Support for people bereaved by suicide

This section focuses on supporting people bereaved by suicide with the aim of reducing the possible negative effects of a suicide. This activity is commonly referred to as 'postvention'.

Aims of postvention

- An ability to draw on knowledge of the aims of postvention, which include, for example:
  - reducing the incidence of suicide and improving mental health in those who have been bereaved
  - reducing the stigma and isolation experienced by those who have been bereaved by suicide
  - offering bespoke support for those bereaved by suicide (such as support through the legal process)
  - signposting to appropriate sources of support
  - reducing the risk of contagion or the emergence of suicide clusters

Knowledge of bereavement

- An ability to draw on knowledge that the experience of bereavement will be influenced by many factors, including cultural norms, belief systems, faith systems and life experiences
- An ability to draw on knowledge:
  - of psychological models that describe the process of grieving as a series of phases, the order and timing of which will vary from person to person, but which broadly include:
    - initial shock and denial
    - acceptance of the reality of the loss
    - experiencing the pain and distress associated with the loss
    - adjusting to a new reality in which the person who has died is no longer present
  - that it is usual for people to oscillate between a focus on loss and some degree of avoidance
  - that rather than grieving leading to a 'detachment' from the person who has died, it usually involves adjusting and redefining the relationship to them, allowing for a continued sense of connection and an enduring bond

Knowledge about the nature of bereavement after a death by suicide

- An ability to draw on knowledge that bereavement after a suicide is often different from bereavement after a death from other causes, arising from survivors' perceptions of, and preoccupation with, issues such as
  - the degree to which the suicide was seen as an understandable choice (e.g. suicide in the context of a terminal illness, compared with a death that is unexpected and not readily explicable)
  - the extent to which the death is perceived as preventable, and the survivors' or other people's role and responsibility in relation to it (associated with feelings such as guilt, blame or anger)
  - a sense of stigma or shame (which may lead to a withdrawal from potential sources of support)

- a feeling of isolation stemming from a loss that they feel others may not understand

An ability to draw on knowledge that survivors may experience trauma, for example, arising from:

- ruminating about the intensity of the difficulties that the person who has died may have been experiencing
- direct exposure, such as witnessing the suicide itself (e.g. discovering the body), visiting the scene of death, being exposed to artefacts related to the suicide or hearing detailed accounts of the death (e.g. in a coroner's court)
- imagined exposure (creating in the imagination, and ruminating on, a mental image of the way in which the person died and the suffering this entailed)

An ability to draw on knowledge that while grieving, close relatives of the person who has died will face unfamiliar legal and practical issues (such as the police investigation, identification of a body, the coronial process, delayed registration of death and the person's affairs) resulting from the nature of the death and its unexpectedness

An ability to draw on knowledge of common reactions in people bereaved after a death by suicide, such as:

- cognitive and emotional reactions:
  - shock and disbelief
  - anguish, longing and searching
  - shame, and self-blame
  - despair, depression and sadness
  - a sense of abandonment and rejection by the person
  - blaming others and assigning responsibility for the death
  - trying to make sense of the death in order to restore a sense of order
  - guilt (about actions taken or not taken, and their failure to save the person)
  - anger, often related to feelings of guilt, blame, abandonment, and a sense of preventability
  - relief, often accompanied by confusion and guilt (e.g. if the suicide comes after a prolonged period of conflict or need for support)
  - searching for answers (e.g. a preoccupation with learning about what led to the death, difficulty living with ambiguity surrounding the death)
  - fear and anxiety (e.g. that another person close to them may take their own life)
- physical reactions (often associated with anxiety and/or depression) such as:
  - stomach pains, tightness in the chest, sensitivity to noise, breathlessness, disturbed sleep, poor concentration, lack of energy
- symptoms of trauma, such as recurring nightmares or flashbacks

Psychological support

An ability to help to validate and to 'normalise' the person's experiences and reactions (e.g. through listening and through psychoeducation about bereavement)
An ability to allow the person to detail the circumstances of the death and its aftermath
An ability to help the person discuss their emotional reactions to the death and thereby:
come to terms with the reality of the death and the meanings associated with it
acknowledge, accept and find ways to manage their emotions
adjust to the inevitable changes associated with the suicide
rebuild connections to the person who has died that are based on reality (rather than idealised or excessively denigratory)
An ability to identify if the bereaved person is themselves at risk of suicide and if so to implement a safety plan
An ability to identify resources and sources of support with legal and practical issues
An ability to enable access to support groups and psychological services for people bereaved by suicide

Peer support groups

An ability for peer facilitators to:
draw on their own lived experience of bereavement by suicide
listen to the stories of others without being immobilised by their own grief
acknowledge that people will have different ways of coping
work with group members whose cultural background and experience is different from their own
respond appropriately to group members with a different suicide experience from their own
work collaboratively with a co-facilitator
maintain the confidentiality of the group
manage challenging group situations in an appropriate manner (e.g. making sure that certain individuals do not dominate the group)
access support if they are finding it difficult to cope with the cumulative effect of supporting others in distress

