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Improving Services for Children Bereaved by Suicide

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Winston Churchill Travel Fellow 2015

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Examples of best practice and relationship between adult and children's services

Introduction and Background to Fellowship

In 2015 I was privileged to be given a Winston Churchill Travelling Fellowship to visit Australia, New Zealand and Ireland to meet with organizations and individuals who support families after they have been bereaved by suicide. As a child bereavement practitioner and until recently a manager of services for bereaved children, especially those bereaved by suicide, I have long been aware that children are often forgotten or not considered in the quest to provide better services for those bereaved by suicide.

Children ***are*** affected by the death of a family member, especially when the person has died by suicide, with all the extra complications that brings. Adults, both parents and professionals, often feel at a loss as to how to talk to children about suicide. It is important that children can be involved in the processing of what has happened in order to develop into resilient adults. Children bereaved by suicide are more vulnerable as they grow up. The largest study to date on the effects of sudden parental death on childhood development, led by Johns Hopkins Children's Centre, looked at the entire Swedish population over 30 years. It found that losing a parent to suicide makes children more likely to die by suicide themselves and increases their risk of developing a range of major psychiatric disorders[1]. (Wilcox *et al* 2010) But importantly the researchers said there may be a critical window for intervention following a parent's suicide and that a loving, supportive environment and careful attention to any emerging psychiatric symptoms can offset even such a major stressor as a parent's suicide. So it makes sense to put in place services for children following a suicide that may prevent mental health issues in adulthood.

There are many developments in relation to support after suicide in the countries I visited that are cited as good practice. For my Fellowship I wanted to consider how children are supported in these models of services, and how specialist child bereavement services relate to these, in order to offer an understanding of what will most benefit suicide bereaved children to the growing partnership of organizations that are seeking to develop a national response for support after suicide in the UK.

Aims and Objectives

Referrals to child bereavement organizations following a suicide of both adults and children are increasing. I am a member of a partnership of organizations, the Support after Suicide Partnership (SASP), that provide services to those bereaved by suicide. This partnership is working together to try and create a national response and common access for support after a suicide and we need to understand what will benefit children in the development of such a service and advocate for this on their behalf.

We need to ensure that the development of services for bereaved children is based on best practice and research. Services related to suicide in Australia and New Zealand are regularly cited as best practice, alongside those in the USA, and organizations involved in adult bereavement in the UK look towards these models. My Fellowship aimed to understand how these models work, to what extent children are considered and supported, and what needs to be held in mind while developing services in the UK for all the family.

Several factors make the grief process after suicide unique and children bereaved in this way experience more debilitating and long term responses than others. (Wilcox *et al* 2010). A review of support after a suicide in Ireland[2] (Petrus Consulting and St Vincent's University Hospital 2007) cited specialist suicide postvention services in Australia and New Zealand, together with examples in the USA, as best practice. It then recommend that rather than setting up a separate suicide specific bereavement support service, it may be more useful to concentrate on factors common after all traumatic death, and that specialist services should be integrated with general bereavement services, while recognizing the specific characteristics of suicide.

The second aim of the Fellowship is to further thinking around whether children bereaved by suicide should be offered a separate service or be integrated in general bereavement services.

Children Bereaved by Suicide

Very few services have the expertise or experience to offer direct support to children who have been bereaved by suicide. More than 6,000 adults die by suicide in the UK every year, (2014: 6,122. 2015: 6,188.*ONS*) probably more given that coroners often give verdicts other than suicide for a death. No data is collected on the number of children bereaved of a parent by suicide in the UK, but The Childhood Bereavement Network 'cautiously estimates that it could be as many as 3,000 children each year'.[3] Many more children are likely to be influenced by a death by suicide of someone other than a parent.

It is important for services involved at the time of, and after a suicide, to work together for the maximum benefit of families. Both families and professionals are often unaware of those services that are available and it is often only by chance that families come across a service, sometimes many years later. Children are often the 'forgotten mourners' after a suicide, with adults who already feel overwhelmed by the situation taking the stance that children are either too young to understand or need protecting from the reality of suicide. Both parents and professionals feel they don't have the resources or knowledge to have conversations with children in such a tricky area.

The professional experience of those who work in the field of child bereavement is that:

- Children do want and need to know how someone has died.
- Families that can talk in an open and honest way without secrets grow together in trust and understanding.
- As a result of this children grow in maturity and personal understanding and are more able to successfully navigate difficult things that happen in the future. In other words they grow into resilient adults, which may protect them from some of the research

findings that show the detrimental effect a bereavement by suicide can have on the wellbeing and mental health of a young person.

- Children who find out about a suicide later in childhood often struggle with issues of trust, anger and identity, as they try and process their childhood years in the light of the new information.

Summary of Main Findings

As a result of visiting many organizations which provide support after a suicide it became clear that the UK can learn from models of best practice in Australia, New Zealand and Ireland, and that consistent funding was important for the development of good practice.

Services that worked best had a strong connection between research and practice, and developed through collaboration and partnership working. This points to the need for research to be funded to provide evidence for the need and efficacy of services, and for ways to be found for services to work together at all levels. A system whereby coroners can report deaths to service providers is a crucial starting point for a service.

Large scale, more generalist services, were better funded than specialist suicide bereavement or children's organizations, and despite good models of practice children and their particular needs were still largely forgotten in the drive to improve services for adults. Only the few specialist children's services, or those who worked out of Family Centres in partnership with children's practitioners, were able to provide a regular, in depth service for children bereaved by suicide. In order for more children to benefit from this expertise there needs to be more connection between large scale national organizations and specialist children's organizations.

The Community Postvention Response Model, with good examples in all three countries, appears to offer the best model for a coordinated and consistent response to support families and communities following a suicide, but needs to develop clear pathways of working with organizations who can provide direct support to children.

Statistics

Australia:

The overall suicide rate in 2015 was 12.6 per 100,000 in Australia. This is the highest rate in over 10 years. The most recent Australian data (*ABS, Causes of Death, 2015*) reports deaths due to suicide in 2015 at 3,027. This equates to more than 8 deaths by suicide in Australia each day. The suicide rate among Aboriginal and Torres Strait Islander peoples is more than double the national rate. For every death by suicide it is estimated that as many as 30 people attempt to end their lives. That is approximately 65,000 suicide attempts each year. (Source*: Lifeline.'Statistics on Suicide in Australia'*).

New Zealand:

The overall suicide rate in 2015 was 12.27 per 100,000 in New Zealand. There were 564 suicides, which is the highest figure since records began 8 years ago. This is twice the annual road death toll.(Source: *Coronial Services of New Zealand*)

Republic of Ireland:

The overall suicide rate in 2015 was 9.2 per 100,000 in the Republic of Ireland. There were 425 suicides. (Source: *Central Statistics Office*)

United Kingdom:

The overall suicide rate in 2015 was 10.9 deaths per 100,000 in the UK. There were 6,188 suicides registered in the UK in 2015 (ONS. 2016). This is a slight increase from 2014 when the rate was 10.8 deaths per 100,000 and there were 6,122 suicides registered.
(Source: *Office for National Statistics 2016*)

Learning Points

Funding

Funding is obviously vital to the development of every service and across the range of my visits I saw how proper funding can enable services to become well grounded and grow. In Australia there is substantial government funding for services related to suicide prevention and bereavement, and I wanted to know why. Jaelea Skehan, Director of the Hunter Institute of Mental Health in Newcastle, Australia, doesn't think funding is necessarily obtained through the logical way of running a pilot, evaluating it, showing its worth and applying for funding. It's as much to do with developing relationships with the right people in government or other positions of influence and convincing them of the need for services, so they can apply pressure or influence where policies are made and funding decided. To this extent the recent Parliamentary Health Select Committee Inquiry into Suicide Prevention and the submission of papers from a wide variety of individuals and organizations was a good development in this country.

Those who have been most influential in driving the agenda forward in the countries I visited have had a personal interest in, or experience of, suicide. In recent Australian elections the Prime Minister Malcolm Turnbull said that 'addressing suicide and mental illness would be a "vital national priority" for a re-elected coalition government.' This statement was in response to a challenge by an alliance of leading mental health advocates to all political parties to announce what they would do to address the rising toll of suicide and self harm.

Most of all funding makes sense. Research undertaken by Health Economists in Australia in 2013 on the costs of prevention and the costs of doing nothing showed that suicide 'postvention services are a cost effective strategy and may even be cost saving if all costs to society from suicide are taken into account'. (Comans,T. et al 2013). The British Government itself has estimated that "each suicide costs the economy in England around £1.6 million, although the full costs may be difficult to quantify. It is striking that 60% of the cost of each suicide is attributed to the impact on the lives of those bereaved by suicide. We know that those bereaved by suicide are more likely to experience mental health problems such as depression and anxiety and we also know that people bereaved by suicide are at a higher risk of suicide themselves. Therefore we have a moral and economic imperative to improve the consistency and quality of suicide bereavement services across the country”.[4]

In New Zealand the schools’ Travellers programme for the prevention of suicide was funded by the New Zealand government and the Mental Health Foundation. At the time the minister was Jim Anderton, whose daughter had died by suicide, making him sympathetic to funding.

