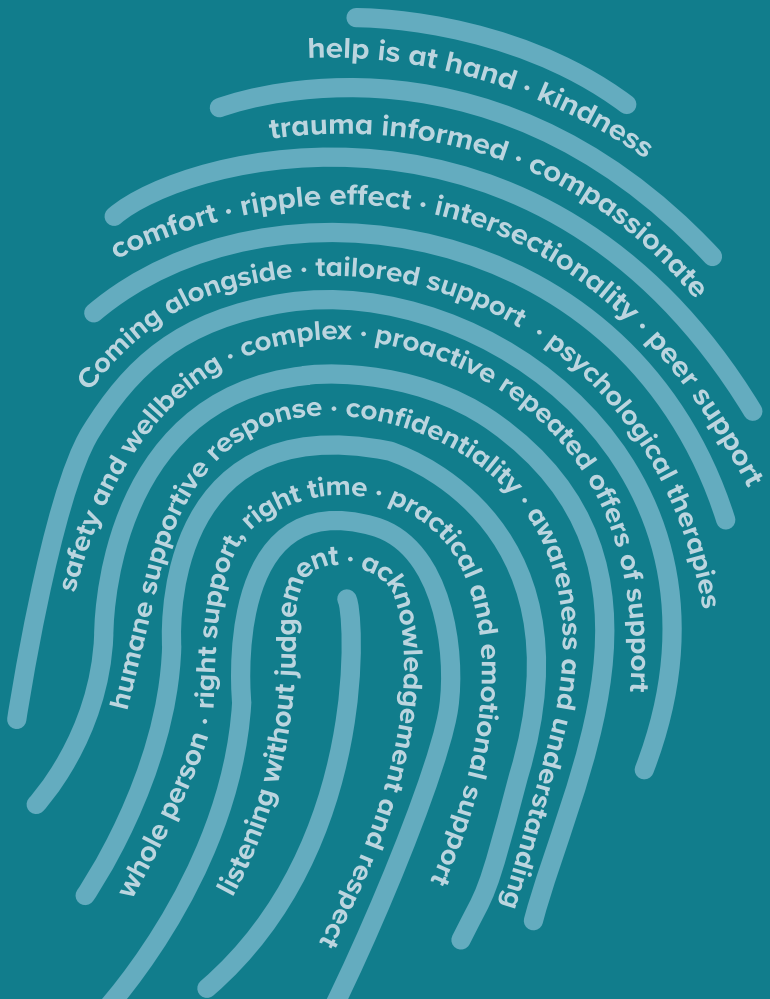
Llywodraeth Cymru
Welsh Government

Responding to people bereaved, exposed, or affected by suicide



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Mae’r ddogfen hon ar gael yn Gymraeg hefyd / This document is also available in Welsh
Rydym yn croesawu gohebiaeth a galwadau ffôn yn Gymraeg / We welcome correspondence and telephone calls in Welsh

Sarah Murphy MS

Minister for Mental Health and Early Years

Foreword

Preventing suicide and ensuring appropriate, timely and compassionate support is available for anyone affected by suicide is a priority for the Welsh Government.

This guidance is intended primarily to support those affected by suicide but it fits as part of a much broader approach that aims to prevent future deaths by suicide.

Suicide is preventable and never inevitable, and we all have a role to play. I would like to express my thanks to those agencies to whom this guidance is directed for their important contribution to the development of the guidance, and for your continued efforts to improve how you respond to those affected.

The guidance has been developed with insight from people impacted by suicide and it aims to help all organisations to better understand their role in supporting people.

The purpose of this guidance is to ensure that those who are impacted receive timely, compassionate and effective support where and when they need it.

This guidance represents our next step in offering support to those impacted by suicide – but they are by no means our last steps.

Our commitment within the guidance to better understand the issues which children and young people are facing speak to our continued dedication to work with stakeholders and continuously develop our understanding of how we can most effectively help those in need.

Foreword from those with lived experience

There is a largely hidden community in Wales that many do not realise exists or become aware of until they become part of it. Every journey to this community is unique. It starts with a sudden or unexplained death that is believed to be suicide. At that moment life can change in a split second. For those at the epicentre of the loss, it can be all consuming, massively traumatising with no idea of how to pick up the pieces of their shattered lives. The ripples of loss and grief can be felt far and wide by so many people and by the community as a whole. It's a loss that has to be absorbed into many people's lives in different ways.

Personal accounts from people in Wales who have been bereaved by suicide talk about the lack of any immediate support and the feelings of abandonment by the authorities. Conflicting reports tell of very different responses from key agencies, ranging from excellent to poor and upsetting, indicating a lack of consistency. Some also describe periods when they thought about taking their own lives.

The guiding vision of this document is for a compassionate Wales that helps all those who have been affected by a suicide and for those who come into contact with them. It is now recognised that the people of Wales need an overarching service that gives an early and proactive offer of support to people at a time when they need it most. A service that is inclusive of everyone, can minimise barriers, and transcend geographical, cultural, and organisational boundaries, through a compassionate, trauma informed response.

