



Leeds Suicide Bereavement Service Evaluation Report

**Professor Steve Robertson
Dr Mark Robinson
Sarah Patrick**

Contact:

Professor Steve Robertson
Calverley Building
City Campus
Leeds Beckett University
Leeds
LS1 3HE

Email: s.s.robertson@leedsbeckett.ac.uk
Tel: 0113 8124359

Contents

Executive Summary	3
Introduction	6
Background	6
Evaluation approach	8
Findings	9
1. Service User Experiences	9
1.1 Experiences prior to engagement with LSBS:	10
1.2 Processes of engaging with LSBS:	11
1.3 The journey within LSBS:.....	14
1.4 Outcomes from involvement with LSBS.....	19
1.5 Suggested changes to LSBS	20
2. Stakeholders considerations	21
2.1 Drivers for the programme	21
2.2 Needs of service users	21
2.3 Strengths and challenges of the service for the users	22
2.4 Expectations of the service from the frontline staff, managers and commissioner.....	24
2.5 Enabling factors for the programme and the frontline staff	24
2.6 Structural issues for frontline service delivery	25
2.7 A flexible pathway.....	27
2.8 Structural strengths – linkages with the wider environment	28
2.9 Wider challenges.....	29
2.10 Gender	30
2.11 Evidencing of success.....	30
3. Integrated findings and key considerations.....	32
3.1 The importance of the work	32
3.2 The approach taken	33
3.3 The qualities of LSBS staff	34
3.4 Setting and branding.....	34
3.5 Gender within LSBS.....	35
3.6 The success of LSBS.....	36
References	37

Executive Summary

The project

Mental health and suicide remain a major cause of concern. Suicide is known to have a significant impact on the mental health and wellbeing of those bereaved including placing them at increased risk of suicide. Furthermore, suicide bereavement has been shown to have some specific characteristics and to have a greater impact on mental health and wellbeing, including the risk of suicide, than other forms of bereavement. Given the importance and significance of this impact, previous work has been undertaken nationally and internationally to support those bereaved by suicide and this shows positive results on various outcome measures. However, a gap has also been previously identified between the need and desire for such support and its availability. The Leeds Suicide Bereavement Service was established in June 2015 in recognition of this need and to help fill this gap.

The evaluation

Leeds Beckett University conducted an independent evaluation of the LSBS programme. The research team aims were to consider: what people value about the service; the quality of support; the benefits of peer support; the impact on the person using the service (including their views on taking their own life); benefits to relationships for people receiving the service; how the service could be improved.

The methodology

The evaluation collected qualitative evidence in two ways:

- 1) *Interviews with key stakeholders* - We completed nine semi-structured interviews with people closely involved with the project including: those delivering various strands of the LSBS pathway; those in external organisations that clients are signposted to; those who may be recommending clients to self-refer.
- 2) *Interviews with people who have engaged with the service* – We completed fifteen interviews with people who have engaged with various strands of the LSBS. We ensured a diverse sample of participants were obtained in terms of representation by: age, gender, type of service pathway pursued.

Both of the above data sets were analysed independently using a thematic analysis framework (Braun & Clarke, 2006) and were then integrated to provide a complete overview in relation to the evaluation aims.

Key findings

The importance of the work

- The need for this service was clearly affirmed. People had been significantly affected by their bereavement prior to engaging with LSBS and this impact was not only emotional but also restricted their ability to function fully in daily life (including in employment and civic engagement).
- The impact of bereavement affected the relationships – partners, family, friends, colleagues - of those bereaved and therefore had a ripple effect well beyond the impact on the individuals concerned.

The approach taken

- The approach taken by all within LSBS emerged as one of its core strengths and the essential elements of this revolved around diversity and flexibility. Open and diverse routes into LSBS were important in meeting the needs of people at different points in their suicide bereavement journey. Frontline staff's ability to make rapid initial contact was imperative in engaging people quickly when they sought help thereby seizing a timely opportunity that could otherwise be missed.
- The flexibility of pathways offered helped meet the variety of differing personal needs: it was clear that a one-size-fits-all service could not meet this range of needs.
- The willingness of all involved in LSBS to be reflexive about whether it was meeting the needs of those it aimed to engage meant it had been adaptable shifting aspects of the work since inception and this was critical to its success.

The qualities of LSBS staff

- The qualities of LSBS staff reflect the values and ethos of the approach and are the frontline expression of this as experienced by the service users. These qualities consist of important emotional attributes (most notably compassion and empathic listening that generate trust and safety) alongside professional attributes (most notably significant knowledge and skills in managing people and groups).
- To achieve the necessary level of these qualities required not only professional training but also personal experience of suicide bereavement. To fully empathise, understand and therefore work effectively with those bereaved by suicide, direct personal experience was seen as vital in being able to identify and adapt flexibly to meet this groups specific needs.

Setting and branding

- There was widespread recognition that mental health still carried some stigma and that the delivery and location of services within mental health organisations may therefore be off-putting to some.
- The split base setting presented difficulties for: communication: coordinating service delivery; dilemmas around possible differences of organisational culture; and challenges of access for service users.

Gender within LSBS

- There was some evidence that LSBS was fundamentally 'feminised', consisting primarily of female staff on the frontline and of those who commissioned, developed and manage LSBS. This can create an impression of a service welcoming to women but perhaps off-putting for men.
- There was strong indication (particularly amongst male service users) for a preference for female workers especially at initial engagement. This was linked to gender stereotypes that females 'naturally' possess greater ability for compassion and empathic listening.
- A possible need/role for male workers was highlighted. This related to the need for choice to be available, but was also linked to developing different approaches, particularly in the longer-term group context, that were more male-sensitive or appropriate.

The success of LSBS

- There is powerful evidence that LSBS made significant differences to those involved and that these changes often seemed sequential. They started with a safe space to talk

about previously suppressed thoughts/feelings. Empathic understanding then helped validate, normalise, and reorient thoughts/feelings re-establishing confidence. Finally, enhanced coping mechanisms emerged that improved relationships and functioning in areas such as employment, education and civic engagement.

- People moved backwards and forwards through these elements but the strong impression is of forward movement toward 'recovery' into a healthier mental state and daily functioning.
- Whilst this evaluation did not measure the economic impact of these changes, we are confident that, given the degree of distress prior to LSBS involvement, and the powerful accounts of the change reported, that there would likely be a reduction in use of other services as well as economic advantages from improved daily functioning.

Future considerations

- Given the high demand for the service, and plans to obtain earlier referral into the service following bereavement, ensuring adequate resourcing, including innovative low-cost approaches, need to be explored to safeguard sustainability.
- Data here suggest early engagement may need to focus on the one-to-one offer: many people are first engaging when they need personal input to stabilise their emotional state and hearing others' experiences at this time could add to their distress.
- Whilst one-to-one work should be a priority, all options should remain available as some are specifically motivated to engage because of the connections that come through the groups that help normalise their own thoughts and feelings.
- Possible routes on from the one-to-one sessions seem difficult to negotiate and further consideration may be required about movement between different aspects of LSBS.
- All (not some) staff should have sufficient training relating specifically to suicide bereavement to more fully understand the complex emotional and psychological needs of this group.
- Ensuring adequate personal support for frontline staff requires a clearer distinction between line management and clinical supervision/support. An increase in the latter could help ensure staff's own needs are being met allowing them to safely maintain the high level of service they are currently providing.
- The planned co-location of the frontline staff will be a major step, especially if in an environment which reduces isolation and can reframe/minimise the 'mental health' branding.
- Further thought should be given to whether or not it would be more effective in the longer term to have one organisation take overall responsibility for delivering the service.
- Ways to address the structural embedding of gender within LSBS should be considered. This may mean including more men on the steering group or incorporating high quality male service user input across aspects of service development and delivery.
- Further work exploring the issue of gender in initial/early engagement and in ascertaining if/how service users in similar suicide bereavement projects have experienced the qualities that male staff involved in initial engagement bring, would be of value.
- Longer term work with male service users could benefit from group work approaches, possibly led by a male worker, that are more 'activity' focused than 'talking' focused.
- It was apparent that it is difficult to demonstrate evidence of longer term success, particularly in relation to reductions in suicide, without sustained funding. It may be useful going forward to undertake a social return on investment (SROI) analysis of the work to demonstrate more objectively the economic and social value of the changes reported.

Introduction

Mental health and suicide remain a major cause of concern generally and for men's health specifically in the UK (Robertson & Baker, 2016). It is the leading cause of death in those aged 20-34yrs and remains the leading cause of death for men in the 35-49yr age group (ONS, 2015). Suicide is known to have a significant impact on those bereaved. A review of studies on the impact of suicide shows that those bereaved are at an increased risk of suicide themselves and also at significant risk of admission to psychiatric care and increased risk of depression (Pitman et al, 2014). These impacts on mental wellbeing and suicidal intent have been shown to be greater in suicide bereavement than in other forms of bereavement (Tal et al, 2017). The complicated grief experienced by those bereaved by suicide has specific features compared to other forms of bereavement most notably the experience of failure; the impact of stigma; the search for an explanation; the impact on social networks and family relationships; and the increased risk of suicide (Flynn, 2009). Pitman et al (2014) similarly suggest there is some evidence of feelings of rejection and shame across kinship groups for those bereaved by suicide. The work of Begley & Quayle (2007) also demonstrates the shame, stigma and self-blame that can be experienced by those bereaved by suicide.