Headspace is a youth mental health initiative which was established by the Australian government in 2006 and is fully funded by the Federal Government. It emphasised evidence based intervention and was founded by Patrick McGorry, who as ‘Australian of the Year[5] gave a big push to youth mental health.

Raising Awareness of Death by Suicide in Comparison to Road Traffic Deaths

Australia, New Zealand and Ireland have all run successful campaigns to highlight that deaths by suicide are often greater than road deaths. The national road safety campaign in New Zealand is based on a high level of research and road deaths have been greatly reduced by a big campaign of posters along roads, proving that funding can be effective. Organizations related to suicide prevention are now using this as an argument for funding. Estimates of the total cost of road deaths to New Zealand society were calculated at around $3.6 billion each year. In Ireland the charity Turn the Tide of Suicide (3Ts) lobbies governments, raises awareness of suicide and provides grants and funding for research and support, highlighting that 3 times more people die by suicide in Ireland than die in road traffic accidents. Recognizing the need for research into suicide to help inform national suicide prevention strategies it funded the ‘Suicide in Ireland Survey’. It states that ‘If adequate state funding for suicide prevention is unavailable, then we need a Suicide Prevention Authority similar to the Road Safety Authority, an independent authority to oversee a dedicated National Suicide Prevention Programme.’

In Australia an audit of 28 electorates between 2009 and 2012 found suicide rates exceeded the road toll in every seat. Between 2004 and 2014 suicide rates rose almost 20%.

Table 1: Comparison of Road Deaths and Deaths by Suicide 2009 -2012

Electorate	Suicides 2009-2012	Road toll 2009 - 2012
Canning WA	90	54
Longman, Qld	162	68
Cunningham, NSW	91	37
Boothby, SA	64	13
Corangamite, Vic	111	65

The above examples demonstrate how funding to address road deaths can save a lot of money. It is self evident therefore that similar effort and funding in suicide prevention will not only save more lives, but also a great deal of money.

In July 2010 the Prime Minister Julia Gillard said a labour government would spend $277 million to help Australians at risk of suicide, with a priority on providing services for men. These would include:

- The Lifeline counselling hotline to be expanded.
- The Beyond Blue organization to be given funds to target men with depression.
- Programmes to be made available to students through schools.

Money was given for research and a proposed service model was drawn up and launched in 2012, initially as a recovery programme, which then led on to a recognition for the need for preparedness. There is now a coordinator in every state and territory.

In December 2014 Julia Gillard joined the board of Beyond Blue. She said “as the daughter of a psychiatric nurse, I have always understood the need to talk openly about mental health and respond to those in need”. In 2015 The Australian Shadow Minister for Mental Health, Katy Gallagher, stated labour’s commitment to a 50% suicide reduction target over the next 10 years and the establishment of 12 suicide prevention pilot projects.

The above examples show how, with commitment from those in government, a real difference can be made to the support available after suicide. Working in partnership in the UK is therefore vital in order to bring maximum pressure to bear on those in government who can influence financial decisions.

Funding and Services

It is not surprising that large well organized agencies attract more funding. Australia has well developed mental health services and a lot of government funding has gone into organizations like Headspace, Beyond Blue and MindMatters, all of which seek to address the mental wellbeing and resilience of young people, either as a preventative to suicide or as a support after suicide. Headspace in particular has grown rapidly with its full government funding, with 100 Headspace centres nationally, 200+ staff in the head office and 2000 schools it has worked with. But these large services are often about facilitation and information and there is a lack of services to refer on to for direct support. A professional working in postvention in New Zealand commented that there are ‘leaflets, leaflets, loads of glossy leaflets, but no one actually works with families’. Large national organizations are better funded and procedures are often highly manualized. They have less understanding of direct work and less ability to connect with the local community, although they attempt to overcome these by referring on and by embedding the service in local organizations.

Those organizations that do work directly with children and families, such as the Jesuit Social Services Support after Suicide, and the Centre for Childhood Grief in Australia, Barnardos in Ireland and The Grief Centre and Skylight in New Zealand, have a wealth of knowledge and experience in supporting children, but are small and find it difficult to attract funding.

It was striking that where Government funding has continued, albeit on a year to year basis, in Australia and Ireland, suicide support services have thrived, whereas in New Zealand promising initiatives and projects have floundered through lack of funding, and experienced staff have become demoralized or lost their jobs. The Ministry of Health is presently discussing the next 10 years for the Suicide Prevention Strategy in New Zealand and many professionals are waiting for the outcome of this. It is problematic that in New Zealand there is a political argument between government departments as to whether suicide is social or a mental health issue. Several professionals stated that no government department wants to be responsible for suicide prevention. They have undertaken the research, written a document and an action strategy, but leave District Health Boards to put this into practice, which has led to a fragmentation of suicide support services in New Zealand.

What I have learnt from this is that in the UK we need to try and get a balance between large scale facilitation, which can co ordinate services at the national level but will be less responsive to local needs, less personal and more bureaucratic; and small scale direct work, which can provide very good practice, expert knowledge and a high level of satisfaction for both those who receive and deliver services, but which finds it hard to attract funding or offer services over a wide geographical area.

Several organizations commented that because vast distances make it difficult for people in rural areas to access services the Australian government is keen to fund e-programmes. One example of these is eHeadspace, which enables young people equal access to a service where they can email, phone or skype with qualified mental health professionals. Similarly in New Zealand 185 of 300 secondary schools are signed up for the ‘Travellers’ resilience programme developed by the bereavement organization ‘Skylight’. Schools are trained to run the programme and the whole cohort of year 9 pupils (13/14 year olds), complete an online survey. On the basis of this high scoring pupils are offered counselling, medium scoring pupils are offered the Travellers course and low scoring pupils have anything of concern addressed.

Table 2: Examples of funding sources for organizations visited.

Organization	**Funding Source**
StandBy Response Service	‘Already in Oct 2006 the Australian government endorsed the StandBy National Response Service by announcing it is to become a national initiative’.[6] (Petrus Consulting and St Vincent’s University Hospital 2007) This decision was reinforced by research undertaken by Health Economists in 2013 on the costs of prevention and the costs of doing nothing. This showed that suicide ‘postvention services are a cost effective strategy and may even be cost saving if all costs to society from suicide are taken into account’[7] Regular data collection and information is the basis of ongoing government funding. After a 3 year initial funding there is now a one year rollover funding, although at the time of my visit StandBy were applying for 3 year funding. In 2015 they got $6 million funding.
Dept of Forensic Medicine	The team were given funding to run a pilot programme for children affected by sudden deaths, which was evaluated, but they failed to get further funding to continue it.
Centre for Grief and Bereavement	Some funding from the Australian government, but not sufficient for growth.
Support after Suicide, Jesuit Social Services	Funded initially through the Suicide Prevention Strategy. Now fully Federal state funded but on a year to year basis, which means constantly reapplying, uncertainty, and no capacity to expand.
Headspace	Fully funded by the Federal Government. School support is funded year to year, Headspace Centres for 3 years.
New Zealand regional	Posts were set up nationally and government funded. After the initial

Suicide Postvention Coordinators	research and set up they were handed over to District Health Boards, who have not continued the funding.
Victim Support New Zealand	Victim Support is funded by the Ministry of Justice and the 5 Bereavement Support Specialists are funded by Health Boards.
Skylight New Zealand	Travellers schools programme is funded by the Government and Mental Health Foundation on a research evaluation cycle of 3 years. The Waves adult group programme is funded by The Ministry of Health.
Barnados Ireland	Funded by Irish Child and Family Agency (Tusla), Victim Support and Electric Aid.
Suicide Liaison Officers Ireland	Each post is funded differently, so there is no consistency.
The Mayo Project	Funded primarily by the Health Service Executive

At the Hunter Institute of Mental Health Jaelea Skehan feels that some countries are similar enough culturally e.g. Australia and the UK, for research regarding practical applications to be internationally funded, with both countries benefitting from the outcomes, e.g.in the monitoring of media coverage of suicide there could be shared round the clock monitoring of news stories, rather than one limited to one working pattern or time zone.

Strong Connection Between Research and Practice

Services in Australia and Ireland are well grounded in evidence and theory, showing that the collection of data and evidence makes a strong argument for funding. Good research shows both the need, and the justification, for funding suicide prevention and postvention services.

Successful projects are often evaluated by external bodies, such as universities or research institutes and have research evidence to highlight the need and show that costs of preventative services are less than the costs of doing nothing, e.g. hospital admissions, working days lost, and mental health. A good example of this is an influential study in Australia that did exactly this and helped deliver funding to the national organization StandBy. (Comans, T. et al.2013) In Ireland the National Suicide Research Foundation in Cork is an independent research unit which undertakes research into topics relating to suicide to provide the knowledge base for suicide prevention, intervention and postvention strategies.

In Australia there is a strong connection between research and practice, this makes the sector very vibrant and services well grounded in evidence and theory. The Hunter Institute of Mental Health in Newcastle, Australia, focuses research on the development of services that have a practical application in mental health, developing projects in relation to organizations on the ground that can carry them out. Jaelea Skehan, the director, is passionate about translating evidence into practice and finding better connections between research and practice. She believes there should be a middle ground between practitioners and researchers with a constant flow in both directions. She sees her team as ‘translators’. The Institute of Suicide Research and Prevention at Griffin University in Brisbane has a taught Masters degree and Diego De Leo, it’s Director from 1998-2015, has been influential for a number of practitioners in their work in suicide pre or postvention. Griffin University in

Brisbane directs the WHO Collaborating Centre on Research and Training in Suicide Prevention. This connection between research and practice has also been true of the Irish National Suicide Research Foundation, which has worked in conjunction with those who are developing services for support after suicide in Ireland.