This document provides a map for everyone impacted by suicide regardless of where they are on their journey. It presents a set of quality standards for all provisions. It requires people at key touch points to guide and support with kindness and compassion at any particular part of the bereavement journey.

The guidance recognises the importance of caring for people when they have experienced the profound loss of a suicide. It is for everyone, and anyone involved in walking that path. It gives a coherent strategic framework to ensure practical help and emotional support, that is underpinned by kindness and compassion is available.

The guidance moves us towards a Wales where people will no longer be isolated and will be helped to navigate their way to touch points of support and ultimately hope. To know they are not facing this on their own. That there are others to travel the path with them, to help them to be strong again. To be part of their communities and live their lives and believe there can be a future again.

Nina Roberts,
Mother to Alice

Responding to people bereaved, exposed, or affected by suicide

Purpose of the guidance

This guidance aims to set out what a sustainably resourced, quality response would look like and how that needs to be delivered to ensure equitable access. The guidance has been produced through the collaborative efforts of the individuals and agencies best placed to act on it.

Audiences

i. Agencies and service providers who support people living with bereavement following a sudden or unexplained death that could be a possible suicide.

ii. Those who come into contact with people who are on their bereavement journey, or who have been exposed or affected by a possible suicide.

iii. Employers of those exposed to,or affected by deaths by suicide in the course of their paid or volunteer roles, as well as employees personally bereaved following a suspected suicide.

iv. Planners and commissioners of services that support people bereaved by possible suicide.

Overview

This guidance is informed by insights into the needs and experiences of people living with bereavement by suicide in Wales, following a listening exercise that explored the points in their bereavement journey when they interface with a range of statutory and voluntary services (herein referred to as 'touch points'). The guidance outlines how we can provide a more compassionate response, offering both practical and emotional support, at the different steps on that journey.

Addressing the needs of children and young people

The information within this guidance is informed by insights into the experiences of adults in Wales. While recognising that existing provision from a range of agencies supports families affected by suicide, further research and insight is needed to be able to describe the most appropriate, evidence-based response to the specific needs of children and young people at different stages of cognitive development.

This further work is already underway. A rapid evidence review has been conducted by Health and Care Research Wales Evidence Centre (HCRWEC)[1] finding that there are gaps in the evidence base and calling for further research.

A specific pathway for the wider bereavement needs of children and young people is being developed through the National Bereavement Framework[2] setting out how we best meet their needs consistently and over time. With particular reference to bereavement by suicide, further insights work has been commissioned that will provide a set of service standards recognising the specific needs of children and young people (under 25), who bear a significant bereavement burden, including potential trauma and increased risk themselves[3].

This work will recognise those settings where children and young people spend much of their time – schools, further education colleges, higher education institutions, youth, and community groups. The work will acknowledge existing provision and service offers, while developing any additional guidance or resources, through co-production, to ensure a consistent, evidence-based, and compassionate response is enabled across Wales.

Action required

All providers of specialist bereavement services, or agencies who deliver at significant 'touch points' on a bereavement journey following a sudden or unexplained death that could be a possible suicide, to use the guidance to identify aspects of their service that can be improved or developed to achieve the most compassionate and helpful response to those impacted.

Commissioners and planners of services across regions to use the guidance to ensure that the different components of support that meet the needs of those affected by a suspected suicide are in place and sustainable. This will require collaborative working across public and third sectors, through safeguarding mechanisms, Regional Partnership Boards (RPBs) and other funded alliances.

Strategic Context

This guidance contributes to the delivery of the **Suicide and Self-harm Prevention Strategy** for Wales which sets the strategic context for reducing suicide and self-harm in Wales and improving support for those bereaved by suicide. The Strategy includes a specific policy objective to:

> *Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.*

The Strategy will be supplemented by Delivery Plans which will detail the shorter-term, 'SMART' actions that will be taken forward to deliver the objectives in the Strategy.

The Strategy and this guidance have been written in the context of **A Healthier Wales: our Plan for Health and Social Care** ("A Healthier Wales")[4] which sets out the vision for a whole system approach to health and social care in Wales. A Healthier Wales lays out the Welsh Government's ambitions for progress and improvement, and describes the core values that underpin the system in Wales, including:

1 https://www.medrxiv.org/content/10.1101/2023.09.13.23295481v2
2 National bereavement care pathway [HTML] | GOV.WALES
3 Bereavement and suicide bereavement as an antecedent of suicide in children and young people: Prevalence and characteristics - ClinicalKey
4 A healthier Wales: long term plan for health and social care | GOV.WALES

Proactively supporting people throughout the whole of their lives, and through the whole of Wales, making an extra effort to reach those most in need to reduce the health and wellbeing inequalities that exist.