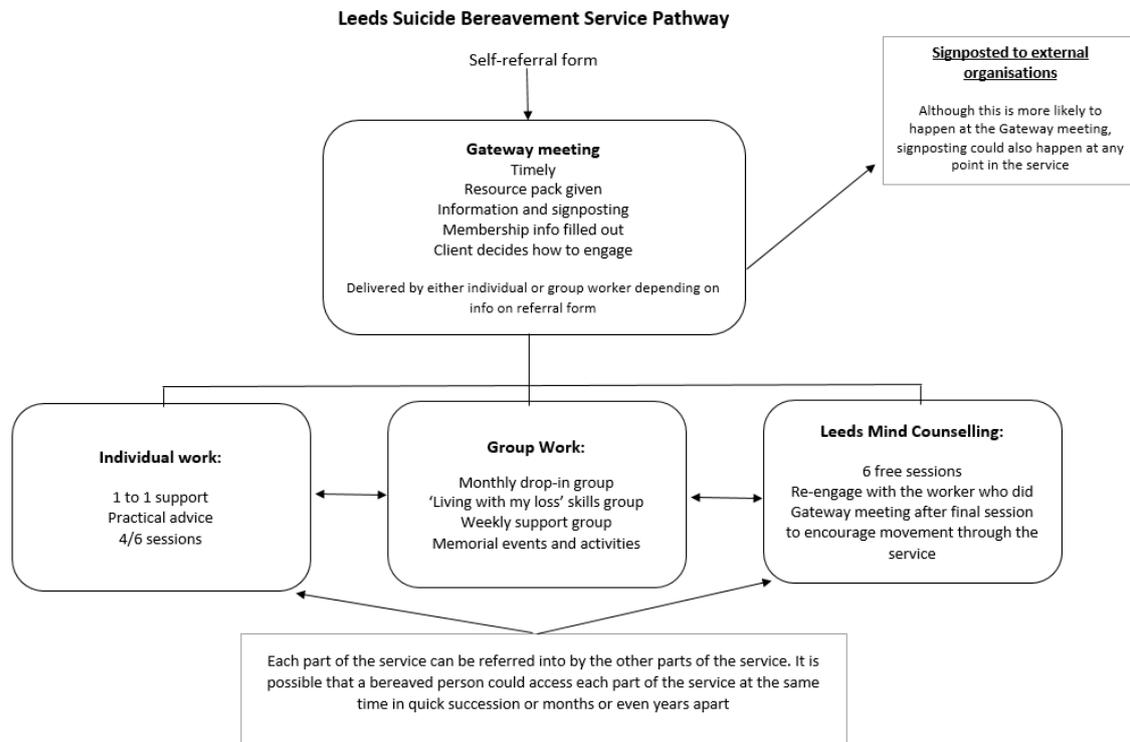
Given the importance and significance of this impact, work has been undertaken to support those bereaved by suicide. Research with those attending a psycho-educational support group in Australia outlined a range of positive experiences including an improved sense of self and improved relationships (Groos & Shakespeare-Finch, 2012). Similarly, work evaluating a suicide bereavement peer support service in Canada demonstrated positive outcomes for both the peer supporters and those using the service (Barlow et al, 2010). It further supported an intervention approach where peer supporters and professionals worked collaboratively to offer cost-effective, client-centred services. Despite such provision, further research in Australia shows that whilst the majority (94%) of those bereaved by suicide expressed a desire for support, less than half (44%) received support and felt satisfied with it thereby concluding there is a gap between the need *for* and provision *of* such support (Wilson & Marshall, 2010).

The importance of this impact and need for quality provision for those bereaved by suicide was recognised within Leeds.

Background

In response to this situation locally, a suicide bereavement service has been set up to meet the previously unmet needs of those bereaved by suicide within Leeds offering evidence-based support and interventions; including peer support, specific suicide bereavement services and outreach work with associated supporting agencies. The service, Leeds Suicide Bereavement Service (LSBS), began in June 2015 having been commissioned by Leeds City Council. It is delivered jointly by Leeds Mind and Leeds Survivor Led Crisis Service with Leeds Mind being the leading contract provider. The work of the service consists of several elements: individual work; group work; Leeds Mind counselling. The referral pathways, and how these elements link, are outlined below:

Figure 1. The LSBS Pathway



The service is commissioned to achieve the following for those it engages:

- Increased ability to use coping strategies for day to day life including maintaining meaningful relationships.
- Reduced social isolation.
- Reduce suicidal thought.
- Reduce self-harm including substance use.
- People accessing the service will be more equipped to deal with feelings related to death and grief (death from suicide).
- Increased ability to access resources and support offered locally and help identify their own needs.
- Ability to maintain positive functioning family relationships.
- The “No Health Without Mental Health Outcomes “ need to be incorporated fully
 - More people will have good mental health
 - More people with mental health problems will recover
 - More people with mental health problems will have good physical health

- More people will have a positive experience of care and support
- Fewer people will suffer avoidable harm
- Fewer people will experience stigma and discrimination

Working together, the commissioners and those delivering the service have already set in place systems for collecting information and data to evidence these. However, they recognise that they are now looking to gather further evidence about the following:

1. What people value about the service (both users and partners in the city).
2. The quality of support.
3. Economic inclusion – i.e. can the service demonstrate how it has helped support those bereaved to stay in work / be a carer / not fall into debt.
4. Demonstrate the benefits of Peer Support, plus the one-to-one face to face work.
5. Has the service the adult individual received directly benefitted any children in the family around their loss etc.
6. Explore some of the themes of grief and loss. “What impact losing someone from suicide has had on you and your family? What are your views on taking your own life (now)?”
7. How could the service be improved?

These seven points constitute the basis of this current evaluation tender. We outline the specific work we would intend to complete to help meet these below.

Evaluation approach

As mentioned, this evaluation aimed to complement and add to the data already being collected by those delivering the services. Given the extent of the seven points noted above, and the limitations of available resource for the evaluation, an approach to data gathering took place across two phases that provided both range and depth of information on these issues¹.

- 1) *Phase I - Interviews with key stakeholders* – We completed 9 semi-structured interviews with people closely involved with the project. The interviews lasted 30-60 minutes and were completed either face-to-face or by telephone. We worked with the commissioners and service deliverers to identify the people best placed to complete these interviews and they included, amongst others: those delivering the various strands of the LSBS pathway; those in external organisations that clients are

¹ It is important to note that within the cost envelope it was not possible to complete any sort of economic analysis that might be suggested by point three, ‘economic inclusion’. Some self-reported data relating to this is mentioned though.

signposted to; those who may be recommending clients to self-refer. The interview guide for this phase was designed specifically to gather information on **points 1, 3, 4, 5, 7**. The interviews were carried out November 2016 – April 2017

- 2) *Phase II - Interviews with people who have engaged with the service* – We completed fifteen semi-structured, in-depth interviews with people who have engaged with the LSBS services. The majority, thirteen, of these were face-to-face and two by telephone at the participants' request. These interviews lasted 30-60 minutes. We ensured a diverse sample of participants were obtained in terms of representation by: age (though all over 18yrs old), gender, type of service pathway pursued (individual work, group work, counselling). These interviews were designed specifically to gather information on **points 1-7**. The interviews were carried out December 2016 - May 2017.

Data analysis – Both of the above phases was individually analysed using the Braun & Clarke (2006) thematic analysis framework (which involves a process of coding, categorising and subsequently clustering codes and categories into themes). Two team members independently completed initial coding of three of the same interview transcripts in each phase. Following this, all three team members came together to reach collaborative agreement on these codes and to develop an agreed coding framework. The remaining interviews were then coded into this coding framework, which was amended slightly as additional data was incorporated. Separate themes were then developed for each of the two phases. Finally, the evaluation lead investigator integrated these two sets of data to provide a complete overview in relation to the evaluation aims.

Findings

To help maintain anonymity throughout the findings no names or demographic details of participants are provided, though certain demographic characteristics (such as gender of services users and role of stakeholder participants) are mentioned at times in the presentation of the findings to elucidate particular points. Instead, participants are identified by a code - using 'SH' for stakeholders and 'SU' for service users - and a number indicating the order in which they consented to participate (e.g SH3 would be the third stakeholder who agreed to participate, SU9 would be the ninth service user to agree to participate etc). Whilst this may seem depersonalising it is important as one of the steps in helping maintain anonymity, particularly for the services users.

1. Service User Experiences

Within this section the experiences of those who have used LSBS services, and how they relate to the evaluation aims, are presented as a journey into and through the LSBS services. We begin by considering experiences prior to engagement, then the experiences of engaging itself, before considering their involvement and views of using LSBS services (including thoughts on the qualities and attributes of LSBS staff) and then how it impacted life 'beyond' engagement with LSBS. The section finishes with participants' thoughts on if/how the LSBS service might be improved. It will become clear throughout this section that

this journey is often not straight-forward and people move into and out of, and backwards and forwards, along this pathway and therefore may engage/re-engage several times.

1.1 Experiences prior to engagement with LSBS:

To understand how far people have travelled within their bereavement journey requires an understanding of where they start from. The depths of people's practical and emotional difficulties prior to engagement with LSBS were, not surprisingly, significant. On a practical level people generally described themselves as 'struggling' as one participant puts it:

"It made everything a struggle, I would quite often just focus on surviving [...] and it's hard to do your work. I'm an [job role] so I have to be really focused on what I do. With the bad memories, just a mention of anything to do with it and I would cry straight-away." [SU4]

This notion of 'struggling', this difficulty in engaging in everyday life, perhaps underplays the range of powerful emotional experiences that generate this state. For many there was an externally recognisable appearance of 'devastation' [SU10], of the 'world stopping' [SU5], of being 'in an absolute state' [SU8] or of 'going mad' [SU4]. However, it was also, simultaneously, a private and internalised experience that was very isolating. Many described themselves as having a 'void' [SU2], being 'numb' [SU6] or of their brain 'shutting down' [SU8] or their head feeling 'heavy' and 'weighed down' [SU7]. All this was wrapped in feelings of being disconnected, aimless and alone:

"You are in a place you don't understand you're lost. You know, you feel lost. You are lost!" [SU5]

These feelings could readily become even more extreme being described as "...going into the pits of hell and darkness" [SU5] and five of the participants explicitly spoke about suicidal thoughts during these times:

"You see I was really struggling and was very suicidal and just not coping at all." [SU2]

"One of the fears I have is that I might go and choose to commit suicide myself because I am so miserable." [SU11]

Some had tried to control these internalised emotions by 'hiding it' [SU3] or 'keeping it all in' [SU7]:

"I kind of pushed it away and thought I'd dealt with it [...] It was like tiptoeing around a big hole and not wanting to look in there." [SU4]

Collectively, these practical and emotional concerns not only took their toll on people's ability to function in daily life but were associated with other feelings of 'guilt/shame' [SU1] and 'anger' [SU4] that were influenced by, and influenced, their relationships with others. Many had experienced difficulties in their communication and relationships with friends, family and work colleagues. This included others trying but not knowing how to act around them:

"The staff [at work] were nice and were trying to help but they didn't seem to get it and wouldn't really know what to say [...] There's this feeling like I should have got over it by now from people around me" [SU2]

It also included communication issues stemming from not wanting to impose on family or friends:

“There were people around to support me, family and friends. But there is only so long that people can... so long that people are able to give you their time and that support.” [SU12]

“You hold it in for other people. You think I don’t want to bother other people with my grief.” [SU14]

But this was a two-way process, with others not knowing how to relate to the bereaved person as this same participant goes onto add:

“And people will, like, put you at arms length... I see it as they put me at arms length but they may see it as giving you some space.” [SU14]

Indeed, many participants had experienced permanently lost or damaged relationships as a result of struggling with the bereavement:

“I had one friend in particular, I only saw him at the funeral and I don’t think I’ve ever seen him since and we were really good friends and that really shocked me because I thought he’d be around a bit more as support. Perhaps he just couldn’t cope with it.” [SU3]

“I’d been lonely, very, very lonely. My boyfriend at the time (we’re not together anymore), because of my grieving, was really struggling. He didn’t know what to do, say, or anything.” [SU14]

These negative experiences were not restricted to family, friends or work colleagues but also included damaging experiences during previous attempts at getting more formal support.