In New Zealand Chris Bowden, lecturer and researcher at Victoria University of Wellington worked with Skylight to develop the Waves psycho-education programme, while also completing his own PhD on young men's experiences of losing a close male friend to suicide. Similarly Annette Beautrais and Prof David Fergusson at Otago University were joint authors of the New Zealand Suicide Prevention Strategy 2006-16 and were involved with the Christchurch Suicide Project.

On the service side in Australia there is a high academic level among practitioners, with many having Masters in Suicidology or a PhD related to their work in suicide. Some are working towards professional doctorates at the same time as working. Several PhD students are being supervised by Dr Myf Maple, associate Professor in the School of Health at the University of New England (UNE). The UNE works with four other universities and a local health district as part of a Collaborative Research Network (CRN) on mental health and well being, which has attracted $4.8 million funding from the Australian government. This means that research is joined up and has a strong profile. As mentioned in the blog of suicide postvention researcher Sharon McDonnell[8] (April 4th 2014), 'it is possible to suggest that Myf's postvention department is a virtual one, in that many of her staff are PhD students and study via distance learning. It is commonplace to hold meetings via a video link'. This again is a practical response to the vast distances in Australia.

Danny Nugus, one of the grief counsellors I spent the day with at the Department of Forensic Medicine in Newcastle, was undertaking research on the experience of families who came through the department – what was helpful and what was not. In this way the development of services is informed by research. Experience and learning is also shared with professional training courses, so counsellors from the Dept of Forensic Medicine teach on loss and grief on the social work course at Newcastle University.

I believe this interrelationship between research and practice, with movement in both directions has greatly helped practice to be grounded in research and research to be based in practice, and has given credibility to both. Governments are more likely to fund joined up working and more likely to be convinced of the importance of funding research that leads into the development of services that are effective, and the efficacy of funding practice that is evidenced by research.

Working in Partnership

I came across many examples of collaborative and partnership working, which encourage co operation, develop understanding of each other's services, and aid the provision of joined up services for those who are seeking support after a suicide. Organizations working at a national level, such as StandBy and Headspace, do so by having a Memorandum of Understanding with local partner organizations and arrangements whereby coordinators of services meet together and train together. In the district around Melbourne Headspace does more general work in schools but refers children to the Jesuit Social Services Support after Suicide for direct work with individual children. This not only encourages cooperation but also develops an understanding of each other's services. In Australia information about The Centre for Grief and Bereavement is given to families by funeral directors.

In all three countries the fact that coroners report deaths by suicide to those organizations providing services makes an enormous difference to their ability to offer services, as people are less likely to fall though the net.

- The Centre for Childhood Grief in Australia works together with the local coroner to run a 'Support after Suicide Group' with social workers from the coroner's office. This group is funded by the coroner, who also provides the venue.
- StandBy was initiated by the coronial service and the police, which has meant an ongoing positive working relationship between the different agencies.
- The Department of Forensic Medicine in Newcastle works closely with coroners.
- As a Regional Suicide Postvention Coordinator in Wellington New Zealand Jennie Jones is informed of every suicide by the coroner, who gives basic information, and by the police who share more details through an encrypted site.
- Victim Support, who offer a service to those bereaved by suicide in New Zealand, also commented on the enormous advantage of being informed of deaths by the coroner.

This is an area that clearly needs a lot of attention in the UK, where contact with local coroners is patchy and sensitive*.*

Many different professionals are involved after a suicide, e.g. fire service, police, ambulance service, clergy, GPs and funeral directors. The most successful organizations had worked to get each profession onboard at a high level, in order that cooperation and good working relationships percolated down throughout the organization, and maintained these by good networking, joint training, clear guidelines and protocols. These are often brought together in manuals. Having a facilitator whose task it is to put all these things into practice seems also to be the mark of a successful service. Prime examples of this are StandBy, the Mayo project in Ireland and the work of the Suicide Postvention Coordinator in Wellington.

Developing a Model

Those organizations that have been most successful in growing and attracting funding have developed clear models of working based on research and evidence.

Services for the prevention of suicide and support after suicide are gradually being coordinated and strengthened in the UK through the coming together of different working partnerships, some in local areas and some nationally. Decisions need to be made on finding models of working that are most effective in our own circumstances in the UK.

As the provision of support after suicide in the UK is developed it is vital that the partnerships of organizations involved have clarity around the models that evolve from their collaboration, with clear theoretical underpinning, evidence for the efficacy of the model from pilots or other examples, and hold fast to best clinical practice as far as possible.

I saw several different models in the course of my Fellowship. Those organizations that had most knowledge and experience of supporting children after a suicide were small specialist organizations undertaking direct work with children.

Direct work with families and children

For example,

- Jesuit Social Services Support after Suicide in Melbourne.
- The Centre for Grief and Bereavement, Melbourne
- The Centre for Childhood Grief, Sydney
- Skylight in New Zealand
- Barnados in Ireland
- The Mayo Project, Ireland

The mark of these organizations is high quality work, long standing experience and a real knowledge around suicide and it's affect on individuals, families and society. These organizations are small and find it difficult to grow because of precarious funding and are fearful they may lose out to other organizations 'that are better funded, better marketed and more glossy.' These organizations, as in the UK, hold the expertise of working with children following a suicide, and it's vital that this expertise is somehow expanded to benefit all children bereaved by suicide, rather than just the small number who are able to access their services.

The use of professionals who have another main job but an interest in suicide

These professionals are paid to offer counselling or run groups. This enables organizations to get input from professionally qualified people, but sometimes means these professionals have less experience in working with those bereaved by suicide.

StandBy refers children who need a level of expertise beyond what they can offer to specialist child counsellors they have an ongoing working relationship with. They provide training around the impact of suicide for these counsellors. They provide similar training to those who provide supervision to staff.

Chris Bowden, lecturer at Victoria University of Wellington, helped Skylight develop their group programmes and supervises students who are doing Masters on the work of groups. He co-facilitated the Waves adult grief education programme for many years and now conducts research on the programme and its impact. He is now researching similar programmes for children. He will also work with individual families if needed.

The Grief Centre in Auckland contracts self employed counsellors to work with bereaved adults and young people. (See appendix A).

Offering internships for qualified professionals

This is a model used by The Centre for Grief and Bereavement in Australia. Professionally qualified interns go through an accredited grief training which is run by the paid counselling team of the organization. It gives interns access to training and 80 hours of supervised individual work, and it gives the organization a stable, qualified workforce, especially as many of those trained stay on with the organization to work as volunteers.

Through the use of volunteers

This seemed to work well where volunteer numbers were small, well trained, well supervised and integrated into the team. e.g. Barnardos in Ireland.

It appeared to provide a poor experience for those receiving a service when there was an unmanageable number of volunteers who were not sufficiently trained, prepared or supported, or given appropriate work, e.g. Victim Support, where volunteers may attend the scene of death and families report poor experiences.

Setting up national Drop In Centres

This is a model used by Headspace designed to offer easy access for young people to local services. It is often run by a local lead agency that is familiar with the local area and resources.

Community Postvention Response Model

The Community Postvention Response Model stands apart in being set up with the sole aim of providing a community response to a suicide, and drawing in all the different agencies and professions to provide maximum support at the grass root level. Because it has protocols and a coordinator, it can respond immediately with an ever increasing knowledge and experience base. It has the capacity to provide training at different levels and support to those who respond, and because it is embedded in the community knowledge is hopefully disseminated and resilience is built up. StandBy in Australia, the Regional Suicide Postvention Coordinators in New Zealand and the Mayo project in Ireland are all examples of this type of model.

Features of this model are:

- A clear protocol for responding to a suicide.
- The coming together and coordinating of all responders to a suicide.
- The gathering and sharing of information in order to make a coordinated response.
- A coordinator to drive forward and coordinate the response to avoid duplication or confusion.
- Work with the local community to train and support those around the bereaved. e.g. families, workplace, neighbours, community, school, local professionals.
- A standardised information pack for the bereaved.
- A clear structure that is replicable.

Even in these countries recognized as having best practice most interventions after suicide are still aimed at adults, with the hope that it will somehow percolate down to benefit any children in the family.

As a result of my visits to a large number of different organizations I am now convinced that in developing services that support people after a suicide in the UK we need to work towards more interaction between adult and children's services, so that

the learning embedded in children's bereavement services can be utilized by those supporting adults, to the benefit of the many children who may be part of those families but not receiving a service in their own right.

Organizations Visited and Support for Children

A review of general bereavement support and specific services following suicide bereavement (Petrus Consulting 2007) felt The StandBy Response Service and New Zealand's Victim Support, together with the Baton Rouge Crisis Centre in the USA 'represented international good practice in suicide postvention' and 'that current trends in good practice are leaning towards developing educated and trained first response teams to a specific standard.'