It is also set in the context of the **Well-being of Future Generations (Wales) Act 2014** which aims to improve the social, economic, environmental and cultural wellbeing of Wales. Achieving the wellbeing goals set out in the Act is vital in relation to tackling some of the key drivers of suicide and self-harm in Wales.

This guidance, and the proposal for a system wide response to support after suicide adopts the principles within the **Trauma Informed Framework for Wales**. The Framework establishes how individuals, families/other support networks, communities, organisations and (joined-up) services take account of adversity and trauma, recognising and supporting the strengths of an individual to overcome this experience in their lives. It also sets out the support they can expect to receive from the organisations, sectors and services that they may turn to for help. It is inclusive of people of all ages.

It is also consistent with the **national framework for the delivery of bereavement care** in Wales which was published in October 2021. The framework sets the standard, and acts as a catalyst to drive improvements in quality, provision, and availability of bereavement support across Wales.

Alongside the development of this bereavement guidance, partner agencies across Wales have developed a **real time, or a 'more timely' surveillance system for suspected suicides**, as initially recorded by police officers attending a sudden death.

The **Real Time Suspected Suicide Surveillance (RTSSS)** system is able to consistently monitor suspected suicide deaths, identifying patterns and trends, and providing a more in depth understanding of communities at risk. This information will help improve our response to suspected suicides and allow for a more in depth understanding to inform policy development and action.

In terms of the immediate response to a suspected suicide, at the time of writing this guidance, **local rapid response processes** are emerging across Wales, with efforts being made at a national level to ensure consistent approaches are adopted and supported. Agencies involved in immediate or rapid response work, following sudden or unexplained deaths or suspected suicides, connect those immediately impacted to a range of support offers, helplines, and resources at the earliest appropriate opportunity.

Ownership and Governance

Suicide and self-harm prevention is a strategic priority for Welsh Government. Strategy development and policy is managed through the Suicide and Self-harm Prevention Team, Welsh Government.

The strategy (and accompanying Delivery Plans) development and implementation is monitored through the Suicide and Self-harm Prevention Strategy Board which consists of representatives from across Government and external partners with responsibility for delivering elements of the Strategy.

The Strategy Board will report into the Joint Ministerial Assurance Board currently chaired (September 2024) by the Minister for Mental Health and Early Years, and the Deputy Minister for Social Services.

The National Strategic Programme for Mental Health based in the NHS Wales Executive will have responsibility for delivering significant parts of the strategy and Delivery Plans.

In the context of the Senedd report on suicide prevention 'Everybody's Business', responsibility for suicide and self-harm prevention transcends sector, organisational and geographical boundaries. It is incumbent on all organisations to take steps to equip and upskill their workers and volunteers so that they can make an informed and compassionate response to issues relating to suicide and self-harm, and to reach out to all those affected without judgement or stigma.

Acknowledgements

People with lived experience in Wales

This guidance has been informed by the invaluable insights provided by people living with bereavement by suicide in Wales. Gratitude is extended to everyone who shared their personal journey to inform how we shape our response.

Agencies supporting the listening exercise

CRUSE Bereavement Support, Cymru

PAPYRUS – Prevention of Young Suicide, Wales

To Wish, Gwent

Jacob Abraham Foundation, South Wales

Enfys Alice, North Wales

LISS (Living in Suicides Shadow), West Wales

SOBS (Survivors of Bereavement by Suicide)

#LetsTalkMensMentalHealth, Welsh Valleys

Powys Teaching Health Board

MIND (Aberystwyth, Pembrokeshire, Llanelli)

The DPJ Foundation

National task and finish group to shape the guidance and its implementation:

Police Liaison Unit, Welsh Government

Mental Health Lead, South Wales Fire and Rescue Services

Consultant Mental Health Nurse, Wales Ambulance Service (WAST)

Consultant Child Psychiatrist Aneurin Bevan University Health Board, and Advisor to Welsh Government on Child Mental Health

Public Health Practitioner, Healthy Working Wales, Public Health Wales

Programme Manager, Compassionate Cymru

Director, CRUSE Bereavement Support, Cymru

Head in Wales, PAPYRUS, Prevention of Young Suicide

Director, Samaritans Cymru

Founder and Project Manager, Jacob Abraham Foundation

SPEAK Project Manager, Cwm Taf Morgannwg MIND

Director for Primary Care, Aneurin Bevan University Health Board

HM Assistant Coroner, South Wales Central Coroner's Office

Senior Coroners Officer, South Wales Central Coroner's Office

Care after death Service Manager, Swansea Bay Health Board

Executive Director, and active Funeral Director in Wales, The National Society of Allied and Independent Funeral Directors (SAIF)

CEO, National Association of Funeral Directors (NAFD)

Suicide Bereavement Project Lead, Powys Teaching Health Board

Pathway Lead for Traumatic Stress, Traumatic Stress Wales

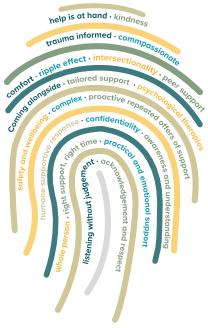
University Chaplain and Faith and Community Manager, Student Services, Swansea University

Bereavement Hub Manager, Support After Suicide Partnership (SASP)

Head of School, School of Journalism, Media, and Culture, Cardiff University

Prison Group Safety Lead, HMPPS Wales

National and regional leadership team for suicide and self-harm prevention in Wales, funded by Welsh Government to support strategy implementation.