“A vicar came round two weeks in a row and both times he fell asleep in the chair and on the second time I asked him to get up and leave, it was an insult [...] As I say, he came and I was talking, I just turned around and he was fast asleep. He said ‘I’m sorry’ I said ‘not as sorry as I am, you can’t do your job, you’re insulting’.” [SU5]

“I had one experience with [another organisation] and I never went back. We were talking about something to do with our loss and I’d said I feel this way and the group leader just shut down what I was saying, just dismissed it.” [SU1]

1.2 Processes of engaging with LSBS:

At the point of engaging with services people were in various stages not only in terms of the time since the bereavement but, perhaps more importantly, their emotional state. Those describing themselves previously as in ‘an absolute state’, ‘devastated’ etc were really coming at a point of crisis and there was a feeling of being willing to try anything as they had not previously found sufficient help and support through other formal or informal networks:

“I just wanted something, anything, to make me feel better. I was so low I didn’t think anything was going to work and I would have tried anything at that moment in time.” [SU8]

“With the situation as it was there is not much to lose.” [SU15]

For others, desire for engagement with the service came from recognition that there were longer term, unresolved, emotional issues having an impact on their lives that would benefit from attention and consideration:

“You know, I have all these unanswered questions but there’s nothing you can say but I suppose you can acknowledge it, you can hopefully learn to acknowledge it.” [SU3]

“You keep asking the question ‘why, what did I miss, did I miss something’. And you kind of go through your life like that.” [SU5]

People found out about the LSBS services from several sources illustrating the importance of having an open approach to entry into the LSBS service and initial gateway meeting. For some it was word of mouth [SU1; SU12], others found it online [SU15], and some through public events that LSBS had a presence at [SU9; SU14]. The majority though came via other services, primarily the GP’s [SU3; SU7; SU8; SU10; SU11] and various mental health support services [SU2; SU5; SU6; SU9; SU10; SU13] – though it was unclear whether these are formal referrals or informal signposting.

An important aspect that stood out following participants’ initial approach to LSBS was the speed with which the service responded. This was mentioned spontaneously by almost all fifteen people interviewed:

“Many people would have to go to the GP, go on a waiting list and it’s a daunting process. Here, you can ring them, and you can see someone pretty much straight-away. It gives great comfort and really great confidence. I’m just very, very grateful.” [SU4]

This speed and ease of engagement is not just a nice convenience though; it can be important in terms of meeting people at a crucial stage of their journey so that timely opportunities to gain significant support are not missed:

“It was quick [contact from LSBS], but, at the time, that was great because I think I would have talked myself out of it if it hadn’t been as quick as that.” [SU8]

This links to another important point made: reservations about engaging. These reservations were varied, again reflecting the differing emotional places that people were at this point in the journey but also reflecting people’s prior life experiences. For some, there was concern that, as bereavement affects several members of a family or of friendship circles they were reticent to engage in the group aspect of LSBS in case they met people they knew. For those who accessed at a point of desperation, there was a fear of possible failure, a ‘what if it does not work?’ fear that arose when LSBS was perceived as their last hope:

“It is like a last ditch kind of thing, these people are like the experts and if they can’t help then that’s quite scary!” [SU2]

For the majority though, reservations and fear related primarily to their emotional safety and vulnerability when opening up emotionally.

“I had a slight feeling of dread, thinking this could rake up a lot of things that might not be pleasant or I might not be able to deal with. That was the fear. It wasn’t strong enough to stop me but it was there.” [SU13]

For many, this vulnerability was spoken about in terms of reservations about engaging with others in group aspects of LSBS:

“I felt it was too early [the group] because it was the first time I was coming out saying a lot of things I’ve never said before. I didn’t feel safe enough to tell it to a group. It was hard enough to say it to one person. Maybe later it would be easier but not at first.” [SU4]

“I find it quite hard talking to people about personal things so doing a group, at the time, filled me with dread [...] at the time I didn’t want to be around people at all.” [SU8]

Part of the issue here also involved a fear that hearing and sharing other people’s experiences and emotions might make things worse:

“I’m not great with groups, and the idea of being in a room full of people that were really struggling as well, I thought that might make things worse.” [SU2]

However, it should be noted that these views were only expressed by those who had not engaged in the groups and therefore should not be taken as a reflection on how those who did engage with the groups experienced them: indeed, both those who engaged in the individual work and those who engaged in the group work were equally effusive in their praise of LSBS. Additionally, for a smaller number of people, thoughts about sharing experiences with peers was a strong motivating factor for becoming engaged with LSBS and specifically with the group aspect:

“The group aspect was important, it was about hearing people’s stories, sharing experiences, hoping to find... not answers but things that had worked for them when they’d got stuck. It definitely helped me engage with old memories and unpick a few behaviours and see other people felt like that as well.” [SU1]

These differing, and often contradictory, ideas about what motivates or hinders begins to show the importance of having a flexible service that can engage people in different ways and at different stages of their journey.

1.2.1 The importance of a mental health/crisis service setting:

One issue given special consideration in the evaluation was that of the delivery of LSBS within a mental health/crisis service setting and the possible impact of this. Views on this were not straight-forward and generally reflected the diverse prior experiences of those interviewed. Some saw no difficulties, and even possible advantages, of LSBS being placed within the wider mental health service provision because a) it is a logical place for something (suicide bereavement) that obviously impacts mental wellbeing b) these services are already known to them c) a state of desperation means it does not matter where services are situated and d) it is useful if further sign-posting into on-going support is required:

“I guess because I know mental health services, having been through loads, it seemed kind of normal, it just made sense [...] Bereavement has a massive impact on your mental health so it makes sense that it’s mental health services that are running it. Also, there is that knowledge there that if you are really struggling they can signpost sort of thing.” [SU2]

“It’s hard for me to judge because I’m around that kind of service [...] For me it just feels like a crisis service that is able to provide help in a lot of different crises and not particularly labelling you with a mental health problem [...] I it is quite a fitting setting for it because there will be a lot of people in that environment [mental health/crisis service setting] that have suffered loss by suicide.” [SU12]

Yet, even for those that it was not a problem for personally recognised that it might be for others:

“It is not an issue for me because I’m happy to go to mental health services. I guess it would be an issue for some people. I am aware that there is an issue, I can see that, but for me it wasn’t a problem.” [SU6]

This was primarily linked to the stigma related to mental health issues and also to some of the negative experiences of mental health services themselves:

“I think the title [mental health] will always put people off... but I don't think there was anything the project did that would put people off, it seemed like it bent over backwards not to put people off.” [SU13]

“I don't think it helps [sitting in a mental health/crisis service setting]. Yeah, because of the stigma, I mean the stigma I've had all through my life.” [SU7]

“It can be difficult [sitting in a mental health/crisis service setting] because a lot of people have had some run-in with mental health services, a lot have been let down which makes it very difficult when this service is just under these two kinds of services.” [SU1]

Whilst views varied then, there remained an overarching perception that, for many, situating LSBS services within a mental health/crisis service setting, or under a mental health umbrella name or brand could be off-putting and problematic.

Having considered people's experiences prior to engagement and their experiences of engaging we now turn to their experiences once engaged within LSBS.

1.3 The journey within LSBS:

It was clear that once engaged with LSBS people's diverse needs were met in various ways highlighting the importance of the different pathways available within LSBS. Given the amount of practical disruption and associated strength of emotions described earlier, many participants commented about how LSBS helped them address or cope with these. One participant summed this up well:

“It's [LSBS] a piece of driftwood to cling to I suppose. It stops you falling under altogether so you can float down life a bit without struggling.” [SU3]

For others it was *“like a weight had been lifted off my shoulders.” [SU10]*. There was a huge relief felt by almost all the participants with LSBS providing a safe place where they finally felt free to talk:

“I went to this service and people were talking to me and it was a shock, a real, real shock. I needed it because I just off-loaded, I think the minute you can talk about your bereavement you probably will. It will be like verbal diarrhoea, if you're given the opportunity it'll just run like a tap.” [SU14]

“As soon as everything started I couldn't stop talking then because it felt so nice. Nice is a strange word, but just to be able to say everything that's been on my mind and just to get it all out... So literally, just from those two hours it made a massive difference.” [SU10]

This safe place to open up and off-load helped people work through a range of emotions and prior questions creating a greater sense of stability by normalising their experiences:

“The main thing I got out of it was that what I was going through was normal, a normal way to react, and that helped me work through my thoughts and feelings and organise my thoughts and organise everything in my head a little bit easier [...] Just being able to talk to someone, vent a little and also answer questions I didn't know the answer to

myself. It wasn't that she [LSBS worker] answered the questions, it was that having a conversation about it helped me to answer the questions myself." [SU8]

"It helped me process a lot of emotions I wouldn't have been able to process without it [...] It helped me engage, I would go so far as to say it helped me get through a really bad [suicidal thoughts] time basically, it was what I needed." [SU9]

Practically, one of the most important aspects within LSBS highlighted by the participants was flexibility. Most seemed quite clear about the aspect of the service (which pathway) they wanted to be involved with but also appreciated that people come at different times and from different places in their journey and deal with things differently:

"The flexibility is good because other people may feel very uncomfortable on their own with somebody on a one-to-one, they may prefer to meet with half a dozen other people or whatever, you know. We're all different." [SU3]

"I didn't feel that the led [group] sessions provided me with the most benefit. I think being in a room with people who will listen and not judge was the key thing for me. I was looking for things like that rather than to have a programme of theory... but some people did like that." [SU11]

Options in terms of timing, venue and style of working were also important for some:

"They were really accommodating as well. Like [LSBS worker] would come to my house, she asked where I wanted to meet and [LSBS venue] was really quite hard for me to get to [...] She's given me loads of options, when to come, where to come, how to work." [SU4]

One of the most important aspects of flexibility described was that of being able to come back to the service and/or to hear from the LSBS staff at key points that might reignite previous emotions (such as Christmas etc). The recognition of an 'on-going' element of support was therefore seen as very significant:

"She's [LSBS worker] still in touch with me and will send leaflets and things if there's anything of interest, a group meeting or anything like that. So even after it stopped [the individual sessions] she's kind of still looking out for me. It feels good, really, really good because it makes you feel you can always go back and get some help if you need it. They're not going to run away, or say 'sod off' because you've been through [the LSBS service] and it's done. They are still there and will always listen." [SU4]

"I don't think I looked after my wellbeing as much during that time. I let things slip. They were very happy I got back in touch and said it would be possible to have a few more sessions because I think six are available and I hadn't used all six. So they were very happy to allow me to do that." [SU12]

"I feel a bit better in myself now, just to go to something that's drop-in and whenever I feel like I want to speak about it. So I can just go whenever I feel like I need to speak about it." [SU10]

Variety in terms of what was available, flexibility in the use of these, and opportunity to engage with differing parts of LSBS provision were then seen as essential to those using the services in terms of it being best able to meet their needs.