These models are also cited as examples of good practice elsewhere in the literature, so my fellowship research started from the base of these organizations, to see how they had developed over the years, and, as examples of best practice, how well children are supported by them. There are child bereavement organizations in Australia and New Zealand, so my question was also:

- What relationship these child focussed organizations have with the examples of best practice in postvention support?
- What expertise do the child bereavement organizations have in supporting children bereaved by suicide?
- What knowledge do the postvention organizations have of the needs of children who are bereaved by suicide?

Support after Suicide

StandBy Response Service   Australia

Objectives of StandBy:

- To provide support for people bereaved by suicide through an integrated, comprehensive and responsive support system within identified community regions.
- To increase the sustainable capacity of communities to respond to, and support, those bereaved.
- To centrally coordinate local integrated support systems built on existing emergency and community response mechanisms.

My time with Jill Fisher, National StandBy Response Service Coordinator showed that StandBy has great clarity about how it works, at both the national and local level, how it works with partner organizations and how it strives to maintain standards throughout its geographically spread work. In each region where they work they form an organizing committee drawn from different local organizations and those with lived experience and recruit people from different professions who have some experience of working with suicide to work on a casual basis.

Each region has a coordinator and coordinators meet together for a yearly conference, which helps to maintain continuity of practice. Coordinators have a handbook with a set of governance, services, training and support, and a manual to work from which maintains standards and the model, which is a six step crisis intervention model.

StandBy has very clear training to support the delivery of their service and ensure negotiation of roles and informed commitment to a response plan. In order to help partnership working all staff have training that includes listening to people who have different roles talking about what responding to a suicide is like for them, and reflecting on what the experience of suicide might be like for families. Service development is informed by research. Many of the staff are highly qualified and Jill Fisher, the StandBy coordinator, is undertaking a PhD with Myf Marple, in spite of working full time.

A referral pathway plan is created that contains information about organizations and individuals willing to participate in StandBy's coordinated response, and training is facilitated to equip those working in the community with an understanding of the impact of suicide on the bereaved, to provide basic suicide bereavement intervention skills and to raise awareness of self care.

The stressful nature of the job and often difficult working conditions are acknowledged through self care that is built into the system at every level. StandBy recruits supervisors all over the country and trains them in how they want them to support StandBy workers. Practitioners must have supervision after three interventions. StandBy also supports its staff in many practical ways, especially safety, given the remote conditions they may have to work in, e.g. four wheel drives, satellite communication, how to change wheels, first aid and self protection.

Where there are no local StandBy groups a Crisis Response Team can go to an area for 3-5 days to undertake short term crisis work after a cluster of suicides. This team:

- Identifies all the agencies in the area that could be of help.
- Lists them for coordinators to use.
- Calls a meeting of agencies to explain how StandBy works and ask if they would like this support.
- If yes, identifies someone to take the lead.
- Writes a report to give back to the community, together with the list of agencies they have identified.
- Has a Memorandum of Partnership with partner organizations as to how they will work together and what information can be shared.

What these actions do is help a community bereaved by several suicides to move into supportive action at a time when it may be still shocked by the deaths.

Clear models, pathways and training are used.

- Immediate referral by police or ambulance staff, with the family's permission.

- Contact with the family is usually one good assessment visit, usually in pairs, in which they are led by the family. Children may be present.
- Use short term intervention model.
- Arrange six sessions of call back.

StandBy has also helped to develop a network of support groups throughout Australia.

Jill Fisher said that very few people are experienced in children bereaved by suicide. StandBy occasionally runs groups for children or young people, but sees children’s work as a specialist area and so employs specialist child practitioners for these. Children who are thought to need individual support may be referred on to children’s mental health services, which carry the stigma of making bereavement a problem rather than a natural response to a death. It calls on a few experts who work with children for particular interventions, to provide training, or give supervision.

While demonstrating clear and replicable ways of working on the ground StandBy have, at the same time, been able to lobby effectively at a high level to influence funding and use the media to raise the profile of suicide, its effects on families and communities, and the work StandBy is doing.

Several things appear to make StandBy successful:

- It started from a good network of professionals.
- It is strengthened by continued good networking of coordinators, and of coordinators with their teams.
- It has a strong academic base and so is in touch with research.
- There is training for everything.
- Strong promotion of self care, especially when working in remote areas.
- Strong lobbying and use of media. StandBy is increasingly approached by the media and influential people.
- StandBy provides a continuum of care, harnessing the co operation of local providers.
- Local services are based within existing organizations.
- Uses clear models, pathways and training.

The StandBy group is embedded in the local community for longer term work. There may be a follow up meeting, but long term support is sought through the local coordinator from within their trained team.

StandBy sits within United Synergies, whose general vision includes ‘to provide holistic and appropriate support’ for people at vulnerable times in their lives, ‘which is solution, not activity focused.’ ‘To engage our clients and communities to co-design, trial and establish meaningful service responses’ and ‘collaborate with our networks and partners who broaden our understanding and capacity to respond’. StandBy’s head office is located in a building occupied by other parts of United Synergies, so there is exchange and understanding around the wider issues of homelessness, education and youth services that can make people vulnerable, or resilient.

Dept of Forensic Medicine Australia

Like StandBy the Department of Forensic Medicine (DFM) in Newcastle offers a very clear and ‘held’ response to the traumatic experience of a suicide for families of those who have died. 15% of the deaths dealt with by the centre are suicide. There is a clear pathway which manages both the forensic needs to investigate following a suspected suicide, and the needs of the family to be supported and given information.

After a sudden unexpected death bodies are brought to the DFM from a large area of NSW and Queensland. The centre receives about 2000 bodies a year, so can only mostly be reactive not proactive. This inevitably means that local families who can get to the centre are offered a better service than those further away, who can only be supported by phone. A police report is sent to the dept triage system to see if the body needs to come to Newcastle, the police report is seen by grief counsellors who then decide what action to take. An autopsy and post mortem are done there if necessary.

The grief counsellors advocate for the families in terms of information, legal rights, requests etc. They seek to empower families and have, little by little, tried to influence how the medical team respond and interact with families, by trying to change attitudes and ways of working to help medical staff consider the human element and needs of what is a difficult and distressing process for families. Medical staff told me they have indeed gradually changed their working practices.

The philosophy is that by meeting with people at such an early stage you can help co author their narrative of the suicide, e.g. help them have good experiences of a difficult process, gently prompt them to start thinking about their children and how to talk to them, and think about their grief or what they might need.

Families can stay in hospital accommodation and there is a counselling room and a family room to meet with families before they view a body. Photos are taken to desensitize and slow down the process of seeing the body and families are in control of choice the whole time. As they cover such a vast area the grief counsellors try and support families to make contact with local resources.

The team did run a pilot programme for children called ‘Keeping Connections’ that was funded and evaluated, but failed to get further funding to continue it. The group ran weekly after school for 8 sessions. The team also trialled a similar group which ran every two weeks, in order for the work to be consolidated over a longer period; a one day group; and a two day workshop with a 6-8 week interval, to allow for the work to be integrated into everyday life.

The importance of self care was emphasised by Danny Nugus. The doctors in the team I spoke to said it is possible for them to view the work in a more detatched way, but for those supporting the families as well as the fact of the suicide there is the added physical element of being involved in the trauma of the death. Being connected – touching, seeing, smelling the deceased. In some sense having a relation with them and needing to grieve them, while at the same time holding the emotional distress of the family. So they are holding together both the physical and emotional elements of the work on behalf of the families. All have external supervision, but Danny said it is difficult to find supervisors who understand the work. One supervisor pointed out that your head knows it’s not your child/family, but your body still reacts and that there is a need to acknowledge this and take care of it. Even with high levels of support there has still been PTSD within the team.

Doctors in the team said they had come to a better understanding of the families' situations and experiences through working alongside the grief counsellors and had changed their working practices to hold the family more in mind. Writing reports differently and conference calls with families were examples. They said they felt more of a team working together to give a better experience for the family and that this had also made the work more rewarding. No separate files are kept for social work recording, which is put in the medical notes, which encourages joined up working.

Lifeline Australia

Lifeline is a national charity primarily providing adult support to all Australians experiencing a personal crisis, with access to 24 hour crisis support and suicide prevention services. Their vision is 'for an Australia free of suicide'.

There are 47 centres for the general crisis helpline, to which there are 2000 calls per night, of which 40 are about suicide. Each centre runs and has to fund their own crisis line. Local centres also provide a range of local community services, which may include bereavement services, counselling for both adults and children, schools programmes, information and education. It also facilitates support groups for those bereaved by suicide. Other organizations refer people to Lifeline services.

Lifeline practitioners run ASIST training, and everyone who works at Lifeline is ASIST trained. ASIST (Applied Suicide Intervention Training) is a 2 day interactive workshop in suicide first aid produced by Living Works. They also offer 'Safe Talk', a half day more general workshop to prepare people to be more suicide alert.

Lifeline has contributed to best practice by producing a set of standards and guidelines for the setting up and running of Suicide Bereavement Support groups to encourage safe and best practice in the support for people bereaved by suicide. They include:

- Establishing and maintaining a group
- Group philosophy and processes
- Group facilitation and management
- Group services
- Research evidence surrounding support groups.