Bereavement journey ‘touch-points’

Statutory agencies experienced by people close to someone who has died suddenly by possible suicide.

First Responders

Mortuary

Coroners Office

Funeral Directors, Celebrants

Other agencies who contributed to the individual bereavement journeys of people living with bereavement by possible suicide in Wales

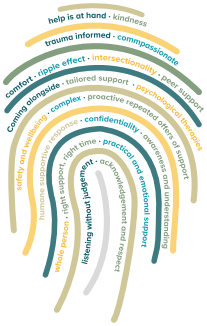
GP or Primary Care Team

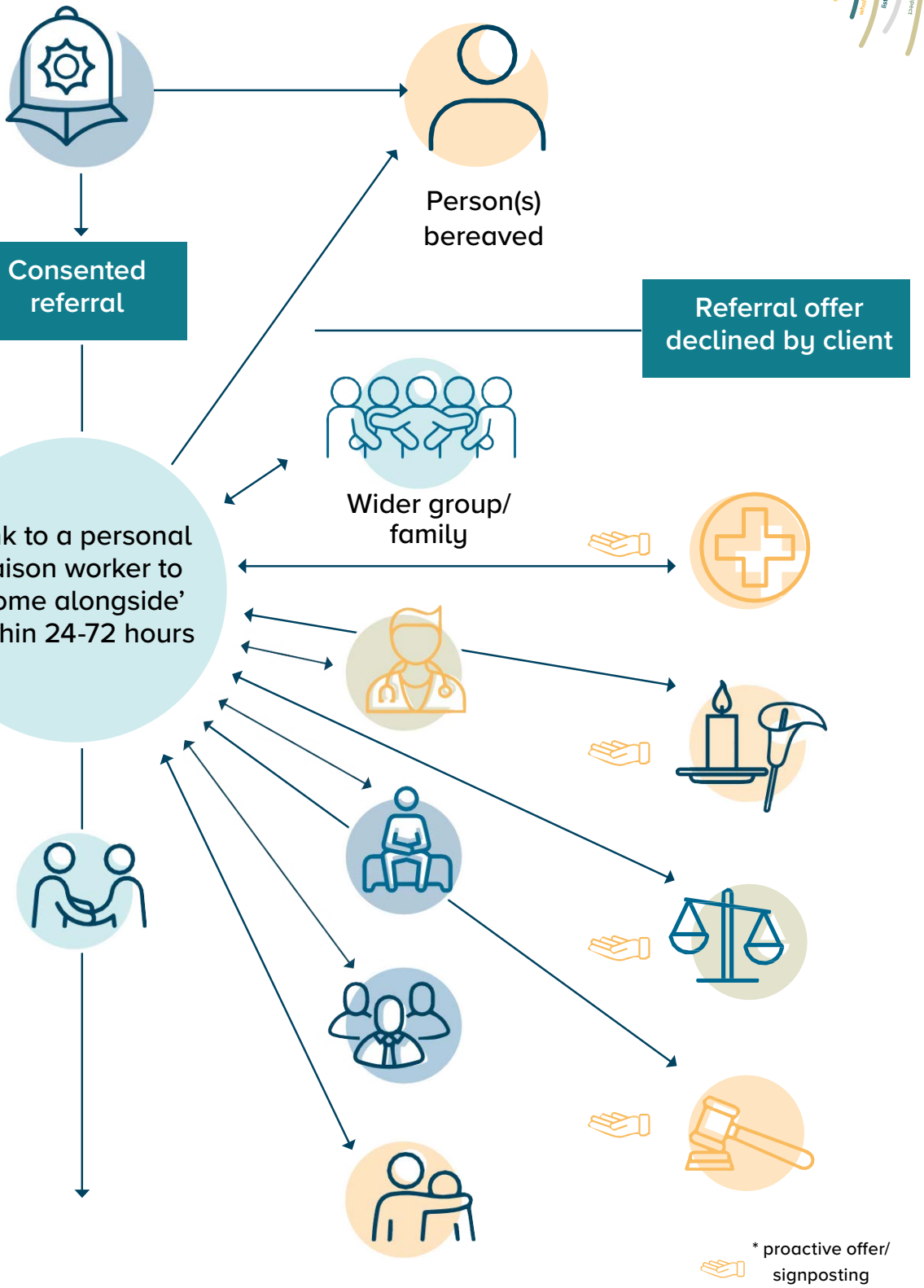
Employers Workplaces

Psychological Therapies / Counselling Services

Peer Support Groups or Networks

Quick guide to accessing a specialist advisory and liaison service following a sudden unexpected death that could be suicide.





