotional support within forty-five minutes of notification to Victim Support. Ongoing support will be provided using a case management model, which addresses issues of immediate practical assistance, self-care advice, information about loss and grief, information about police and legal requirements, and when needed, referral and linkage with other specialist agencies.

Support workers will be directly managed and supervised by a Suicide Bereavement Specialist to ensure that best practice is followed, gaps are identified, and the well-being of support workers is in place. Peer support groups will be identified for those wanting to participate in a local peer support group.

Workers within the Victim Support suicide bereavement service will receive assistance with workforce development. This will involve support, training and ongoing supervision by advisors from Clinical Advisory Services, Aotearoa (CASA). National standards for service provision will be set and monitoring will occur to ensure that families and whanau receive high quality assistance; wherever they live within New Zealand. In the period up until June 2008, the Bereavement Support service will be established in the Auckland/Waitemata districts and Eastern and Canterbury districts. Victim support will continue to offer its standard services in other areas. The Bereavement Support Service will be evaluated throughout the development phase with the aim of ensuring a high quality service.

Postvention Planning for Communities

This service focuses on assisting community and government agencies to:

- Create or further develop their own individual co-ordinated plans for response to a completed suicide
- Formulate an overarching, community-wide interagency postvention response plan.

Plans would typically include information about how to respond to media; responsibilities for key tasks (e.g. identifying and screening for other people who may be a risk); identification of counselling and support services available in the region; outlines of the process for identifying cluster formation, and a plan for how key groups can stay informed.

An advisor from CASA will meet with community groups and government agencies to help facilitate the creation of the plans. The advisor will support the community in their planning through provision of relevant literature and advice on any key areas of concern. The emphasis is upon capacity building within a community and working alongside local leadership. A one day training seminar will be offered to key community gate keepers with the community being able to participate collaboratively on the content of the training. Services which have participated in the response planning will have access to a CASA advisor for a six month period subsequent to the service provision should they need further support with any aspect of their plan.

Assistance with postvention response planning will be offered to two or possibly three communities during the contract phase.

Flexible Response Team

CASA will provide a consultation and advice service in situations where there is a cluster of suicides occurring; or where there are strong indications that a cluster may form. Involvement will occur when approval is granted by the Ministry of Health, when the cluster, or components of the cluster, fall outside of the sphere of responsibility of other sectors (e.g., mental health services, education), and when there has been an invitation by the community and relevant agencies. CASA has a network of staff throughout the regions of New Zealand. The team co-ordinator will join with a regional staff member to form the response team. Funding is available for assistance with three clusters to end June 2008.

The level of need for this service is unknown and the service will be characterised by a high level of responsiveness to individual situations and community needs. The start date of this service will be mid to late 2007.

Research Project: Supporting Families and Whanau after a Suicide Attempt

There is a need to develop support services for families in which there has been a serious, non-fatal, suicide attempt. However, the needs in this area are largely unmapped and little is known about what service models are effective. A research and development approach is being taken to develop appropriate services. A pilot randomised controlled trial (RCT) of two family support programmes has been designed to explore options for services to family members after a suicide attempt.

Two types of support services will be compared:

- Acute Family Support - families will be offered an individual consultation with a mental health professional within 48 hours of the suicide attempt, with the option of one further consultation
- Group Family Support - families will be offered a six-session psycho-educational programme to be delivered in a group setting with other families with similar experiences.

All family members of patients admitted to Emergency Departments in two centres will be eligible for the RCT during the research period. In total, between 48 and 60 people will receive the programmes. At the conclusion of each programme, participants will be asked a series of questions evaluating their experiences of the programme. Responses will be subject to simple quantitative and qualitative analysis to provide a description of client satisfaction with the services. The study will also compare the acceptability of each programme with the client population and will ascertain demand for, and uptake of, support programmes by families.

Evaluation of the Postvention Support Initiative

Associate Professor Beautrais will evaluate the various services under the Postvention Support Initiative. The evaluation will include process evaluations, before and after comparisons, criterion evaluation and consumer satisfaction surveys. A full report will be submitted to the Ministry of Health by June 2008 and this will inform decision making around the future shape of the New Zealand wide service.
www.victimsupport.org.nz. www.casa.org.nz

Appendix ix Citing this Report and Contact Details

Citing this Report

Petrus Consulting, Bates, U., Jordan, N., Malone, K., Monahan, E., O'Connor, S., & Tiernan, E. (2008). *Review of General Bereavement Support and Specific Services Available Following Suicide Bereavement*. Dublin: National Office for Suicide Prevention.

The report is published by the Health Service Executive and is available from the National Office for Suicide Prevention (www.nosp.ie).

Research Team

Ursula Bates B.A., M.A. Ursula Bates is a Principal Clinical Psychologist and Director of Psychosocial Services in the Blackrock Hospice, Co. Dublin. She is an Associate Fellow of the Psychological Society of Ireland, a member of the Clinical Psychology Division of the Psychological Society of Ireland and a registered psychologist. ursula.bates@ucd.ie

Michael Griffin B.Comm., FCA, MBA. Michael Griffin is the founder of Petrus Consulting and has extensive experience examining and reviewing organisations and services. He is a Chartered Accountant and holds an MBA from University College Dublin and has over 20 years experience as a management consultant. michael@petrusconsult.com

Norah Jordan, B.A. Norah Jordan holds a first class honours degree in Applied Psychology from University College Cork and has been involved in research into referral pathways of neurosurgical patients to neuropsychological services, as well as into student attitudes towards seeking professional psychological help. jordanno@tcd.ie

Prof. Kevin M Malone, M.D., M.R.C.P.I., F.R.C. Psych. is Professor of Psychiatry in the Department of Psychiatry & Mental Health Research at St. Vincent's University and University College Dublin. He is also Clinical Investigator at the Conway Institute for Biomolecular and Biomedical Research and the Dublin Molecular Medicine Centre. k.malone@st-vincents.ie

Elizabeth Monahan, B.A., Dip. Psyc., M.Sc. Psychotherapy Elizabeth Monahan is a widely experienced management consultant with experience in several international industries, including health, food, and services to the I.T. sector. She also runs a private psychoanalytic clinic; and is APPI (Association for Psychoanalysis and Psychotherapy in Ireland) registered. liz@petrusconsult.com

Suzanne O'Connor B.A., M.A., Clinical Counselling in Psychology. Suzanne is an experienced researcher with direct experience of liaison with suicide support groups and families bereaved by suicide. suzanne.oconnor@st-vincents.ie

Dr. Eoin Tiernan, M.D., F.R.C.P.I., M.I.C.G.P., is a consultant in palliative medicine, St. Vincent's University Hospital, and Medical Director, Blackrock Hospice, Dublin, Ireland. He is a member of the Irish Association for Palliative Care, the Association of Palliative Medicine of UK and Ireland and the European Association for Palliative Care. e.tiernan@st-vincents.ie

Published by Accent Publications Limited