Lifeline centres facilitate SOS (Survivors of Suicide) open groups and may run a more closed group to offer a model of grief. It was emphasized that the group in Newcastle is not a social group, although it is informally structured. The group is kept focussed and boundaried. Coordinators are not informed of suicide deaths by the coroner, although they would like to be. They have produced both pre and postvention packs for the police and ambulance staff to give out.

Individual and couples counselling is available from volunteer professional staff for a nominal fee and people self refer. It is also possible to have 'Care Calls' once a week from the counselling team in between counselling sessions and they work towards people making their own safe plan. Lifeline doesn't generally work with children but through case management children may be directed towards support. Robyn Lawrence, who I met with, said she was not aware of anyone who offers a family intervention, but felt this would be useful to families.

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Most Lifeline branches don't have a coordinator but in Newcastle Robyn Lawrence goes to networking and community events and runs both suicide prevention and postvention training.

- ASIST two day subsidised training and Safe Talk
- A suite of training for corporate, for which they charge.
- SafeAlert training to schools and Save our Kids, funded by Rotary so more trainers can be employed.

Support after Suicide – Jesuit Social Services Australia

Support after Suicide (SAS) was started 11 years ago when the Jesuit Social Services applied for some funding that was made available for postvention support through the Suicide Prevention Strategy. There is a pro active approach whereby people do not have to seek help at a difficult time but are offered it as part of the process they go through. Police refer with permission and SAS call the bereaved to explain what is available and their resources, answer immediate questions and then leave the person to respond themselves, having been supplied with the information of what is available.

Initial contact is usually with parents, but holding children in mind. During their contact with the organization if adults talk about their children they may be offered a service in their own right and be invited to attend a group. This is an open group held four times a year in school holidays, as some families have to travel a long way to attend, sometimes 2 – 21/2 hours. Louise Flynn, Manager of Support after Suicide, said that practitioners remark that children are really relieved to be with others who share a similar experience. The group for children bereaved by suicide run by Diana Sands is a example of this. The group produced a book and DVD to support other children bereaved by suicide. (See appendix B). SAS also cater for the older 17-25 year old group, which have opportunities to meet for dinner. This is a similar response to the needs of those moving into young adulthood as described to me at The Australia Centre for Grief and Bereavement. Suicide rates are higher in rural areas, which is problematic when services are based in urban areas. Groups are also run for adults 3 times a year. They also hold Friends and Family sessions.

SAS are very experienced but have remained small because funding levels have not allowed them to expand. They work in partnership with Headspace, which does systems work and school support and refers to SAS for individual support and direct work. Although they have specialist knowledge in relation to suicide support for both adults and children they expressed the fear that they may lose out to other organizations that are better funded, better marketed and more glossy. Beyond Blue, Lifeline and Headspace are all funded by federal and state government but work more at the broad level of information and advice, rather than working directly with families.

Wellington Regional Suicide Postvention Coordinator
New Zealand

A Community Postvention Response was set up in New Zealand in 2006 by the Mental Wellbeing Commission in response to an increase in deaths by suicide. Suicide Prevention Officers were set up nationally and government funded, the idea being that there would be a managed and coordinated response to suicides so as not to replicate and to bring clarity to the situation.

Talking to Jennie Jones, the Suicide Postvention Coordinator in Wellington, it was clear this set up was an example of best practice, that had it continued to be funded and rolled out nationally would have provided a good national postvention response. What appears to have happened in New Zealand, in contrast to Australia, is that this initiative has floundered as a result of political indecision and a will to continue funding, with no government department wanting to be responsible for suicide prevention and take a lead. The postvention response was funded as a pilot and handed over to District Health Boards to implement, who were at the time of my visit, trying to decide if they could afford it. This move puts suicide bereavement in the medical field and is liable to contribute to the stigma of suicide, it changes how suicide is perceived. From the standpoint of a Suicide Postvention Co Ordinator Jennie thinks the work should be held under Public Health, as it is more about wellbeing than illness. There is a political argument as to whether suicide is mental health or social. Meanwhile this example of good practice has not been able to develop. Jennie has fought for the continuation of her post, supported by local organizations, but in other areas the post now no longer exists through lack of funding.

As in other examples of best practice Jennie is informed of every suicide by the coroner or police. The coroner gives basic information, the police give more social details shared on an encrypted site. She then coordinates the coming together of a team of professionals who are nominated by their agencies, sharing information as appropriate, who look together at helping to develop supportive networks. This is a similar arrangement to the Mayo Project in Ireland.

Victim Support New Zealand

I began my Fellowship with a particular interest in the role of Victim Support in supporting families bereaved by suicide in New Zealand. In the UK Victim Support Homicide Service is put in touch with every homicide bereaved family by the police and has very good arrangements for supporting children and families bereaved by homicide by funding specialist Third Sector organizations. I wanted to see if anything could be learned from Victims Support in New Zealand that could lead to Victims Support in the UK expanding their role from support after a homicide to include support after a suicide. This could be a potential area for development in terms of offering initial support after every suicide.

VS New Zealand has a chequered history as far as support after suicide is concerned, some of which mirrors what has happened in the UK. It started as a regional initiative which has now become a national NGO with national guidelines, while still retaining local fundraising and local organization of volunteers. As in the UK VS was given funding to pilot a specialist service for those bereaved by homicide with paid homicide Family Support Workers. The research evaluation showed a big improvement for families on the basis of feedback from both families and the police, as is the case in the UK, so the question was whether this model could be replicated to support those bereaved by suicide.

At the time of my visit the service was struggling to have clear lines of accountability and a consistently high level of service provision. This may be related to the fact that VS seems to have been drawn into the work by more and more police referrals without having a structure or training with which to respond, and by relying on poorly trained volunteers of very varying quality and over stretched Bereavement Specialists with a confused management structure. None of the Bereavement Specialists had a specialist background in suicide and the volunteers are all generalists.

Donna Fitzgibbon was new in post and working hard to raise the standard of support offered to those bereaved by suicide, she said that being informed of a death by the coroner is a huge advantage in developing a service. As with other organizations VS does not work directly with children and Donna repeated what I had heard elsewhere, that although CASA was contracted to provide postvention support alongside VS it works more at the level of suicide clusters than individual support. Donna said that in general people did not feel enough was being done to help children.

I also spoke with Russell Baines, a VS Bereavement Specialist in Wellington, who clarified that the service for those bereaved by suicide was set up because of the increasing pressure to respond to some suicide clusters. VS is funded by the Ministry of Justice, the five bereavement specialists are funded by Health, and those who work directly with families are unqualified volunteers. Support is offered when the bereavement specialist is alerted to a suicide and arranges for a support worker to go to the family, sometimes already to the scene of the death. The bereavement specialists train the volunteers, support and debrief them. A funding discrepancy in VS is that while it does fund counselling for victims this does not cover suicide. Children are not worked with directly but may be referred to Skylight.

The potential for VS to provide a national and consistent service following a suicide based on a successful homicide service is clear, but it is struggling to do this. The lesson for the UK from the experience of VS is in stressing the importance of those areas that seem to mark out successful services with good practice, as referred to earlier – proper funding, a strong connection between research and practice, working in partnership, being informed of a death by coroners, strong professional training, and developing a clear model and structure that can be replicated.

Mayo Suicide Bereavement Project   Ireland

The Mayo Project is an example of best practice that grew organically from the recognition of a need by a pre existent organization that was able to secure funding for a pilot project, and Maire Ni Dhomhnaill, who I met with, has clearly been the driving force behind it. As with StandBy and the Regional Suicide Postvention Coordinator role in New Zealand it developed a clear model that involved a community response across all professionals with one facilitator, who insisted that families were put at the centre of the project, but because it developed through a Family Centre it also has the capacity to provide good support to children.

The funding in 2011 was for a 3 year project to set up a protocol and develop the role of the Suicide Bereavement Liaison Officer. After 3 years the project was externally evaluated, seen to be effective and rolled out nationally. The organization Console was approached to replicate it down the west coast, but in these areas it doesn't seem to have been so successful, possibly because they have not been as responsive to local need as the Mayo Project and because they have failed to take advantage of the expertise of those already working in the area and what the Mayo project learned as it developed.

It is creativity, the close listening to families and the careful engagement of all professionals that highlights the best practice here, along with a clear pathway to enable families to be supported and access support at a traumatic time. The development started when the Family Centre became aware that people had no one to respond to their needs immediately after a death, and the difficulty professionals had in responding to suicide deaths. The support of the garda (police) was considered essential as they represent the coroner in Mayo, and high ranking people in the garda were approached. They found there was a personal interest in the project because of 3 recent teenage suicides and an approach by local garda to their national office received support. The garda did make a proposal to the national office for Family Liaison Officers to be appointed for families bereaved by suicide. The recession put this on hold but it is now being promoted again.

Different professions were approached to sit on a steering group, including the specialist funeral director who was contracted to work with all sudden deaths. Clergy were involved by approaching the Archbishop to explain what they were trying to do and why the support of clergy was important. (Their experience is that most families still want their priest to be present at the scene). He put out an invite to all priests, and one responded to be on the steering group. Doctors were also important as a doctor has to be called to the scene to pronounce death. The Health Service Executive was approached and gave addresses for all GPs in the county, who were written to and invited to respond. Although they have found it difficult to engage GPs they are sent regular update information, and an evaluation of the service in 2014 showed that most referrals came from GPs. Previously known bereaved families were also on the steering group, as was the local Suicide Resource Officer, and after a meeting with the coroners one said they would like to be on the steering group. After a number of meetings a protocol had been drawn up, addressing issues of confidentiality and who would take the lead after a suicide. There was a top down dissemination of information among the police, clergy and GPs which meant that everyone was aware of the service and it was clear that there was support for it at the highest levels, and all funeral directors were met with. The general population were informed by using local media.