Summary

This guidance sets out an optimal system-wide response that delivers an early proactive and evidence-based offer of support, and subsequent recurring offers of support, through four pillars for action:

1. A specialist advisory and liaison service linked to wider provision

A national advisory and liaison service

An agency or service that receives referrals from those who come into early contact with those impacted by a possible suicide and makes a proactive offer of support to those exposed, affected, or bereaved. This service would also respond to those who contact the agency independently (self-refer) seeking help at any point in their bereavement journey.

The offer will involve a conversation to discuss immediate and longer-term needs, and to identify the most suitable sources of both practical and emotional support, working alongside the bereaved, and those around them who are also affected.

The agency or service will accompany those affected on their journey as they engage with the different touch points and processes leading up to an inquest and beyond. They will either help them directly, or sign-post to a range of other possible options according to need and availability, ensuring that the provision is safe and appropriate.

The service will be staffed with experienced and skilled paid workers (see appendices for a sample role descriptor), who understand all aspects of the processes associated with an unexpected and unexplained death that could be a possible suicide, and will be accessible to people affected by a suspected suicide as soon after the death as is practical, within the first 24-72 hours.

Wider provision

There are a range of agencies across Wales who already provide bereavement support, including support for those affected by a sudden unexplained death that could be a possible suicide. Different services, often provided by third sector agencies, are available in different areas, and across regional boundaries. Many of these are already accessible through recommendation or referral, and information about these support services will be key to the signposting offered by the national advisory and liaison service, and the digital Help is at Hand Cymru resource.

These wider services include telephone helplines, peer support groups, counselling support, family group-work or therapy, and longer-term support and follow-up.

Local planners, commissioners and providers of health and care services will need to work collaboratively to ensure that a sufficient range of this wider provision is available to support their local citizens, particularly those who find it difficult to access support due to rural isolation, challenges around communication, mobility or transport, caring responsibilities, digital exclusion, and other, potentially changeable barriers.

2. A compassionate response from agencies that feature on the bereavement journey

A range of 'touch point' agencies who consistently feature on bereavement journeys following a sudden or unexplained death including possible suicide, whose staff will understand the challenges that people face on those journeys, and who respond to them compassionately, linking them to the specialist advisory and liaison service and other local support agencies, ensuring that consistent offers of support are made recurrently and at each touch point.

3. 'Help is at Hand Cymru' resource

This comprehensive resource, available in Welsh and English, is considered valuable by both the bereaved, and the agencies with whom they come into contact, and it will be updated and made available in different formats, including digital, so that it is readily available through different means and sources to increase its use and relevance for all ages and communities. As a digital resource it can continually evolve, working closely with those for whom it is intended, to ensure that it meets their needs.

4. Workforce Development

As set out in the Health, Social Care and Sport Committee's report on suicide prevention (2018) 'Everybody's Business'[5], calls to action transcend geographical and organisational boundaries, requiring all sectors to recognise their part in fostering a compassionate Wales, recognising when others may need help, and being kind to one another.

The needs of people who are bereaved, exposed, or affected by a sudden or unexplained death, that could be a possible suicide, must be more widely understood, and people need to feel confident, and capable of responding to those needs, or in helping those affected to find the right help.

Training and development programmes across sectors need to identify opportunities to learn about bereavement by suicide, the needs of those impacted, and the importance of postvention. To facilitate this, new learning units will be co-produced with those living with bereavement by suicide, and the representatives of the touch point agencies they meet. These accredited training units, with clearly defined learning outcomes, will be made available in a range of delivery formats, and in a way that enables training providers across Wales to help to build understanding and compassion into the system at scale and pace.

5 https://senedd.wales/laid%20documents/cr-ld11947/cr-ld11947-e.pdf

Introduction

One of the six objectives set out in the Suicide and Self-harm Prevention Strategy for Wales, commits us to:

Ensure an appropriate, compassionate and person-centred response is offered to all those who self-harm, have suicidal thoughts, or who have been affected or bereaved by suicide, promoting effective recovery and reduced stigma.

Providing support for those bereaved by suicide is both postvention and prevention. Research suggests that for each person who dies, between 6 and 135 other people could be exposed, affected, or bereaved and requiring support[6]. Those who have lost someone through suicide are also at increased risk of suicide themselves[7]. Too often people with lived experience say they have not felt supported at the very time they most needed it.

From published data[8], the number of deaths registered as suicide in Wales over the last ten years ranged between 247 – 393. In 2022, there were 339 registered deaths by suicide in Wales reported by the Office for National Statistics (ONS)[9]. In 2022, there were 95 deaths recorded due to road collisions[10]. If, for each of those suicide deaths between 6 and 135 people are affected, there are potentially between 1,482 – 2,358, and 40,500 – 47,250 people processing their shock, grief and loss following a suicide every year, in addition to those for whom the grief endures.