1.3.1 Qualities of LSBS staff

The safe space needed for this emotion work, and the necessity of flexibility in LSBS delivery, require a particular calibre of staff with various qualities. These qualities were not asked about directly, rather they were elicited through a question about 'the approach of the service' or they emerged spontaneously at other points in the interviews. Some summarised these qualities in abstract terms that nevertheless demonstrated the high regard in which staff were held:

"She [LSBS worker] just seems a lovely person, very nice." [SU3]

"The staff have been absolutely amazing, brilliant." [SU14]

"She [LSBS worker] were very good, really honest. I can't speak highly enough of her herself as a person. I speak as I find and she were good." [SU7]

Others were more concrete in highlighting what they valued about the staff. On making initial contact, LSBS staff were positively described as "friendly" [SU2; SU8], "welcoming" [SU9; SU10] and "approachable" [SU4]. The overall outcome of this was one of feeling at ease and safe which, as described in an earlier section, were important aspects in securing and consolidating initial engagement:

"But [LSBS worker] was great, she came in and I was put totally at ease" [SU2]

"It was just very welcoming and I felt really safe there" [SU9]

These early attributes, necessary for creating the right tone for the work that was to follow, were added to by other qualities that were well recognised and appreciated by those using the LSBS services. Being easy to talk to and good listeners were qualities specifically highlighted by more than half of those interviewed:

"From the very first visit with [LSBS worker] she seemed very nice, I felt she was somebody I can talk to. How you improve on that I haven't got a clue" [SU3]

These were linked to qualities of understanding, care, compassion and empathic sensitivity:

"It was a great comfort to me, it really was [being able to talk]. It's helped me a lot and she's [LSBS worker] a very understanding, caring girl. A very understanding woman, really." [SU5]

"To be sensitive is very important [...] but also just to sit there and listen, just to show empathy, was very important." [SU12]

Yet it was important to those interviewed that these more subjective qualities ran alongside other professional and practical abilities in terms of the knowledge staff possessed and their ability to skilfully handle the group or one-to-one work:

"I found her [LSBS worker] incredibly knowledgeable and professional. She knows what she is talking about, that's clear. And she knows how to be with you as well, it's incredible." [SU6]

"The way they engage people, they're not afraid to kind of gently challenge people when it needs to be done. But they're also very much about getting people to realise something by themselves." [SU1]

Most, if not all, of these qualities seemed to be linked by those interviewed to a depth of understanding about suicide bereavement that could only come through personal experience: that is, the personal suicide bereavement experiences of the LSBS staff were seen as significant in the development and practical implementation of these qualities. All

participants talked about the LSBS staff level of personal understanding and 'getting it' and saw this as a crucial element of the work in developing some of the qualities and attributes they valued:

"I think a lot of it was understanding, being able to empathise a bit and, yeah, that... someone to talk to that had been through it and is able to get it and has come through the other side of it. So it's that approach of like 'I understand where you're coming from, really, I get it.'" [SU2]

"Because it's very hard to understand suicide because the people seem quite normal and then next thing they're gone. Suicide is an entirely different kind of death and you need to have had that experience before you can comfort anyone else really." [SU5]

"I've always been very, very grateful in a way that anybody involved in Leeds Suicide Bereavement Service, any facilitator, has been bereaved by suicide. You can have all the empathy in the world but you will not get it unless you've been bereaved by suicide." [SU14]

This peer experience was also very important in terms of normalising people's experiences and emotions, helping them open up, and also in providing practical insights into how to cope:

"It was nice talking and obviously she had been through the same thing that I had been through. So it was comforting to know that I wasn't doing anything wrong if you know what I mean [...] To know she had gone through the same thing and that some of the things that I was saying she identified with was really helpful." [SU8]

"The people that ran the groups did it very well. I think they gave quite a lot of themselves as well and did talk about their own stories. That had a big effect on people and helped people to open up about their story." [SU13]

"Of course, the massive benefit is that she [LSBS worker] can emphasise because of her story, she has been through a very similar thing. You sort of take strength in the fact that she can offer insight into what she did. She never forced it, I asked." [SU15]

1.3.2 Gender of staff member

A further important consideration explored was the views of those interviewed on the gender of those undertaking suicide bereavement work given the LSBS work has been more successful in engaging women than men. Opinions around this were complex and nuanced. For some, particularly those that engaged more at a time of crisis, gender genuinely did not seem to make (much) of a difference:

"I've never honestly thought about it [gender] until you've said it. It doesn't make a difference if they were male or female to me." [SU10]

"She [LSBS worker] is female and I'm female and maybe that does make us easier, in a way, to relate to each other. But, there used to be a male volunteer and in no way did I find that strange or uncomfortable or anything like that. I think any person that can relate to you on such a raw and complicated thing, I wouldn't care if they were an alien from outer-space!" [SU14]

For others, both men and women, recognising the impact of previous negative life experiences with men meant that they, or similar others, would understandably prefer a female worker and that this option should be available:

“I’ve had experiences in the past with men, partly why my mental health got really bad. So because she [LSBS worker] came here, if it had been a man I probably wouldn’t have felt as comfortable - having somebody I didn’t know, if it was a man coming to my flat. So yeah, it’s important that there was the option that it was female.” [SU2 - female]

“I think for myself a female worker would make sense. Because there are a lot of vulnerable people, vulnerable males and females that have had very bad experiences of males in the past.” [SU12 – male]

It was very notable that more of the men interviewed suggested a preference for female workers and clearly related this to women being calmer, better listeners (making it easier to open up), and more empathic:

“She did ask whether I’d rather have male or female coming to see me, and I hadn’t really thought about that before. I thought, possibly female better, quite why I don’t know, I’m wondering if it’s this little boy needs mothering or something or whether women have more empathy than men, I don’t know. Maybe I feel I can open up more to a woman than a man. I mean I’m sure the guys just as capable as a woman but, I don’t like it, you have a different relationship with a female than you do with a male when you’re in a bad way. Immediately there’s this barrier, with blokes you know.” [SU3 – male]

“I don’t think it [gender] matters. I was quite happy for it to be a woman because generally speaking women are more empathic. There aren’t many men that I meet who are very good at listening.” [SU11 - male]

“I feel safer around female staff but that’s just... but it wouldn’t be say an issue to me” [SU9 - male]

“I think probably, because men are of a similar ilk, even now aren’t they, I think. You know, more and more are opening out as generations change, but it’s still..., males find it harder probably to talk about stuff like that. They’ll talk about football all day long. I think they’re [women] calmer. Well, I don’t know if I’m being unfair to the rest of the male population here, but I just think that they’re... I do believe they’re calmer. And I think that they’re better listeners than men are.” [SU7 –male]

Whilst these qualities are not biologically female specific, the view that they are more female predominant seems to have an effect on many men’s preference for gender of the worker. That said, some women (though fewer) also shared a similar view:

“You know I don’t know, maybe [gender would make a difference. I think maybe, yeah. I don’t know if it’s to do with her [LSBS worker] personality or her approach or her just generally being a woman because maybe it would make a difference, I’m not sure, but it might have done. At first at least, when you first start coming out and it’s really embarrassing to be saying that stuff as well, you feel embarrassed you feel humiliated even that you’ve got that weakness in you and you have to share it with someone. Maybe, I can’t lie, maybe it would.” [SU4 - female]

Several people though, male and female, pointed out the possible importance of having male workers and that having this might provide different ways of working more attractive to men:

“I think they definitely do, need a male member of staff to run, like men’s groups. Because I think, with women you know, women are quite open with women but men

might not want to kind of share some of their, you know, feelings or feeling vulnerable, but another man might get that.” [SU1 – female]

“I think three quarters of staff are ladies and a quarter are men. I am used to speaking to female staff. I didn’t really give it a second thought but to some people it might be difficult. I guess if you are thinking about how males engage and how men don’t really talk about their feelings as much and men have the highest chance of ending their lives and so on, maybe they are more likely to engage with men so it might be useful to have a male worker but at the same time I don’t know. I don’t have a strong feeling. [SU6 – male]

“It [a men’s group] might have to be different to just sitting in a room. Perhaps men are not as easy with that as women. It might be like a walking group or it might be meeting somewhere it feels that men are a bit easier or some activity so that men... if they don’t want to talk they don’t have to, there is something to be getting on with rather than we are here to talk and open up now. [SU13 – male]

There was an overarching ambivalence then with most people not wanting to deny a possible role for male workers within LSBS but with many suggesting a preference for female workers particularly during initial and early engagement and when engaging in ‘talking’ rather than ‘doing’ approaches.

1.4 Outcomes from involvement with LSBS

There was a great deal of abstract but powerful comments about what the LSBS service had done for people:

“It’s kind of like lifting a load really. It is, it’s the best thing that I can ever recommend to anybody and I would recommend it in a heartbeat. Absolutely in a heartbeat I would.” [SU5]

Whilst acknowledging that feelings associated with their bereavement never fully go, the help with normalising, managing and organising emotions outlined in the previous section made an important difference to how people feel and cope with these feelings:

“I’ve developed coping strategies. If I’m about to get upset, or anxious, if something’s been triggered, I can ground myself. I also know where certain behaviours or feelings are coming from. This has made me feel better about what has happened and how I’m moving forward and has given me the tools to do so.” [SU1]

“I was just going over and over everything in my head. I think I would have just kept putting off getting to the root of the problem. And it’s [LSBS] just lifted my mind out of that loop and that means I can get on with the rest of my life.” [SU10]

“It’s [LSBS] made a difference, I don’t feel as down anymore. I was always down. It’s like you have this weight all the time and she [LSBS worker] definitely lifted some of that weight. Yeah so I’m more interested in things that are going on around me.” [SU5]

As implied in some of the above, these changes in emotional state and coping helped significantly with the practical aspects of life that many had been finding difficult or had been affected prior to LSBS engagement:

“A couple of sessions in I was feeling a lot better and sort of a little more able to re-grasp on life and get my life back on track.” [SU8]

“I completely lost all structure and function and it [LSBS] definitely helped in giving me something to think about, focus on and look forward to. Now, I’m even thinking about doing some volunteering. In that sense it’s bringing me even further forward.” [SU14]

People described a range of practical differences they attributed to their involvement with LSBS, such as those above, but also including returning to work, volunteering, family holidays they never thought they might take and regaining a positive focus and re-engagement with their education.