Organisational competences relevant to postvention

An ability to draw on knowledge about the structure and content of postvention services set out in public health guidance and the recommendations contained in national suicide prevention strategies
An ability to gather and interpret local data on death by suicide that can be used to inform the need for postvention, for example by:
collating demographic data on suicide deaths
identifying patterns or trends in data on suicide deaths
identifying geographical areas of concern or other evidence of clusters
An ability to identify current local provision of postvention and the availability of funding for services
An ability to identify and contract with organisations/agencies with the capacity and ability to set up and deliver postvention services
An ability to identify the required characteristic of postvention services, for example:
identifying the recipients of services, such as:
adults only, adults and children, children and young people only

	those with close connections to the person who has died, such as next of kin and/or close family members
	non-family who were close to the person, such as friends
	people who knew (but who had variable levels of contact with) the person, such as school friends or work colleagues
identifying the ways in which the characteristics of recipients of services will influence service specifications	
identifying what the service offers to recipients, for example:	
	information and signposting only
	outreach to people who are bereaved
	practical support (e.g. with funerals, legal processes)
	individual clinical support
	peer support
	group support, facilitated by professionals or by peers
	referral pathways to other services
	annual remembrance services
An ability to audit the effectiveness of the postvention service (e.g. through feedback from service users and those offering postvention services, or a requirement for formal reporting on uptake and use)	

Support for people within an organisation after a suicide

This section focuses on the organisational competences required to coordinate a response to a suicide that impacts on an organisation (such as a school, college, healthcare organisation or a workplace).

It identifies the competences associated with offering psychological support to affected individuals or the workplace as a whole, intended to reduce the possible negative effects of a suicide. This activity is commonly referred to as 'postvention'.

Knowledge of postvention

An ability to draw on knowledge that postvention refers to a range of interventions intended to ameliorate the negative impact of a death by suicide
An ability to draw on knowledge that when a suicide impacts an organisation (such as a workplace or school), postvention can be offered both to individuals and at an organisational level
An ability to draw on knowledge that the stance taken by the organisation's leaders sets the tone for the ways in which people in the organisation respond

Instituting postvention

An ability for those in a position of leadership to convey empathy for those who have been bereaved, and to recognise:	
	the potential impact on others and the importance of self-care
	that the responses of members of the organisation will differ depending, for example, on their relationship to, and prior involvement with, the person who has died, and on their own history and experience of bereavement
	that psychological reactions to the death will vary from person to person, both immediately and over time (e.g. shock, guilt, blaming others, anger, sadness)
	that distress can be expressed in different ways, both explicitly and implicitly (e.g. through withdrawal, absenteeism or presenteeism)
	that the level of support offered both to individuals and across the organisation will need to reflect an appraisal of the difficulties that need to be addressed
An ability for those in a position of leadership to recognise the impact of the death on themselves and their own need for support	
An ability to draw on knowledge of basic principles for intervening after a suicide, namely:	
	that all deaths should be approached in the same way regardless of cause (to avoid stigmatising a death by suicide)
	that because of the risk of suicide 'contagion', care should be taken not to glamorise or romanticise the person who has died or provide excessive detail about the method of suicide (such as the means or precise location of the death)
	that the organisation should broadly indicate the likely reasons for suicide (e.g. that the person had psychological difficulties that may or may not have been apparent to others) and highlight that the causes of suicide are complex
	that help should be made available for people who have similar feelings or are in distress

Communicating information about the death

An ability to coordinate organisational communications about the death (e.g. being clear about who is responsible and the medium through which information is relayed)
An ability to draw on knowledge that it is helpful for communications about the death to be clear about the cause of death, for example:
making a full disclosure where the family or carers have consented for it to be known that the person died by suicide
where the family or carers are unwilling for this to be disclosed, managing this appropriately (e.g. indicating that the family or carers do not wish the cause of death to be known, but also facilitating discussion if there are rumours about suicide)

Interventions

An ability to offer organisation-based interventions that can help to:
normalise reactions to the death by discussing the grieving process, and the ways in which this might manifest over time, and the fact that there is no 'right' way of grieving
create opportunities to share stories, thoughts and memories
encourage discussion of the feelings engendered by the death (particularly expressions of guilt, anger or abandonment)
convey the need for self-care
An ability to make practical arrangements for workplace interventions, for example:
establishing debriefing meetings for groups and/or individuals, led by appropriately trained facilitators
varying working practices so as to allow time for meetings to take place
ensuring that there are follow-up meetings in place
An ability to ensure that there is long-term provision of support so as to recognise that feelings about the death can re-emerge (e.g. around the anniversary of the death or around significant events that signal the absence of the person who has died)
An ability to draw on knowledge that most people will adapt to the death without professional support (reflecting their 'natural' resilience), but that some may experience more profound emotional reactions (such as complicated grief, trauma or suicidal ideation)
an ability for the organisation to have systems in place that identify people who are having significant difficulty coping and which can direct them towards appropriate sources of support
An ability to consider whether it is appropriate for the organisation to conduct a memorial event (with the aim of helping people to acknowledge the death and share their grief)
an ability to ensure that any ceremony strikes the right balance between commemorating but not memorialising (and potentially glamorising) the person who has died

Judging when to end postvention

An ability to balance the need for changes in usual patterns of activity to accommodate reactions to the death against the need to re-establish the usual functioning of the organisation, and to:
judge the pace of a return in relation to an assessment of the degree to which the organisation and individuals within it have had time to adjust to the death
accommodate the needs of people who are not ready to return to their usual pattern of functioning