A range of agencies provide suicide bereavement support in Wales, nearly half of which are funded by registered charities[11]. Several organisations provide timely and high-quality support to people experiencing loss through suicide, but not enough is consistently available across Wales.

The Health, Social Care and Sport Committee report into suicide prevention 'Everybody's Business'[12] (2018), recommended the development and implementation of a 'Wales-wide postvention strategy for suicide', suggesting that this 'should be taken forward as an immediate priority'. At the Senedd Cymru Plenary on 22nd January 2020[13] (item 6) members further discussed the urgency of developing a better postvention response in Wales.

So, what would a good level of service look like, particularly in a COVID altered environment, and how could we establish that consistently across Wales? How will we know that we are doing this successfully?

6 https://pubmed.ncbi.nlm.nih.gov/29512876/
7 https://bmjopen.bmj.com/content/6/1/e009948
8 Suicides in England and Wales Statistical bulletins – Office for National Statistics (ons.gov.uk)
9 Suicides in England and Wales – Office for National Statistics (ons.gov.uk)
10 Police recorded road accidents: 2021 | GOV.WALES
11 https://gov.wales/sites/default/files/publications/2019-12/scoping-survey-of-bereavement-services-in-wales-report.pdf
12 https://senedd.wales/laid%20documents/cr-ld11947/cr-ld11947-e.pdf
13 https://record.assembly.wales/Plenary/6076#C258995

Terminology and language

Throughout the process of developing this guidance, partner agencies regularly convened and discussed the many complex aspects of the impacts of unexpected deaths such as those where people may have died by suicide, and where the cause is not always known or clear, leading to an inquest.

Armed with insights from those with direct experience, both from those bereaved, and those working in the key agencies who are inevitably involved in events following a suicide, recognition of the many ambiguities and uncertainties around suicide seemed increasingly important.

It was agreed that the following assumptions could be unhelpful when offering support:

- That a sudden or unexplained death is a suicide or will be confirmed as a suicide at inquest. It is not always helpful to refer to a death as a suicide, even if recorded as a suspected suicide by the police, if it has not been fully investigated through the coroner's office, with a judicial verdict confirming death by suicide (though inquest outcomes do not always confirm or reflect what families think or understand to be the cause).
- That the people affected by an unexplained sudden death acknowledge the possibility that it might be a suicide or feel able to accept suicide as a possible cause. This requires sensitivity and caution when support agencies first contact individuals outlining the nature of their services, and offering support for their sudden loss, recognising that the individuals affected should be able to choose the type of support they feel would best suit them, according to their felt needs.
- While many people will have lost someone they love very much, others will have lost someone with whom they may have had a remote or difficult relationship. This can often make the subsequent loss and grieving process more complex, particularly amongst families or groups where the nature of the relationships with the person who has died differ from person to person.
- That the people affected by a death will welcome the offer of bereavement support (though some people living with bereavement by suicide say that they wished someone had proactively reached out to them with this kind of help, feeling unable to be proactive themselves, when they were at their most vulnerable).
- That there might be any consistency in the duration or timeframe regarding the processes that follow an unexplained sudden death, that might be a suicide.

The ambiguities and uncertainties of both the official processes that follow a possible suicide, and the varied nature and complexity of the trauma and grief that is experienced by all those exposed, affected, or bereaved, sets the tone for the nature of the support that people need. This has led to the decision to talk about those **bereaved, affected or exposed to a sudden and unexplained death, that might be a possible suicide**, rather than the shorthand 'suicide bereavement' (unless references are being made within this document to guidance or documents relating to coroner confirmed suicide deaths).

The experiences and needs of each individual, their immediate contacts, and the wider community, need to be explored on a one-by-one, step-by-step basis, and revisited regularly over an indefinite timeframe, by a range of agencies. Immediate solutions or remedies will not necessarily be available to professionals, however experienced or well qualified, and being able to accept this and offer a compassionate and human response, with the commitment to come 'alongside' people on their unpredictable journeys, may provide much of the comfort that is needed.

Advice within other UK guidance documents

There are guidance documents and studies available in the UK that provide helpful direction regarding the components of an effective service response to bereavement following a possible suicide, often referred to as postvention. These documents have influenced both the process of guidance development for Wales, and the recommendations within it.

National Institute for Health and Care Excellence (NICE) Guidance

The NICE suicide prevention quality standard [QS189], published September 2019, advises that people bereaved or affected by a suspected suicide are given information and offered tailored support.

The essential elements of a quality response, set out by NICE, is that people affected are:

- offered information
- asked if they need additional help
- signposted to support if needed.

This should occur as soon as possible and at other opportunities to ensure support is offered when the people affected need it[14].