1.5 Suggested changes to LSBS

When asked the question about possible improvements most participants had only positive things to say and no suggested changes. For a few who had been sign-posted on to other services (both within LSBS and outside) there was a feeling that they would rather have been able to access further LSBS one-to-one support sessions and others shared this view that more than the current number of one-to-one sessions could be made available:

“I guess when I was going through the swap [between services], that felt quite disruptive, because I’d spoken to [LSBS worker] quite a lot. So I’d had six sessions with her and then going on to somebody totally new, that was quite daunting and the idea of sort of having to start again. So yeah, that was hard, the fact that you couldn’t have the extra sessions with her, you had to go onto somebody else.” [SU2]

“The only thing was that after so many sessions [LSBS worker] said that, that was all there were that was all they usually offered to people, was so many sessions. And then she explained about the other counselling service that they offer which sounded a bit intense to me, like more intense counselling rather than it just being a chat between two people [...] I don’t know, it felt like, to me, it would pressure me to talk about things more rather than it being a voluntary thing, from my point of view.” [SU8]

“the only thing that comes to mind is maybe increasing the number of sessions. Four sessions in the end it turns out there is, that they were enough for me, but there’s still a lot of stuff left and I’m sure that there’ll be enough to fill one or two more hours of that just to get, but yeah, that would great.” [SU4]

Some felt that occasional contact or reminders about groups or events would be useful (though others highlighted that this does already happen) and others suggested a wider awareness raising of the LSBS services and improvement to the website would be useful:

“It would be useful to keep sending you reminders. I am not sure how that would work, either an email or something. Yes, it is nice to be invited back to something. I might not be able to make it but just knowing that someone is out there thinking of you.” [SU11]

“But I actually struggled to find out the details of the monthly drop in on the website. I had to ring up and just check where it was and what time it was. So I think that could be... the website I found a little bit difficult to get around, so just ease of finding it.” [SU10]

Finally, one person highlighted the lack of ethnic diversity of people engaging with LSBS and that expanding the work into these communities would be extremely useful but also very challenging:

“Expanding some of what they do more into BME communities, yeah definitely, it’s going to be a very difficult one that though. So, you know, especially with some

communities not wanting to even disclose that it was a suicide... it's going to be a long road to that one, but definitely, definitely. I don't think it's through lack of trying either, I just think it's a difficult one to get people to trust the service or, you know even want to come and share." [SU1]

2. Stakeholders considerations

This section outlines the key themes raised by stakeholders interviewed for the evaluation. Stakeholders discuss the drivers underpinning the programme and its success. They report their views of the needs of the people bereaved by suicide recruited into the programme, their views about the strengths of the programme and some challenges that service users face in engaging with the programme. The expectations held of the programme by commissioner, programme managers and frontline staff are outlined and some perceived challenges of delivering the programme for these frontline staff described. Factors enabling the success of the programme are explored and perceived structural challenges to the programme's effectiveness summarised. Pathways through the service are considered by stakeholders with an emphasis on the importance of choice and flexibility. Gender issues are considered and, finally, the stakeholders discuss how success is being evidenced to support programme sustainability.

2.1 Drivers for the programme

Among the drivers mentioned underpinning the programme were national policy, specifically the good fit with suicide and mental health prevention policy agendas, the results of local audit, the personal motivations and lived experience of people in key positions, and making a substantial contribution to the international evidence base:

"It was National policy, so it was one of the six objectives in the National Policy and we felt there was a real need in Leeds to understand that and support some of the voluntary sector as well." [SH4]

"I would hope that by receiving some support at an appropriate time, after their bereavement, whenever they feel ready for that, it's going to reduce the likelihood of severe mental health problems developing that may lead to suicidal behaviour." [SH8]

2.2 Needs of service users

Concerning stakeholder views of the users' needs, there were said to be different phases. Early after bereavement, trauma, isolation, and stigma around suicide can aggravate the grieving process. Being bereaved by suicide can also contribute to relationship strain. So it was important at the first phase to have a safe space and a person to talk to, to begin to build trust. At this early phase, visits to home were perceived as safer, with quick response to a referral vital. It is then important to begin to allow a person to develop a narrative. It was said that people bereaved by suicide need a witness to what they have seen. They need a frontline worker to hear and understand, helping the person bereaved to feel understood and have their overwhelming experience in some way normalised by sharing. This occurs through experiencing empathy and unconditional acceptance, without any judgement. In due course they may need support to re-establish boundaries around psychological safety:

"I would say isolation, stigma, I would say for some people who have found somebody who has died, or has to continue living in the same house that somebody has died in,

actually, there's a lot of trauma that they really struggle with, and for a lot of people that I've worked with, they wouldn't necessarily feel like reaching out to mental health services, which they've seen as mental health services.... But just normalising grief. I think I spend pretty much all of my time saying, that's normal, that's okay, that's meant to be worried about." [SH2]

"I think they need that safe environment to be able to - for the one-to-one work - to be able to open up, that safe space to be able to open up and not feel judged and, you know, so you give them that time and space...that safe space but also giving them bounded sessions so they know what they are getting, they've got boundaries." [SH1]

"Sometimes if you have caught someone quite early on in the bereavement they do get distressed and they need that space to be able to hold it and not feel judged. I think a lot of the time their needs are just that they need to have someone else say what you're going through is normal and it's okay and it's to be expected." [SH1]

It was emphasised by stakeholders that it is very important that the lived experience of the front line supporter allows them to empathise with what the person bereaved by suicide is going through. The person needs to have moved beyond and worked through processes of grief, including anger, and the effects of stigma. Providing front-line support contains a danger that the experience can reawaken vulnerabilities for staff with their own lived experience. It is very important that the frontline staff have training, however having a person with lived experience on the frontline working with newly bereaved men and women is a *great strength*:

"This service had to be delivered by those who had understood suicide bereavement and been bereaved, but it couldn't be recent, it had to be some time had gone past." [SH4]

"A non-bereaved by suicide person would be perfectly competent but it would take a carefully trained, specifically trained person to do that I think. But peer support is very helpful in so many situations." [SH7]

2.3 Strengths and challenges of the service for the users

Stakeholders gave accounts of what they see as the strengths of the service for the user. Among these are the offering of choice and different types of (individual, group and counselling) support:

"We offer both the peer support and the individual support and that support is ongoing, I think, and we are flexible to change." [SH4]

"Different options for support – individual, group, counselling, family support." [SH9]

It was also felt important that the service offers a face-to-face and local service rather than a national telephone and email service. It is peer led, with a person with experience fronting the contacts with service users. The peer led approach is congruent with the organisational approach in the partner organisations (e.g. Mind has a peer support service). The frontline workers are highly experienced, have received training and are very committed. The use of workers with experience of bereavement fits with evidence of effective practice:

"If before someone rang me up and said, 'I've been bereaved by suicide, what do I do or where do I go', I would have had to refer them to a national organisation because

there wasn't anything local... So there's a gap and suicide bereavement was a gap and it's been filled, which is brilliant because it makes it so much easier to refer people and know that they're going to get a good service." [SH6]

It was claimed that for many of those bereaved by suicide the opportunity to have individual support in a safe space to begin to develop some narrative around bereavement and manage very chaotic emotions can be very valuable before any possible choice to take part in a group of peers:

"I think as part of that role, particularly for the one-to-one worker, is to support people when they are really struggling and maybe can't talk to people on a bigger range with it, but also to help support and connect them into other organisations, other groups, other things that will support them." [SH5]

Peer support in group contexts was also considered to be a very valuable opportunity on the journey. Flexibility is a major asset. The drop-in-group provides the opportunity for people to come when they need, because grief is not a simple linear process, and there may be delays before people feel comfortable or ready to attend. Peer support allows people to share lived experience and re-connect with others, as they may have become very isolated:

"Peer support is very helpful that people really get a huge amount from that, and they ask questions of each other they would never dare to ask professionals." [SH7]

The option of referral from the individual work or group work on to in-depth counselling, and external services, was considered particularly important for those in particular need, for example some people who may have troubled, complex family histories. The service supported people to keep coming back at different times, or to become a volunteer:

"The idea that not everyone is going to go down one pathway, not everyone is going to want individual support and not everyone is going to want to go to group support and the fact that you can make those decisions and talk to the people and find out what they need, or what they think they need, or what they want initially. And then, it's adaptable, it's changeable." [SH6]

An emerging strength was the service specific brand, and it would certainly be advantageous for users to have a co-located service, aligned with the wider bereavement service, and separate from the crisis or mental health service.

Despite its success, the frontline service posed a number of challenges for the user, which seemed remediable. Some locations in mainstream service buildings of the partner organisations were perceived as geographically inconvenient. For example, specifically, the formal counselling offer located in the north of the city would be quite difficult to access for people from other areas. In the early stages the accessibility of the service was also affected by having two phone numbers, and split locations. More recently there is a specific phone number, and plans to relocate the core service to a single shared location:

"I think we need to look at getting something central that again is away from the two organisations, it means that the two staff are together and we have that identity of it being a bereavement, you know it's bereavement through trauma, traumatic situations, but it's a separate identity." [SH5]

A further challenge has been the potentially stigmatising branding of the organisations where services have been housed. One service has mental health branding and the other crisis service branding. This, it was said, could be a deterrent at the gateway. There was a view

that the suicide bereavement service branding should be completely separated from both mental health and crisis vocabulary and images:

“It feels like a bereavement issue more than a mental health one.” [SH1]

“I have had quite a few people who have said, they didn’t get in touch straightaway because they saw those names and didn’t necessarily see the Suicide Bereavement Service so put it off.” [SH2]

One view was that the length of the free counselling offer was short in relation to the complex needs of the relatively small number of people who took up formal counselling. Some people, it was said, need more than twenty counselling sessions.

2.4 Expectations of the service from the frontline staff, managers and commissioner

A number of expectations were expressed by the frontline supporters concerning their role. It was very important indeed that they have lived experience, to help them support a narrative of grief and recovery. They need qualities of empathy and insight to carry through early contact, usually in people’s homes, at a time of crisis. They need the skills to do an ongoing assessment, and signpost to pathway options for professional support and peer support. It was said that experience and flexibility are needed, as grief is individual and not completely predictable:

“I would hope and expect that assessments are done at regular stages throughout to make sure that client is receiving the right type of support for them, and thinking about going forward as well.” [SH8]

“That flexibility has to be there... the counselling needs to be very robust, very, quite experienced and flexible.” [SH3]

The commissioner and service leads also had expectations around the service and its delivery. These included the ‘postvention’ goal to reduce suicide among those whose risk is heightened by bereavement through suicide. Outcomes aspired to included building resilience and supporting people to reconstruct their lives so they are not tainted by grief and guilt. It was important to support people in building coping strategies, to work towards reducing loneliness, prevent the use of crisis/emergency services, support family cohesion, and perhaps support people bereaved by suicide to remain in employment. Benefits for individuals should include being enabled to articulate their feelings, work through family impacts, reflecting on the process of grief, and being empowered to articulate these gains back to their family so having longer term family ripple effects:

“Being able to have the time to articulate what you’re feeling around bereavement and the impact the person who’s died has had on the family and working through that and going away and reflecting on bereavement, the bereavement process I think has been massive for the individuals and the families. Because I think that’s the other thing that we maybe don’t capture as well as we could do is the conversations that then happen in the families so that the person that has been referred is almost empowered to be able to articulate some of that back.” [SH4]

2.5 Enabling factors for the programme and the frontline staff

Stakeholders discussed some of the enabling factors which were making it possible for the programme to be effective. Among these were programme flexibility. Managers have

empowered the frontline staff to take decisions responsively. The openness of the steering group, commissioner and management interest in improving the programme, and acceptance of change in programme planning in relation to delivery logistics were important. The commitment and in some cases lived experience of key individuals was vital. Ongoing training of staff was very important:

“I think the amazing thing about the project from the word go was let’s see what works and if it doesn’t we’ve got the flexibility to change. Like our evaluation sheets, like seeing people in their own home, like the resource pack, is let’s see what works, get some feedback and then, they gave us a lot of flexibility, on what we are doing.” [SH1]

“Training has been fantastic, they are really good with, you know, any training that we need to go on” [SH1]

For frontline staff certain enablers were very important. Good quality supervision by management was vital, although it was said that there is a need for more distinct clinical supervision, given the emotionally demanding and skilled counselling role involved in working with people bereaved by suicide. A very powerful enabler for the frontline staff was said to be their motivation, they have lived experience and are strongly supportive of the pioneering ethos of the programme:

“We’re pioneering! You know, this area... I mean I’ve always been motivated to do it since the word dot, but it just gives you the want to keep going and to keep offering it and to expand it and to get everywhere in the country...” [SH1]

Certain changes that are being planned or implemented were also seen as enabling effective delivery. A third, possibly male, worker would reduce the great workload pressure on the two frontline staff. A central location where workers would be co-located would improve communication and support, enhancing networking and affording companionship, and plans were afoot to share space within the bereavement forum premises. On the other hand, it was also said that some choice of location is desirable, and that workers will visit people in their homes if wanted was considered very important. The development of a branded website, now in place, was very important:

“I’m not sure clinical supervision is enough, I think that they need somebody whose focus is us, not our clients.” [SH1]

“I think what we’ve done to overcome both those points, being sat within mental health and crisis services and the workers working together is to try and identify a common base where they can work for within the cities and kind of linking up with Leeds Bereavement Forum, so we’re hoping to be co-located with them.” [SH5]

2.6 Structural issues for frontline service delivery

There were said to still be structural barriers to the frontline service delivery. Non-recurring funding was said to deter take up by GPs. The separate location of the two frontline workers potentially posed structural problems around the pathways. For example, it was apparently possible that not all people passing through the gateway with home visits were fully aware of all their options. It was also possible that not all referrers were aware of the pathways available. One referrer, for example, was not aware of the depth counselling option. Where sub-contracting occurs, e.g. to a counselling service distinct from the two host organisations, there can be issues of communication. Training of frontline staff has been good, but there

was a view from a counsellor that they might have appreciated more training around specifics of bereavement by suicide:

“These third sector things have non-recurring funding so it’s difficult to spread the message necessarily.” [SH7]

“I think I thought there was two... That pathway would take you down two routes, either individual counselling, I thought, or group support. I wasn’t really aware of that, third Leeds Mind generic category, because the first one, does that include counselling? The individual support?” [SH6]

There were some concerns from the frontline supporters about safeguarding, especially during home visits. It was also felt that doing this job over an extended period of time carried risks to emotional wellbeing and so clinical supervision, e.g. counselling, needed to be provided separate from line management supervision:

“Actually, a phone call to say, is everything okay, are you back yet?” [SH2]

The two ‘host’ organisations were said by stakeholders to have different structural models and co-location would help to overcome some of the issues arising such as difficulties coordinating diaries, and different professional models for working respectively with people with mental health problems and people in crisis. The mental health/crisis service branding on display was considered potentially off-putting for people bereaved by suicide. It was also said that many people bereaved by suicide have different challenges to other people in crisis attending the crisis service. It was asserted that in some cases service management were not bereavement specialists. Working with two organisations with different remits and two managers with different styles had the potential to lead to collisions of practice between supporters. Any differences between organisational cultures could be overcome by co-location. It was suggested that having one organisation take overall responsibility for delivering the service might in the long-run prove effective:

“Leeds Mind and the Survivor Led Crisis are going to have very different organisational cultures which they are then going to have to try and fit into and then, somehow, magically create a culture for their own organisation as well which can make it seem very desperate, I think. So I think that can only strengthen them by joining together.” [SH6]

Resources were not sufficient to meet demand during the first year. High level of referrals in the first year were very validating but also overwhelming for front-line supporters, so the individual support option had formally been reduced to 4 sessions from 6. The limited number of sessions both for individual support and for specialist counselling were said to be a challenge. There was a need for more staff time, e.g. for a further paid worker, and the different number of hours worked by the frontline staff across the two host organisations was said to be challenging. Staff were very overstretched within the hours of their part-time contracts:

“Having a male worker and a paid rather than a voluntary position I think is important. Having a family worker to help support families and children feels important. I think more staff time.” [SH5]

“I’d like to go full time.” [SH1]

“X is the lead agency even though there’s less hours and less pay, I’m told that that’s firm.” [SH2]

2.7 A flexible pathway

A great strength of the programme was said to be that it offers a flexible pathway and user choice. The process of referral including self-referral was easy and quick. The importance of early intervention was stressed e.g. of police and ambulance staff providing immediate information. The Gateway meeting was also vital for determining the initial route. The partnership was believed to be very effective in supporting the people bereaved by suicide onto the pathway of support, for example Leeds Bereavement service passing on referrals and signposting people in:

“Sometimes by the end of that gateway session they’ll say “Oh yes, I really want one-to-one” or “I really fancy the support group” or the drop-ins or whatever and we will kind of direct them from there about where they can go and how they access the other parts of the service.” [SH1]

Some teething troubles were noted. The support workers were said to have slightly different promotional roles requiring coordination. There was a question of how easy it feels to some people bereaved by suicide to move from one-to-one support in their homes to support groups in a distant central location, and how they might be prepared for this. Group numbers had not been high enough in the early stages for opening different locations:

“What we usually do is offer a central location and a kind of community location, we don’t have the numbers coming through to mean that we could have two groups at the moment. So I think the numbers for the groups feel quite low to be able to start to expand and offer more choice so we’re having to just offer one central location.” [SH5]

A strength of the programme is that it allows evolution from the ground up, but this in turn poses a challenge of developing the model. For example, there were different strands to the peer support groups, which may not have been clearly modelled at first. As drop-in groups morphed into friendship groups, they should remain able to absorb newcomers:

“We go round, talk about what support we can offer and what the service does. Also, run multiple peer support groups, so there’s an educational group, there’s a monthly group at the [venue A], there’s another group that’s starting at [venue B] through the daytime.” [SH2]

The one-to-one work included a strong component of counselling and was obviously crucial especially in early stages of coming to terms with bereavement, when group contexts might not feel safe. However, the lower take up of formal counselling and of groups remains a concern about the pathway. There is said to be some ambiguity around the number of 1-1s offered and referral on: 1-1 support should be 4-6 sessions long but actually people come back ‘if needing it’, which is good practice responsive to the cycles of grief and recovery:

“They may not come to the group all of the time but they know that that’s there and similarly with the one-to-one work if they have completed a series of four or six one-to-one sessions, they know that they can come back.” [SH5]

The importance for some people of forming a primary attachment prior to participation in groups was emphasised. At the same time, it was said that most group members are not being recruited through the Gateways. These groups need active promotion. The different aspects could be promoted more to raise awareness of options e.g. counselling for more deep-rooted holistic and family aspects. Flexibility for crossing between the different components was seen as important. For example, some clients may not be able to engage quickly, it could even take a year or two even from their first having a leaflet. Some of those undertaking 1-1 support might not be ready for a group at that time, but that might come

much later. Some might wish to take a break from the service and later come back for more counselling. It might also be important to maintain openness for people so they are able to move across from the group to the one-to-one support. It was suggested that some clients could benefit from having counselling at the same time as participating in group support. It might be valuable in some cases, it was said, to have pathways to counselling open for group participants over a long period rather than to counsel prematurely:

“I think people need to be in the right place as well, and that actually a bit of their own individual healing might be needed before they can even start to talk to somebody, and certainly before they can be in a group. So I think there is a bit of letting people go at their own pace. And getting an understanding I guess of people who don’t engage and getting that understanding why people, what factors mean that people are able to engage.” [SH5]

The link between the service and the host organisations meant that it was possible to refer people on to other support services effectively if that is valuable. The service was perceived to have a good fit with other bereavement services which might offer 6-8 sessions of one-to-one support and then peer support options:

“The issue may be there’s other stuff going on as well, and maybe other support agencies that can support as well and again, that’s all working in partnership with... Which is the good thing about working with Leeds Mind and Survivor Led Crisis, they do have that back-up support and they do know that if what they’re doing isn’t working for somebody, they do know there’s a list available of other people, or whether it’s something completely different.” [SH6]

2.8 Structural strengths – linkages with the wider environment

The strengths of the programme were described by various stakeholders. The delivery organisations had a strong relationship with the lead commissioner who consistently raised the programme profile. There was a consistent programme of outreach with use of social media and presentation events. The breadth of the partnerships was a key strength. There were strong links to promotional organisations like Volition. The reputation of the two lead delivery partners helped to encourage referrals from partner organisations e.g. the bereavement service Cruse and Leeds Bereavement Forum. The importance of continuing to develop strong partnerships with frontline services for quick referral such as the police was strongly emphasised:

“The project has been very well thought out and there has been a consistent programme of outreach and a number of presentations and events.” [SH9]

“At the beginning of the service we had quite a lot of people being referred from the police and the reason for that the chief police person that we linked in with had got suicide prevention under her remit...X has moved on so that’s the thing, I think we have to find the right champion for every partnership otherwise it will be forgotten.” [SH4]

“I think Leeds Bereavement Forum and Leeds Cruise are the other two organisations or forums where they have had support directly from.” [SH4]

Aspects of the mainstream mental health service which had good fit with the LSBS were said to include the commitment to challenge stigma, and the high value placed on peer led frontline delivery:

“What we’ve found is that the model that we’ve got for working with people with mental health difficulties is transferable to a bereavement service around traumatic bereavement, and I think that’s, I don’t know how many other services there are across the country who would kind of have that peer approach in that way.” [SH4]

2.9 Wider challenges

Stakeholders discussed some wider challenges the service faces. The importance of taking a holistic view was highlighted. The aim of postvention – preventing further suicide – demanded a family focus. It was said that there are two ways to directly address family dynamics within the pathways themselves. One of these is through counselling which takes account of family dynamics being worked through by the bereaved individual, and the other is encouragement of family groups within the pathway, which was being thought through:

“Maybe offer some family therapy support...if that’s needed, and if the stuff comes to fruition that it’s better through the Leeds Children Bereavement Pathway then that’s fine, but how do we then, is it a family approach, is it family therapy?” [SH4]

The challenge of reporting suicide data quickly was considered. For live reporting and earlier referral, it is important to have the coroner and police fully on board. At present, it was said, the coroner was not sending referrals. Emergency services (ambulance and police staff) could be trained further so they inform people very promptly about the service:

“The earlier the intervention the more likelihood of the support and the reduced risk then, so in an ideal world I would like that to be really smooth and through the coroner’s office and through the police as equal partners, but the infrastructure is not there for that to happen quite yet.” [SH4]

The importance of wider joined-up work to de-stigmatise talk about death, bereavement and suicide was emphasised. The issue of inclusiveness was also discussed, with one stakeholder suggesting greater effort was needed to engage LGBT and BME communities. It was also pointed out the bereavement from suicide can be extremely complex in migrant and refugee communities bound up with wider traumas from, for example, war and displacement:

“So I think there is that big stigma attached to death, dying and loss full stop and that stigma gets even bigger when you’re talking about suicide...So I think encouraging people to talk about death, dying and loss generally and making more people aware of what services exist generally around bereavement, I think the Suicide Bereavement Service is doing a great job and accessing everyone who is being referred to it.” [SH6]

The challenge of widening the range of referring agencies was mentioned, since the majority of people participating to date are said to have been self-referred. The possibility of embedding the work further in community venues was discussed, linking with community promotional events. Currently LSBS do memory remembrance events which offer support within a community event if people don’t think they now need a full service:

“I just would like more organisations to be refer into it straight away so I think there is something that we could do more with GPs and primary care, ... I don’t think we’ve had as many GP referrals, but we know from experience that just as a project is shutting down and coming to the end of its three-year pilot, GPs start to refer because it just takes that amount of time.” [SH4]

The question recurred whether a service relying on just one or two people at the frontline is sustainable, and it was asked whether IAPT workers could be upskilled to engage in this kind of work. The need for secured funding was strongly highlighted:

“We also need secured funding.” [SH6]

2.10 Gender

Stakeholders were asked about the importance of gender within the shaping of service delivery. Referral rates were lower for men, possibly reflecting an initial prevarication among some men about talking openly about their vulnerability. There was some discussion around strategies for coping. It was said that many men may prefer to structure their coping strategies around activities rather than unmediated talk about emotion. There was also a suggestion that some men may find it easier to talk about their emotions away from home, in a safe space. Some men may feel more comfortable about the flexibility of one-to-one support than the more highly structured offer of a series of weekly formal counselling sessions. There was said to be a need for groups specific to men which would not just be chat groups, as well as a need for family groups:

“It’s almost something that they [men] go and do and they manage outside the home and it’s not about that mental health, it’s about that kind of, I’m doing something practical to then be able to function.” [SH1]

It was said that having no choice of male or female counsellor was perhaps a problem, and that such choice would be good for postvention. A male worker would be valuable, to encourage male participation and possibly support men to stay longer, but the male would, it was said by one frontline worker, need training to an equivalent level as the corresponding existing staff. The age of the worker was also said to be potentially important; an older male worker could be valuable in the team:

“I’ll go round to somebody’s house and they’re 20 years my senior, and I’m trying to tell them it’s really normal. It just feels as though the imbalance is there straightaway. So it would be nice to have more of a range.” [SH2]

It was said by one person that there were female-led or feminised structures within the steering group and the partner organisations. The current flower with a petal falling off logo was seen as representative of such feminisation. Having female management (as was the case at the time of the interviews) and also exclusively female front-line workers was potentially a barrier to male engagement, according to one stakeholder. On the other hand, many of those engaged felt particularly safe with the (female) individuals they worked with. There were also said to be lower levels of male representation among staff in the partner organisations than male clients in the organisations. Enablers proposed by different stakeholders for the future include having (more) male volunteers who could become paid male workers with groups, and possibly a male individual worker, including for initial engagement.

2.11 Evidencing of success

A further important area was evidencing success. The high numbers of people recruited, especially to 1-1 work, was cited by stakeholders as evidence of success. In addition to measuring short-medium term personal outcomes around resilience and recovery it was also said to be important to evidence ripple effects to other services taking account of families, linking for example to child bereavement pathways and so measuring the emotional impacts on children. Short term impacts mentioned by stakeholders included: better coping; feeling

less alone; normalising feelings such as anger and shame; understanding bereavement as a process; supporting and sharing understanding of grief cycles; supporting individuals to bring their system into balance, including relaxation; and to maintain the essential structures of life e.g. being able to eat and sleep, retain physical health, family relationships and friendships, retain financial security, and sustain a livelihood. Having people bounce back resiliently so they feel they can take part in a group was also positive evidence. Longer term impacts mentioned by stakeholders included people returning to the group becoming more verbal, with more voice and confidence, not being scared of their feelings, being able to ask for help, and perhaps able to drop in less often. An associated long term impact involves become more re-engaged with society during the time in between attending a group. Although it was said that LSBS has supported people to retain employment, and sustain family relationships, while normalising grief, and maintaining their mental health, it was also strongly emphasised that longer term funding for up to five more years would enable further evidence of long term success and change:

“I think just by being able to have the time to articulate what you’re feeling around bereavement and the impact the person who’s died has had on the family and working through that and going away and reflecting on bereavement, the bereavement process I think has been massive for the individuals and the families...conversations that then happen in the families so that the person that has been referred is almost empowered to be able to articulate some of that back...they are almost like the glue for everything else, so I think some of that long-term impact that we have yet to see and understand but I think there is as well.” [SH4]

Less direct evidence of success was said to be that the model was flexible and was being adapted through ongoing learning. An example was the feedback from the ‘living with my loss’ group that people might want to start a parent’s group or other groups. The programme was identifying opportunities for further development. Gaps have been identified, it was said; there was a need for greater engagement with men, better provision for children and families, and being able to respond to identified need in an ongoing way. This was leading, for example, to a bid for funding for a family support worker:

“Other successes are that we are able to see the challenges and respond to those and see the gaps and respond to them, so being able to see that there’s nothing that’s men specific or that would kind of support a different way of working with men feels really important. We’ve identified that we’ve not got very good support for children and young people and we’re looking at how we can kind of better support children and young people within the families, or support the families to support the children and young people. So I think the fact that we can kind of respond to what’s going on feels really important.” [SH5]

Finally, certain challenges exist to evidencing success. Attendance at groups in the early stages had been quite sporadic, participants might come from time to time without the staff knowing how they were progressing in between. This illustrates the more general problem, on a short term programme, of evidencing success in the longer term, for which more funding is needed:

“We’ve got the idea that postvention prevents longer term problems, we’re not going to know that...you’re not going to be able to prove that in three years.” [SH1]

This section has presented evidence from stakeholders showing their perceptions of the immense importance of the programme for people bereaved by suicide. It has been strongly emphasised that having people with lived experience delivering the programme, offering a

rapid response in a safe space to build trust at a very difficult time, retaining choice and flexibility within the pathways, and some co-location and strong coordination between the different strands are vital elements in the success of the initiative. The initiative has been showing demonstrable success around referrals, recovery, movement along pathways, and social engagement, while planned changes e.g. around co-location and family engagement show the programme's strategic responsiveness.

3. Integrated findings and key considerations

This sections considers, integrates and discusses the main emerging findings from both the service users and the stakeholders. One of the most interesting features is how congruent most of the data is between those delivering the services and those using them. To this end, LSBS seems to have been developed and delivered in a way that both recognises and meets the needs of this important group of people.

3.1 The importance of the work

It seems clear that there is a need for this work, and for the work to continue, and several factors highlight this. Suicide remains a leading cause of death nationally, especially amongst younger adults, and in Leeds the suicide rate is marginally higher than the national average for England, and suicide prevention work is consistent with Leeds City Council's stated values and priorities (Leeds City Council, 2016). There is strong evidence of the impact of suicide including an increased risk of mental health concerns and suicide amongst those bereaved (Pitman et al, 2014). This current evaluation confirms this previous research, showing that the depth and level of personal distress, and the impact on individuals' emotional wellbeing and ability to function in daily life (including in employment and civic engagement), was significant and should not be underestimated. This impact on those bereaved was well recognised by the stakeholders and clearly articulated by those using LSBS services. Furthermore, this affected the relationships – partners, family, friends, colleagues - of those bereaved and therefore had a ripple effect well beyond the impact on the individuals concerned.

This work then provides part of an important response to national and local policy drivers, having good fit with suicide and mental health prevention policy agendas, and meeting a very significant and what has been shown to be a quite specific support need (Tal Young et al, 2012).

However, whilst LSBS is making clear inroads into meeting this specific need we suspect it will not have fully closed the gap between the need for and provision of such support that Wilson & Marshall (2010) have highlighted. A couple of key points have emerged which may require consideration when thinking about how best to continue meeting the needs of this group as the service moves forward. Firstly, the level of response (the number of those coming forward for support), particularly in the first year of the programme, brought challenges to frontline staff in being able to respond as fully as they felt was needed. One example of this was having to limit the number of one-to-one sessions available during that period to four (this has since been extended to six in order to more fully meet this need). Second, in order to ensure the quickest possible intervention (thereby minimising the impact of distress at the earliest opportunity) it was felt by some stakeholders that systems to ensure earlier referral via coroners, police, ambulance etc. could be established and that wider system support might need to be mobilised to secure such cooperation. [NB this does not mean that all those referred would be at a point where they were ready, willing or able to

take up LSBS services but it would at least provide the opportunity rapidly for those that were]. Finally, with these two prior points in mind, it was suggested in interviews with stakeholders (and alluded to in some service user interviews) that adequate resourcing would be required to meet any further increased uptake of LSBS services. Whilst this was mainly spoken about in terms of some increase to frontline staffing, it was also implied that current staff need to be adequately cared for in order to fully meet any increased need, and more is said about this shortly.

3.2 The approach taken

The approach taken to developing and delivering the LSBS work emerged as one of its core strengths. The full commitment and on-going involvement of those commissioning, developing and delivering the work was not only apparent but significant in creating the specific 'feel' that those using the service found so important to engagement, involvement and personal progress. In practice, the essential elements of this approach seemed to revolve around diversity and flexibility. The openness and diversity of routes into LSBS was recognised as important to meeting the needs of people at very different points in their suicide bereavement journey. The fact that there was no formal referral system that could create delays was imperative in ensuring people were engaged quickly when they reached out for help thereby seizing a timely opportunity that could otherwise be missed. This approach was supported by frontline staff's ability to respond rapidly in making initial contact both remotely (by phone, email etc) but also in establishing a first face-to-face meeting quickly.

Alongside this, the flexibility of pathways offered following the gateway meeting also helped meet the variety of differing personal needs that presented themselves following initial engagement: it was clear that a one-size-fits-all service would not and could not meet this range of needs. The willingness of all those involved in developing and delivering the work to be reflexive about whether it was best meeting the needs of those it aimed to engage meant that LSBS had been adaptable and flexible in shifting aspects of the work since its inception. This was critical in making it the success it has clearly been to those using the service. The ethos of the approach was underpinned by core values about being open, non-judgemental and empathic and these will be discussed further in the following section.

Underpinning the whole approach, from the initial idea of the LSBS to its design and implementation, was recognition of the importance of personal experience of suicide bereavement and this is discussed further in the following section 3.3. However, it is important to state here that this personal experience was not only seen as crucial for frontline staff but also of great significance for others involved in various stages of design and delivery to ensure the commitment to the diversity and flexibility outlined above.

A couple of key points emerged that may require consideration when thinking about if and how the approach may need to be amended going forward. First, work here suggests that early engagement may need to focus as a first priority on the one-to-one offer. Many people are looking to engage at a time when they need personal input to stabilise their emotional state and are concerned that hearing/sharing others' experiences at that point could add to their distress. That said, a minority are engaging at a time when they need the opportunity to share and hear others' stories in order to help normalise their own thoughts and feelings and/or to share positive memories about the bereaved in a situation where doing so will be fully understood. This being the case, whilst the one-to-one work should be a very strong priority, all options should remain available at the gateway meeting as some are specifically motivated to engage because of the connections that come through the groups. Additionally,

concerns around groups likely links to a wider fear of group work within mental wellbeing services rather than specifically to the LSBS group work offer which was well-received by those using it. Second, further consideration may be required about movement between different aspects of LSBS. Possible routes on from the one-to-one sessions seem difficult. The lower uptake of the formal counselling pathway, yet with some service users saying more of the one-to-one sessions would be useful, perhaps suggests a need that is falling through these two pathways. Whilst the group aspects certainly work for some at this point they do not seem attractive or appropriate to others. This could be a question of how different pathways are explained by LSBS staff or it could be that there is an unmet need for some at this point in their journey through LSBS. Third, the approach needs to be congruent with the approach of partner organisations. A positive example of this is the peer support approach and the valuing of lived experience which is highly congruent with Mind's practice.