30-40 families who had previously been supported were contacted about the new service and asked what had worked for them and what didn't work for them. The continued importance of this is shown in that many of these families remained as a family advice group, and so as not to lose the information a leaflet was written for families. This was followed by a leaflet for professionals. An information pack was put together for families and a book was recorded on CD by the local radio station. Families on the steering group also each shared two books they had read and found helpful after the death, which the library service then agreed to add to their Healthy Reading Scheme with a review. So there was, right from the beginning, a lot of community engagement, and this will have contributed greatly to the success of the project.

The service recognizes the lack of training for professionals around suicide and has started to address this by running training days for priests on the impact a suicide may have on themselves and others, self care, and what families say their bereavement experience is like. Clergy shared their own experiences and said they felt very affirmed after the training. The service has also trained a number of peer supporters who are given supervision. As yet there is no support for first responders. From very early those involved were already thinking about the possibility of the service becoming national and had this in mind when developing their information packs and protocols.

As with all examples of best practice in postvention support the service is primarily aimed at adults, but the strength of this example for the development of services for children is that it grew out of and is based in a Family Centre which provides specialist services for children. A Rainbows programme is run in the Family Centre by 2 facilitators. Rainbows offers group support for children and young people who have been affected by the death of a close family member. At the time of my visit children bereaved by suicide participated in general bereavement groups, but facilitators there were beginning to consider the specific needs of suicide bereaved children and the impact of these stories on other children. In order to provide a specialist service for children the coordinator met with clinical psychologists in the area who agreed that the service could refer children to them and that these children would be prioritized. A good degree of confidence and inter professional working is evident here, for the benefit of bereaved children. It was pointed out to me that the big concern of families is the children, and the idea of a bereavement group for children has been presented to the psychology team and Family Centre.

At the end of the day it comes down to people working together

The Steering Group for the Mayo Suicide Bereavement Project, Castlebar Family Centre 2013[9]

Those present: Funeral director, Coroner, Suicide Prevention Resource Officer, Representative from Choose Life, Psychologist, Family member, Priest, Chief Superintendent, Director of Family Centre, Counsellor/Project Coordinator
Together with: An Taoiseach/Prime Minister

National Developments

There have been attempts to roll out the learning of the Mayo Project on a national basis, but its success has not been replicated. (See appendix C).

General Bereavement Services for Children

Australian Centre for Childhood Grief

The Australian Centre for Childhood Grief has 22 years experience of working with bereaved children. They run professionally rigorous group for all types of bereavement. The process of support for a child involves a two hour assessment with the parent, individual sessions with a counsellor in preparation for attending a group, and the opportunity to tell the story of how the person died in a supported way within the group. Groups are open but a child needs to give two weeks notice if they wish to leave, and if staff feel they should leave they will talk with the child and parent. Volunteers are used to support the groups and a group for parents is run at the same time, making it a family intervention. This supports Jaelea's proposition that families are the most important place to help develop resilience in children.

Although the service is generic rather than specialist the local coroner runs and funds a support after suicide group, providing both a venue and social workers from the coroner's office to run it. Referrals are made from professionals who may be seeing adults and who are looking for support for the children. Apart from this local arrangement the Centre has no particular partnerships with adult or suicide organizations.

Skylight. New Zealand

Travellers Groups in Schools

The Travellers programme was developed, piloted and evaluated under contract for the New Zealand Ministry of Health by Skylight, in partnership with the University of Auckland. It is a school based programme run by trained facilitators from within the school environment. The programme has run for 10 years and 200 schools nationally now offer the programme to students. Skylight has trained over 900 facilitators to run the programme.
The programme puts into practice the comments of Jaelea Skehan at the Hunter Institute of Mental Health in Australia, that resilience is the key factor in children being able to manage difficult life experiences, including suicide. The programme covers change, transition and loss:

- How to navigate their way through these difficult and confusing experiences in safe and adaptive ways.
- Understanding how their thoughts and feelings influence how they cope and respond.
- How to nurture supportive environments.

Schools sign up for a 2 day workshop for 2-4 people which includes a resource pack to support their work, with leaflets for the school, the parent and the child. The group is aimed at year 9 pupils who all complete an online survey. Only the staff who attended the training have access to the results, and pupils are told this. The survey enables the staff to identify pupils who are struggling, who are then offered counselling, while those who have a medium score are offered a Travellers Group.

The programme consists of 90 minute sessions every week for 8 weeks. Feedback from students shows that 80% of those who attend don't want it to stop. The success of the group is probably because it has a clear purpose and direction, has fun and accessible activities where children can mark their progress, is child focussed and has a clear theoretical underpinning. The group is well supported by very good resources. There is a clear metaphor for the group of making a journey, with cards to track the student's journey through the group, life maps and a passport at the end of the group.

The strength of this programme is that, as with examples of best practice specifically related to suicide in Australia, there is good training, clear identification of those who can benefit, a clear pathway through the programme, a well evaluated programme, a clear manual to follow and information for trainers on the theoretical foundations of the course related to bereavement, grief and loss. Facilitators meet once a term to maintain contact. Data has to be supplied to the government to support continued funding and participating schools are sent surveys.

Although they don't yet run groups specifically for children bereaved by suicide Skylight's work with these children is enhanced by their experience of running regular groups for adults bereaved by suicide. As is often the case, services are developed firstly for adults.

Barnados. Ireland

Barnados specialist children's bereavement service is based in both Dublin and Cork, although they work with children from across the country and some families travel long distances to access the service because of the good reputation it has. The service was reduced in the recession and modified to make it focussed on family support rather than therapeutic counselling, but the majority of their work is with sudden death and suicide and they are known among other services for being able to support the suicide bereaved and for being able to offer advice to other colleagues and professionals. Although the teams are small they are very experienced and have a good reputation, but they have a waiting list of four months and need to keep a low media profile in order not to be swamped by referrals. There is a very high rate of suicide among travellers and young people.

Within their limitations the bereavement service offers an assessment meeting with parents/carers first, then 6-8 sessions with the child, followed by a closing session. They work hard at networking and are part of the recently established Irish Childhood Bereavement Network, whose conference I was invited to speak at in 2016 about children and suicide. Their approach is to support children within supportive families and to bear in mind the context of the bereavement. So they support children to ask the questions they want to ask and support the adults to answer them. Their work recognises that the adults are also struggling, that schools need support and that the response to suicide of society in Ireland is still very much silence and shame. Gina Cantillon, Project Leader for the Children's Bereavement Service in Cork, feels that most families don't need specialist help but that families may be referred because people don't feel confident in the issue of suicide bereavement. For her the benchmark is around the degree of trauma and the need to manage arousal, which is physiological, before children can think about the things that make them vulnerable - their bereavement and how the person died, which is psychological. This sense of self control is very empowering.

Suicide was not decriminalised in Ireland until 1993, so there is still a resistance to talk about it, especially among older generations and Barnados' experience is that most families have not told children a death was by suicide. I was told that it is still common for people to wait until after the first communion or confirmation before telling children. This would mean a delay in children knowing how someone died and a period of family secrets, which often leads to a breakdown of trust for children in their parents.

The bereavement work done by Barnados is enhanced by the fact that the teams work in offices where all kinds of attachment work is done, so they are in a creative environment where research and knowledge is exchanged. Groups are run when possible, but lack of staffing makes this difficult.

General Bereavement Service for Both Adults and Children

Australian Centre for Grief and Bereavement

The Australian Centre for Grief and Bereavement (ACGB) is a good example of an organization where bereavement support for children is embedded in a service that also offers bereavement support to adults. ACGB is funded by the Dept of Health to provide a state wide specialist bereavement service for adults, children and families and their contact number is given out by funeral directors. Children are not an afterthought but are provided for alongside adult referrals to the centre. It also provides a range of education, training, research and an advice and consultation service for those working in the area of grief.

The ACGB runs a support group for children called 'Kids Grieve Too' which aims to help children 'explore and express their bereavement journey and to develop the resilience and resources they need to manage their bereavement experiences.' The person who ran this group was very knowledgeable about child bereavement. A thorough assessment is undertaken before children attend a group and because of the organizations experience they are able to work with more complicated cases. The organization has a clear referral pathway, with one intake worker on the Helpline to help clarify and develop decision making and the process of taking referrals. Referrals are discussed by the team because of increasing complexity and cases are allocated according to practitioner capacities to ensure a good match.

They run both open and closed groups which are both seen as 'seriously fun and seriously deep', combining the need for children to do both. There are short groups in the school holidays, ongoing groups, and an adolescent programme for 8-10 young people where they go away on camps. This older group may also help at the children's group. 17-25 year olds have the opportunity to meet informally once a month to go out for dinner. So children are ‘held’ at different levels and are enabled to change their relationship with the organization without having to relinquish it as they get older**.** This is important as we know that children revisit their grief as they get older and need to process it again at different levels of maturity. Parents are integrated in the children’s groups in ways that enable them to learn about what their children are doing and what may be supportive for them at home.