NICE also provides guidance for suicide prevention partnerships on supporting people bereaved by suicide in guideline [NG105] preventing suicide in community and custodial settings (Sept 2018)[15].

This suggests that partnerships also consider:

- Providing support from trained peers who have been bereaved or affected by suicide or suspected suicide.
- Whether any adjustments are needed to working patterns or the regime in residential custodial and detention settings.

Public Health England (PHE) and the National Suicide Prevention Alliance (NSPA)

Guidance published by the National Suicide Prevention Alliance (NSPA), working with Public Health England (2016) sets out the following 10 stages for the development of local bereavement support services[16]:

- Understand your local context, community, and perceived needs
- Galvanise the stakeholder community (including accountability)
- Create a vision of what good support would look like

14 https://www.nice.org.uk/guidance/qs189/chapter/quality-statement-5-supporting-people-bereaved-or-affected-by-a-suspected-suicide#quality-measures-5
15 https://www.nice.org.uk/guidance/ng105/chapter/Recommendations#supporting-people-bereaved-or-affected-by-a-suspected-suicide
16 https://suicidebereavementuk.com/wp-content/uploads/2020/09/NSPA_Developing-Delivering-Local-Bereavement-Support-Services.pdf

- Define the service
- Develop the service and plan delivery
- Develop evaluation process
- Consider piloting the service
- Review the service
- Extend the service
- Take stock

Health Education England (HEE), National Collaborating Centre for Mental Health (NCCMH) and the University of Central England (UCL) competency frameworks

Supporting people who are bereaved by suicide requires a particular kind of understanding and skill set, for which many provider agencies will have training for their staff. In October 2018, Health Education England (HEE), the National Collaborating Centre for Mental Health (NCCMH), and the University of Central London (UCL) produced a suite of competency frameworks for suicide and self-harm prevention[17]. This guidance presents the specific competences required to support people bereaved by suicide[18] including:

- understanding the aims of postvention
- knowledge of bereavement
- knowledge about the nature of bereavement after a death by suicide
- psychological support
- peer support groups
- organisational competences relevant to postvention.

The framework also describes the competences relating to the support of people within organisations after a suicide (such as a school, college, healthcare organisation or workplace), including:

- knowledge of postvention
- instituting postvention
- communicating information about the death
- interventions
- judging when to end postvention.

Support After Suicide Partnership (SASP) and University of Manchester

In 2020, SASP and the University of Manchester published the report 'From Grief to Hope: the collective voice of those bereaved or affected by suicide in the UK', which included 350 participants from Wales. The report looked particularly at the impact on individuals, and their experiences of accessing support. Findings from an anonymised survey, involving over 7,150 people affected by suicide either personally or professionally, include:

- 82% reported that the suicide had a major or moderate impact on their lives.
- 38% of 5,056 respondents had considered suicide themselves, and 8% had made a suicide attempt.
- The most common relationship reported was the loss of a friend, and those who had lost a friend were more likely to have experienced multiple suicides.
- Of 7,158 responses, 60% did not access support following a suicide, and of 4,621 responses 62% perceived local suicide bereavement support to be inadequate.

17 https://www.ucl.ac.uk/pals/research/clinical-educational-and-health-psychology/research-groups/core/competence-frameworks/self
18 https://www.ucl.ac.uk/clinical-psychology/competency-maps/self-harm/adult-framework/Postvention/Postvention.pdf

- After initial contact with agencies, participants indicated that support should be available with a specialist suicide bereavement support worker.

The report makes a series of recommendations for a national response to bereavement:

- the implementation of national standards
- a national on-line resource
- a campaign to raise awareness of the impact of suicide bereavement
- suicide bereavement training for front line staff
- support for people with risk taking behaviours
- workplace suicide bereavement support
- further research on the impact of suicide.

Wider research

There has also been increasing focus on suicide bereavement and postvention globally, and a suite of research papers on advances in research, practice and policy are openly accessible to inform our approaches (2023)[19]. They observe that, as individuals and groups experience suicide loss differently, their needs for support may evolve over time, and so various support options must be available. Taking a public health approach will provide universal interventions for wide audiences; selective interventions such as support groups or community support for those with moderate grief reactions; and indicated interventions focusing on those with adverse grief and mental health reactions, requiring specific therapy or psychological support.

19 Suicide Bereavement and Postvention: Advances in Research, Practice and Policy | MDPI Books

Understanding the needs and experiences of people in Wales

In the Spring of 2021, a 'listening exercise' was commissioned, to engage with people living with bereavement by suicide in Wales[20].