3.3 The qualities of LSBS staff

The qualities of the LSBS staff are reflective of the values and ethos attached to the approach described above – they are the frontline expression of this that is experienced by the service users. These qualities were well described in section 1.3.1 and were recognised as vital to the success of the work by both stakeholders and those engaged by the service. These qualities consist of both important emotional attributes – most notably compassion and empathic listening that generated trust and safety – alongside professional attributes – most notably significant knowledge and skills in managing people and groups. There was strong agreement from stakeholders and those engaged that to develop the necessary level of these qualities and attributes not only required a degree of professional experience and training but, to be fully deployed in the most effective way, it also required personal experience of suicide bereavement. The ability to fully empathise, to fully know and understand and therefore effectively work with those bereaved by suicide could only come from direct personal experience of this and this was highlighted as a vital aspect of what made the frontline staff, and the programme as a whole, so able to identify and meet need and adapt flexibly to continue to do so.

There are two issues emerging here of relevance moving forward. Firstly, that of staff training. All (not some) staff, including for example counselling staff, should have sufficient training relating specifically to suicide bereavement (as opposed to bereavement generally) in order to more fully understand the emotional and psychological needs of this group. As Flynn (2009) and Andriessen & Krysinska (2012) suggest, grief following bereavement by suicide does have specific psychological features that may therefore require specialist input. Second, the issue of sufficient personal support for front line staff for their own needs was raised. Specifically, it was felt that there needed to be a differentiation between line management supervision/mentoring and clinical supervision and support, with an increase in the latter to ensure that staff were able to continue to maintain the very high level of service they were providing given the emotional labour and challenge this entails.

3.4 Setting and branding

The mental health setting and branding of the two organisations that LSBS was delivered through was asked about directly. Some using the service saw no personal issue in engaging with organisations that had mental health or crisis service labels or branding. This was primarily because they had prior familiarity with such services or because their level of distress had been so great they would seek help anywhere it could be found. However, even

for these people, and for other service users and the stakeholders, there was recognition that mental health still carried some stigma (though less than in previous times) and that this may therefore be off-putting to some. A further clear theme was that having two organisations deliver the service with a split base (setting) for delivery presented difficulties for communication, coordinating the delivery of services by frontline staff, challenges of access for service users, and dilemmas around possible differences of organisational culture.

In moving forward then, the planned co-location of the frontline staff will be a major step, especially in an environment (e.g. in the same building as a bereavement service) which reduces their isolation and which can reframe or minimise the mental health/crisis service branding. However, perhaps further thought also needs to be given to whether or not it would be more effective in the long run to have one organisation take overall responsibility for delivering the service.

3.5 Gender within LSBS

Gender was a key area of consideration and emphasis in the evaluation given the important role it plays in suicide (Robertson & Baker, 2016) and the expressed difficulties encountered by LSBS in engaging men. The information obtained was complex and nuanced. There was some evidence that LSBS was fundamentally 'feminised', consisting primarily of female staff on the frontline but also of primarily female professionals who had commissioned, developed and managed the service. This is not uncommon within health services generally or within mental health and wellbeing services specifically and can create an outward impression of a service welcoming to women but perhaps therefore off-putting for men. A simple example of this within LSBS was the flower with a petal falling off logo. Such simple things can collectively create particular outward facing impressions that have an impact on engagement. There was strong indication (particularly amongst male service users but also some female service users) for a preference for a female worker especially at initial engagement. This was primarily linked to gender stereotypes that females naturally possessed more of the subjective qualities of compassion and empathic listening that were seen by all as so vital for the success of this work. That said, those using the service had no male staff to make comparisons with. It could be the same qualities could have been recognised, experienced and appreciated by service users if male staff had been present. Despite this apparent preference, a possible need and role for male workers was also highlighted by both stakeholders and service users. This appeared to relate to the need for choice to be available, but was also linked to creating some different approaches, particularly in the longer-term group context, that were more male-sensitive or appropriate.

Three important issues emerged here then for future consideration. First, ways to adjust the structural embedding of gender within LSBS could be considered. This may be incorporating more men into the steering group or finding ways to incorporate high quality male service user input across future aspects of service development and delivery. Second, whilst any biological basis for gender stereotyping of women as being more compassionate and empathic is certainly contested, this perception should nevertheless be considered when thinking about engagement and especially initial engagement. This does not necessarily mean employing only female frontline staff for initial engagement. But further work, perhaps approaching similar suicide bereavement projects, to ascertain how service users have experienced the qualities that male staff involved in initial engagement bring, would be of value. It could be that they bring similar qualities or they could bring different qualities that are equally valued by some service users. Third, and linked to this, it is possible that longer term work with male service users could benefit from group work approaches, possibly led

by a male worker, that are more 'activity' focused than 'talking' focused. Such activity focus has been shown to be effective in mental health promotion work with men (Robertson et al, 2016).

3.6 The success of LSBS

It is not only identifying the local need for suicide bereavement work, or showing that people can be engaged, that is of consequence; being able to demonstrate that this work makes a difference is obviously also of key importance. There is powerful, self-reported evidence here from both the stakeholders and, perhaps more importantly the service users, that LSBS had made significant differences to those involved. To some extent these changes seemed sequential (though not exactly so as people engaged at different points in their journey). It began with opportunities being created in a safe and trusted space to talk openly about thoughts and feelings, some of which had been internalised but never aired before. The compassionate and empathic understanding demonstrated when these were shared helped normalise and validate these feelings and this often helped re-establish confidence. It also helped people begin to be able to reorient their thoughts and feeling and/or find positive coping mechanisms for dealing with them. In turn, this helped them reengage in positive relationships and in various aspects of life such as employment, education and civic engagement such as volunteering. These successes are in line with other suicide bereavement projects that have a strong peer component (Groos & Shakespeare-Finch, 2012).

Whilst we present this as linear, some people moved backwards and forwards through these elements but the strong impression was always one of an overall forward movement toward 'recovery' into a healthier mental state and daily functioning. This evaluation did not attempt to measure the economic impact of these self-reported changes, but we are confident that, given the degree of distress prior to LSBS involvement, and the powerful accounts of the difference engagement made (including accounts of improved coping mechanisms), that there would likely be a concomitant reduction in use of other services and therefore a reduced burden to the NHS and possibly social care. Other studies have shown improvements in work functioning and reductions in health service use for those involved in postvention services (United Synergies, 2011).

Two further points should be made here. First, some caution obviously needs to be applied. This evaluation was only small scale and took place only with those who had engaged with LSBS and were willing to be interviewed; we cannot say whether similar processes occurred or not for those who did not wish to engage or be interviewed. Second, we understand objective measures of the degree of change using some validated scales are already being collected. It may be useful going forward to undertake a social return on investment (SROI) analysis of the work to demonstrate more objectively the economic and social value of this change. We believe from the data collected here that this work would show significant value in those terms. Finally, and linked to this, it was apparent that it is difficult to demonstrate evidence of longer term success, particularly in relation to reductions in suicide, without sustained funding. Impact on suicide rates are influenced by a range of factors and, despite not being able to easily demonstrate whether this work has direct impact on this, the impact of the work on the individuals involved and those around them remains significant.

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The interviews for this service evaluation were conducted in the first few months of 2017, the majority of people interviewed engaged with the service in its first year and therefore some of the details in this evaluation have already changed. This extra section has been written by LSBS staff to bring readers up to date with how some of the key findings and recommendations have already changed and what else we have planned to respond to this report.

Referral rate and Capacity

The biggest challenge for LSBS in the first two years has been a high referral rate. In the first 18 months, support and development was provided by two-part time members of staff. In April 2017, our work force grew to three part-time staff members and three active group volunteers. This change has helped ease the capacity problems for the service, we hope moving forward that we will be able to increase hours in roles, share work across the service in a more productive way and have funding for some sessional work.

Current Service Pathway

The service pathway diagram in the evaluation report has changed in the last 6 months to include family work, a larger work force and changes to the eligibility of counselling in the service. The kind of work completed in each type of support has also been further clarified although the list included is not meant to be exhaustive. The feedback process has been made clear and what information we take from clients has been simplified and focused on our outcome targets. Everyone who enters the service is now seen in a Gateway meeting, an initial face-to-face support session, these are completed by all workers and are helpful with moving people through the service from one kind of support to another. Please see the referral pathway document attached.

Family work

We won a bid to introduce family support, for families with children under 18, in April 2017 from national Mind. Although only 5 months into this work we have noticed the community element of working with, at times, hard to reach families. This work is gradually developing, responding to the needs of parents and families and is an integral part of reducing cross generational suicides. We have already learnt that the stigma surrounding suicide appears to impact parents and carers and a lot of our work has been working with caregivers to plan age appropriate disclosure of suicide, alongside how to talk to children about suicide and grief and to help families to build resilience relationships.

Setting

There are difficulties with being a postvention organisation set in mental health charities, we have recently tried to become more arm's length from our host organisations and have moved in to a co-located office in Leeds City Centre with Leeds Bereavement Forum. We are hopeful that this will make us more approachable, for those people who struggle to ask for help from mental health charities after a suicide loss. We are also working to limit the difficulties of being located over two organisations with different approaches and the effects that has had in the efficiency of our work.

Gender

The evaluation talks about the issue of gender in the service and the limitations of having a female only front line team. Although not mentioned in the report we have had a male volunteer in the peer groups since the start of the service and have had a man's peer support group in the pipe line for some time, but until we took on our third worker we have capacity problems and could not support more groups. The men's peer support group now meet twice a month and are led by two male volunteers. We hope this will increase the referral of men into the service from the current rate of 26%. It feels important to note that although suicide rates for men in Leeds are higher than that of women, we are not working with the actively suicidal population. Postvention is not only about working with people in crisis but instead working with bereaved people to avoid crisis and suicidal thoughts in their future, therefore although we will work towards a higher referral rate of men, we would expect this to be of a similar level of other bereavement organisations. This is also complicated by the fact we know more men die from suicide, so we would expect to see the people around the deceased referred to us in the first instance, which may not be the same gender as the person lost.

BME

We are currently working with key organisations to break down barriers and raise awareness of the effects of suicide in the BME community. In the first instance, we want to work towards clarifying what the barriers are we are facing and whether these are connected to people's culture, religion, race or ethnicity and how we can best engage with these. It seems important for our service to not reduce people with diverse beliefs and backgrounds to one category and therefore our new worker, Surinder will be working to develop a targeted outreach strategy.

Staff support

Our staff are supported in several ways; managerial supervision, external supervision, an experiential group and weekly team meetings. As a result of the key findings in this report we will also look to arrange group supervisions and to reflect on the impact such work can have on peer workers in our operational meetings. We realise the peer element of our service has been highlighted by clients as an important part of their experience and we have a role to be honest and reflexive in our work and own experiences.