The ACGB doesn’t offer a separate suicide bereavement group as they don’t have sufficient numbers, but they feel a specialist group may be helpful. They certainly understood the issues specific to suicide and how they impact children. Children bereaved by suicide join general groups and are supported to have open conversations.

Research and the Development of Suicide Postvention Services

Hunter Institute of Mental Health - Jaelea Skehan

Australia

Jaelea Skehan, Director of the Hunter Institute of Mental Health, develops programmes in conjunction with organizations that deliver them, so there is an immediate connection between research and practice. She is passionate about translating evidence into practice, building resilience in individuals, families and communities around mental health and suicide, and is an advocate for finding better connections between research and practice.

In terms of support for children bereaved by suicide Jaelea has gone back to the basics of how children manage adversity in childhood. Resilient children will be better able to cope with bereavement, and she believes that it is families that can most help to make children resilient, so they are developing a programme focussed on this. She has also developed a programme to support those who have attempted suicide. When they leave hospital after being admitted they offer a programme of awareness/training to those they go back to. This may be family, workmates, friends or teachers. Different levels of support are offered so people may be invited to a short workshop, a whole day or a series of workshops. Participants are streamed to different levels and evaluated for lower levels of distress.

I asked Jaelea how she feels children are supported generally in Australia after a suicide. She feels it is rather hit and miss, depending on the organization. She recognizes the long term implications of a death for a child and said “people don’t know what to do with children, so they don’t do anything”.

The Black Dog Institute – Karl Andreissen

Australia

Karl kindly offered to meet with me at the Black Dog Institute in Sydney, where he is currently undertaking a PhD on the experiences of children aged 12-18 years after experiencing a death by suicide. His research was in its early stages but he was hoping to follow up children at various periods after the death, which would make it possible to look at change over time. Karl is a respected researcher who has been writing on suicide prevention and postvention for many years, but I was struck by the difficulty he had recruiting children to the research. Karl had contacted many of the organizations I visited to explain his research and ask for support in finding participants but had had few positive responses. This is an example of the difficulty of doing research in a sensitive area that involves direct contact with bereaved families and the hesitation that organizations that work with families may have on behalf of those they work with.

I was mindful of the conversation I had had with Jaelea Skehan about the need for research and practice to go hand in hand. It may be that such delicate research can best be undertaken within organizations that directly work with families, perhaps having earned their confidence, or at least in partnership with an organization that works face to face with those who may be invited to participate in research.

As a researcher Karl personally believes that research hasn't found anything different about bereavement by suicide that would point to the need to develop separate services. He was aware of the statistics around increased risk for the bereaved but pointed out that emphasizing the differences of suicide bereavement may also increase stigma. He feels a better approach is to emphasise resilience in order to counter the differences. This supports Jaelea Skehan's proposition that it is building up resilience in children that most helps them to manage adversity in childhood, be that a death by suicide or any other difficult circumstance.

Victoria University of Wellington - Chris Bowden
New Zealand

Chris kindly found time to meet with me having just returned from presenting his research work at a conference in Canada. Chris is a lecturer in the School of Education at Victoria University of Wellington and was writing a PhD on young men's experiences of losing a close male friend to suicide. He has authored various government reports on suicide prevention and has written and presented on suicide and suicide bereavement. Chris developed the Waves psycho-educational programme for adults bereaved by suicide in conjunction with Skylight in Wellington. Chris also co-facilitated this programme for many years, helping people learn about grief and how to cope with suicide bereavement. He now conducts research on the programme and its impact.

Chris' overview is that the political situation in New Zealand has hindered the development of support services for families bereaved by suicide, with no government department wanting to be responsible for suicide prevention and no one willing to take the lead, in spite of an interagency committee being set up and an action strategy. He feels this has led to services becoming fragmented. This would certainly explain my experience in trying to contact people and work out exactly what different organizations did and how they related to each other.

As I visited organizations in New Zealand I not only became aware of the devastating impact the withdrawal of funding has had, but I also learnt that Victims Support had gone through a period of real upheaval and change since I first contacted it. Chris felt that Victim Support had been drawn into support after suicide by being called on more and more by the police. CASA (Clinical Advisory Services Aotearoa) was contracted to provide postvention support alongside Victim Support, but this support is very limited. When I met with Donna Fitzgibbon, the newly appointed Manager for Specialist Services at Victim Support, she was able to say that Victim Support felt ill equipped to do this work and was struggling to organize itself to deliver a sufficiently high standard of response to bereaved families. She echoed what I had been told by Jennie Jones and Chris Bowden that having been delegated suicide postvention by the government District Health Boards had poor commitment to postvention. Lois Tonkin in Christchurch also spoke of a lack of political commitment to active postvention in New Zealand. (See appendix D).

The present CASA website indicates that the Community Postvention Response Service (CPRS) they now run, funded by the Ministry of Health, is '*only to deliver services if evidence is accumulated through the Community Risk Assessment process it undertakes determines the presence of a suicide cluster or suicide contagion'. 'CPRS does not provide direct clinical input with any vulnerable individuals'.* It is mandated to work from a community development model in that CASA does not lead the postvention response but contributes its expertise and knowledge to work in partnership with the expertise and knowledge within the community. So the aim is to help the development of a community postvention plan. Working at this high level direct support for individual families bereaved by suicide seems to have been left to teams of volunteers who work with a small number of bereavement specialists from a variety of backgrounds who are employed by Victim Support.

Chris stated something I heard several people say as I travelled through New Zealand, that there is a real lack of direct services for children, services being aimed at caregivers, with the hope that support will somehow just percolate down to benefit children. Chris also repeated something I had heard in Australia, that organizations produce lots of leaflets but offer no therapeutic work. Families can go to a GP for referral to a counsellor, CAMHS or Skylight, but at the other end of the island in Auckland Trudie Vos, Manager of The Grief Centre, also said there was a distinct lack of therapeutic services for children and that she had been unable to source a child counsellor at a time she was getting a lot of calls about children. With Chris' support Skylight is now thinking of developing a programme for children to run alongside the Waves programme for adults.

Early Intervention Mental Health Service for Young People

HeadSpace

At the opposite end of the scale to SAS in terms of size, funding and emphasis, HeadSpace grew in four years to have 30 centres by 2010, and in 2015 had 200+ staff in head office and 100 centres nationally, each run by a local lead agency, with the aim of bringing services together. This means they may be slightly different in each area. I was informed there was no mental health service before this, so development at a general level was important. HeadSpace aims to improve overall mental wellbeing for 12 -25 year olds on a range of issues which can be accessed through one of their centres which are staffed by professionals across medical, mental health services, youth work, education, employment, drugs and alcohol counselling and social work. This is to avoid stigmatising.

HeadSpace school support is an initiative funded by the Dept of Health and Aging that provides support to secondary schools affected by the suicide of a student. They have worked with 2000 schools and will go into a school for 1-4 days. They offer training to staff and can help schools review or make plans. The aim is to minimize the impact and trauma of suicide on individuals and the community. They also offer professional consultation to local professionals and parent information nights. Resources include a Suicide Postvention Toolkit. eheadspace is an online and telephone service that supports young people who don't have access to a centre, or don't feel ready to use it yet.

So HeadSpace could work as a good first point of contact for young people who may have been affected by a suicide, but needs to be able to refer young people on to more specialist services for them to receive support that is specifically related to suicide. Services are well supported by research and evaluation teams and a knowledge transfer team.

Conclusions

I visited many different organizations related to suicide bereavement in three different countries, ranging from those which work at the broad level of improving mental health, through national organizations that have a proactive response to a suicide, to small specialist organizations that focus on suicide bereavement or child bereavement. The aim of my research was to look at models of good practice in Australia, New Zealand and Ireland, to look at the extent that children are considered and supported within these models, and whether it is beneficial for children bereaved by suicide to be offered a separate specialist service.

I did indeed find examples of best practice in all three countries and there are examples of postvention services which those developing services in the UK would find useful to look at. However, even within this good practice it was difficult to find easily accessible and consistent support for children who had been bereaved by suicide. Suicide specific services focussed primarily on adults, doing their best for children when they were made aware of them, referring them ad hoc to counsellors, while child bereavement services had less expertise in suicide and less capacity to offer a specialist service. Many organizations said there was a lack of expertise and services for children following a suicide, and this was backed up by parents I spoke to. So in spite of good practice, children in general still experience disenfranchised grief, that is, their grief related to the particular impact of bereavement by suicide is not acknowledged in a way that allows them to process the experience, and develop resilience that will protect them against poor mental health in adulthood.

The Community Postvention Response Model, with examples in all three countries, appears to offer the best model for a coordinated and consistent response to support families and communities following a suicide. This model is supported by automatic referral by the coroner, with the families' consent, and a proactive approach to the family with an offer of services. However, the best support for children lay within services that were child focussed, where practitioners were practised at seeing the world through the child's eyes and understanding the impact a death might have on them.

This leads me to conclude that services for children bereaved by suicide could be improved by more integration of child and adult services. By this I mean that as adult services develop, possibly along the lines of the Community Postvention Response model, a greater awareness of the needs of children is developed within that model which leads to more interrelationship with those children's services that have developed an expertise in suicide bereavement, or possibly even the purposeful setting up of a service for children within the overall service. Bereaved children live in families where adults have also been bereaved and the wellbeing of the child is linked to the wellbeing of their carers, it therefore makes sense that support following a suicide should be a family intervention. The Mayo Suicide Liaison Project is an example of how Family Centres could be used to good effect by providing a family friendly venue for meeting children and their parents, while providing a supportive environment for liaison workers, and access for children to child specialists and support groups.

Research is clear that experiencing a death by suicide when you are a child can impact negatively both throughout childhood and in adulthood. Children need support after experiencing a suicide and are still the 'forgotten mourners'. They don't all need counselling but they do benefit enormously from:

- Honest and open information sharing, including knowing that the person died by suicide.
- Opportunities to think and talk about the person who died.
- The chance to ask questions and make sense of what has happened when someone has taken their own life.
- Psycho education around thoughts and feelings that are a normal reaction to death, and suicide in particular, and the responses of those around them.
- Opportunities to express how they feel, which may be complex and difficult to verbalize.

'Postvention is prevention for the next generation'. [10] (Shneidman 1972)

Learning Points and Recommendations

I hope the following learning points and recommendations will add to the increasing body of knowledge and determination among many in the UK to provide a better service for families who have been bereaved by suicide. In particular I hope that children who have experienced such a devastating bereavement in their formative years will meet people who understand their needs and are able to help them articulate and express them.

1. Support for families bereaved by suicide has developed most effectively where those in government have recognized the need and taken a lead in committing to the reduction of suicide, backed up with funding appropriate to the task. The recent Suicide Prevention Strategy for England now includes the need to 'provide better information and support to those bereaved or affected by suicide'. It is important the government commits to achieving this by supporting partnerships that are evidence based and professionally run with proper funding, while at the same time holding them accountable for the work they do. There is a growing body of evidence to show that this makes sense economically, and not only saves lives but also money.

2. When developing postvention services in the UK we need to try and get a balance between large scale facilitation, which can coordinate services at the national level but will be less responsive to local needs, less personal and more bureaucratic; and small scale direct work, which can provide very good practice, expert knowledge and a high level of satisfaction for both those who receive and deliver services, but which find it hard to attract funding or offer services over a wide geographical area.

3. Partnerships need to be developed between coroners and postvention services that allow for referrals to be made to services by coroners, with consent, on the understanding that immediately after a suicide families benefit most from a proactive response.

4. Services for the prevention of suicide and support after suicide are gradually being coordinated and strengthened in the UK through the coming together of different working partnerships, some in local areas and some nationally. Decisions need to be made on finding models of working that are most effective in our own circumstances in the UK.

5. As the provision of support after suicide in the UK is developed it is vital that the partnerships of organizations involved have clarity around the models that evolve from their collaboration, with clear theoretical underpinning, evidence for the efficacy of the model from pilots or other examples, and hold fast to best clinical practice as far as possible.

6. As a result of my visits to a large number of different organizations I am now convinced that in developing services that support people after a suicide in the UK we need to work towards more interaction between adult and children's services, so that the learning embedded in children's bereavement services can be utilized by those supporting adults, to the benefit of the many children who may be part of those families but not receiving a service in their own right. The partnership between Victim Support Homicide Service and

Third Sector organizations in the UK that provide direct therapeutic support to children is a good example.

7. A way forward for support after suicide may be the development of a model such as the Community Postvention Response Model, which could be replicated in different regions and works alongside those communities that experience suicides. These response models need to have a defined way to call on the services and expertise of those who have most experience in the area of supporting children after a suicide.

8. In the UK we should work towards a strong connection between research and practice. I believe the interrelationship between research and practice, especially in Australia, with movement in both directions, has greatly helped practice to be grounded in research, and research to be based in practice, and has given credibility to both. Governments can therefore be convinced of the importance of funding research that leads into the development of services that are effective, and the efficacy of funding practice that is evidenced by research.

9. It is important therefore for suicide related research to be supported in universities and for this research to be translated into practice.

Acknowledgements

I would like to thank:

The Winston Churchill Memorial Trust, for offering me the opportunity to learn from best practice in other countries and for their support at all times.

Previous Churchill Fellows who encouraged me to apply for a Fellowship.

Those in the UK who offered support, information and encouragement.

The individuals I met in Australia, New Zealand and Ireland, who generously shared their work, enthusiasm, expertise and often hospitality.

My family, for their unfailing encouragement and support from beginning to end.

Australia

Jill Fisher: National StandBy Response Service, Tewantin

Danny Nugus: Dept of Forensic Medicine, Newcastle

Robyn Lawrence: Lifeline, Newcastle

Jaela Skehan: Hunter Institute of Mental Health, Newcastle

Liz Mann: National Centre for Childhood Grief, Sydney

Diana Sands: Bereaved by Suicide Services, Sydney

Karl Andreissen: Black Dog Institute, Sydney

Wendy Howard: Australian Centre for Grief and Bereavement, Melbourne

Louise Flynn: Jesuit Social Services Support after Suicide, Melbourne

Gabriel Baldwin: Headspace, Melbourne

New Zealand

Lois Tonkin: Bereavement Counsellor and Educator, Christchurch

Aileen Davidson and Jenny McIntosh: Skylight, Wellington

Jennie Jones: Regional Suicide Postvention Coordinator, Wellington

Chris Bowden: Victoria University of Wellington

Donna Fitzgibbon: Victim Support, Auckland

Trudie Vos: The Grief Centre, Auckland

Mark Wilson: Solace Support Group, Auckland

Ireland

Mary Lynch and Gina Cantillon: Barnados Children's Bereavement Service Dublin and Cork

Sinead Raftery and Bernie Carroll: Suicide Bereavement Liaison Officers for Roscommon and Living LInks

Maire Ni Dhomhnaill: Mayo Suicide Bereavement Liaison Project

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[5] The Australian of the year award represents a celebration of outstanding achievement, the criteria being:
- Demonstrated excellence in their field
- Significant contribution to the Australian community and nation
- An inspirational role model for the Australian community

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[9] Castlebar News, June 2013. (Ken Wright Photography)

[10] Sneidman, E. in ' *Survivors of Suicide'* by Cain, A.C. (p. X)

Appendices

Appendix A

The Grief Centre. New Zealand

The model used by The Grief Centre is to contract counsellors to work directly with families. Local funeral services have a contract with The Grief Centre which includes one session of counselling. This would be a good model to replicate in the UK as it would mean that every family that uses the Funeral Service would have at least one opportunity to reflect on the impact of the death. Support is mainly for adults and occasionally for young people. Trudie Vos, manager of The Grief Centre, said she has had a lot of calls about children but finds it difficult to find support for them. There is also demand for groups, but Trudie said it is difficult to run these because of numbers, geography and time.

Appendix B

Bereaved by Suicide Services – Group work funded by the Salvation Army

Diana Sands, educator and researcher, wrote her PhD on meaning making and adult experiences after suicide. She was funded by The Salvation Army to run groups for children bereaved by suicide. Out of that came the development of the Red Chocolate Elephant book and DVD which gave a platform to children bereaved by suicide to share their thoughts, feelings and questions. The children who attended the groups also wanted to give something to other children who couldn't attend. The DVD is a powerful way for adults who may feel unsure in their support of a bereaved child to hear how open children can be about the subject.

Appendix C

Suicide Liaison Bereavement Officers in Ireland

While in Ireland I was able to meet with two other suicide Liaison Officers, Sinead Raftery, who is based at a Family Centre, as is the Mayo Project, and Bernie Carroll, who is funded by HSE National Office of Suicide Prevention through Living Links. They were quite new in their posts and during my meeting with them it was clear that the roll out of the learning from the Mayo Project has not been able to replicate its scope and clear organization. Each Suicide Liaison Officer is funded differently for very limited hours, meaning they have to primarily be facilitators, although Bernie is able to offer individual sessions and Sinead runs a monthly suicide bereavement group. Both felt that the service was very fragmented, with a need to develop a protocol for first responders. Like the Mayo Project Sinead is able to access support for both adults and children from the Family Centre where she works. Bernie explained that Living Links is in a state of flux, which may explain why I was unable to make contact with any other Liaison Officer advertised on their website, so they may find it difficult to attain their aim of providing a support service which covers most of Ireland.

Appendix D

Lois Tonkin – Bereavement Counsellor and Educator. New Zealand

Lois had been involved with the Christchurch Suicide Project, together with Annette Beautrais and Prof. David Fergusson of Otago University, both of whom were the principal authors of New Zealand's Suicide Prevention Strategy 2006-2016.

Lois echoed what I heard time and again, that there was no political commitment to active postvention in New Zealand. The Christchurch Suicide Project was another good initiative that came to an end because of lack of funding, and demoralization among staff. The project looked primarily at suicidal behaviour risk factors, but also at family experiences of bereavement following suicide. The Ministry of Education does send out teams to support a school after a suicide, but this does not extend to individual support for bereaved families.

Lois said that everyone with an interest in postvention was waiting to see what might happen now the Suicide Prevention Strategy was due for renewal. I also heard this from others I spoke to. (Currently a draft document is out for public consultation: 'A strategy to Prevent Suicide in New Zealand'. This consultation has now closed).