With the help of key support agencies, individuals came forward to help us to understand their bereavement journeys. They told us what had happened to them after the death, who they met, where those 'touch points' or agencies had shown compassion and helped them along that journey, and where and when their experience was not good, making their bereavement journey more complicated, difficult, and distressing. As the number of participants was relatively small, their experiences do not represent those of everyone affected by suicide in Wales, but their stories provide valuable insights into how they found themselves navigating a complicated process, involving a range of agencies with whom they'd often had no prior experience. Their feedback also affirmed our understanding that bereavement following a sudden or unexplained death, that might be a suicide, is a very personal and individual journey where generalisations are not helpful. However, some key themes did emerge from the conversations including:

- The very specialised nature of suicide bereavement, compared to other forms of bereavement.
- The need to have contact with a person, who understands bereavement by possible suicide, who can help them to navigate the system, and identify their needs in the days, weeks and possibly months following the death.
- The need to be consistently met with a compassionate and considerate response from all individuals and agencies they liaise with, or who they may approach for help and support.
- The significant impact of the inquest – the period leading up to the inquest, the inquest itself, and the period post-inquest particularly if the press or media have reported.
- The need for more clarity and better understanding around the different forms of emotional and mental health support, therapy, or counselling; what each provides in relation to different needs; and how to access a service at the time it is needed.
- Positive experiences relating to peer support offers, found to be more quickly and easily accessible, and attended by people who share the experiences of a bereavement by suicide, but perhaps with a need for more groups to be available or more appealing to men.

20 https://collaborative.nhs.wales/networks/wales-mental-health-network/suicide-and-self-harm-prevention/suicide-and-self-harm-documents/bereavement-by-suicide-insights-jan-march-2021/

Finding out that someone close to you has died by possible suicide

The Police are most likely to inform you that someone close to you has suddenly died in unexpected or unusual circumstances. All police forces have a 'sudden death' protocol, including deaths where the possible cause is suicide.

If a sudden death requires a criminal investigation, police forces in the UK provide a family liaison officer (FLO) or victim support officer. As an unexplained death that is suspected to be a suicide does not constitute a crime, this support is not provided by the Police, though in some instances officers may follow-up in the days following the notification that someone has died. For some of the people who we spoke to, the absence of any immediate support left a profound feeling of abandonment and isolation. While no crime has taken place, sometimes the cause of death is unclear and evidence needs to be collected to support any subsequent investigation, and so that the police can prepare for the inquest that will inevitably follow, and this matter of important police business can sometimes overshadow the needs of those affected by the death. This can present pressures for front line police officers who may not receive in-depth training to manage the conflicting demands at such critical moments, which can also impact on their own wellbeing.

Some of the participants we spoke to had very positive experiences with the Police, where officers made efforts to follow-up with those affected, even when shift patterns made this more difficult, however it remains that it is not the role of the police to provide a more substantive support service.

Practical support early on

Many who took part in the listening exercise, who expressed a lack of support in the immediate days and weeks following the death, said they would have benefited from practical help to navigate those agencies they needed to engage with, and the various support agencies available. Where there were delays in inquests families said ongoing help during this time would have been appreciated. The impact of the COVID-19 pandemic meant many more inquests had a longer lead-in time[21].

Support for those experiencing a deep sense of loss but who are not immediate family

Not all of those bereaved by suicide who participated in the listening exercise had lost someone in their immediate family. Some lost relatives of their spouse or partner, friends, people with whom they were in a relationship. Their relationship to the person who had died meant that they were not able to make direct contact with some of the key agencies or become involved in any plans regarding the person they had lost, and this reduced the opportunity to benefit from any potential offers of support. These participants were emotionally very attached to the person who had died, but were either not next of kin, or deemed a 'person of interest' by the coroner to be engaged in the processes involved, such as the inquest, and so they felt either excluded, or unable to speak on behalf of, or what they felt was in the best interests of, the deceased.

21 https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/impactofregistrationdelaysonmortalitystatisticsinenglandandwales/2020

Challenges around the inquest

Considerable anxiety was expressed regarding the run up to inquests, the inquests themselves, and the period following. Many were not aware that statements they may have made to police officers in the very early stages, could be read out at an inquest. The very public nature of an inquest was also not always explained, or the rights of the press to be present and to report on the death and the circumstances of the person who has died, immediately following the proceedings.

Psychological support and counselling services

For some of those individuals we spoke to, the provision of counselling and psychological services was extremely positive, with some reporting that they had developed life-long skills that helped them with relapses and triggers later in their bereavement journey. However, accessing counselling or psychological support did not always lead to a positive experience. Some did not seek this type of support, never having considered it as something they had needed before or could benefit from, and others who were referred through their GP were faced with significant waiting times. Some people sought the support privately but were not always sure what they needed and sometimes the resulting experience was disappointing. Again, because of the very specific nature of bereavement by suicide, the quality of the therapeutic relationship appeared to be extremely important, and some found their counsellor quite distant and lacking compassion or understanding.

Response to the 'Help is at Hand Cymru' resource

'Help is at Hand' was originally developed by Professor Keith Hawton and Sue Simkin at the Centre for Suicide Research[22], University of Oxford, in collaboration with an advisory group. It was published in 2006 supported by funding from the Department of Health. In England, the resource was refreshed in 2015[23] with the involvement of people with lived experience, and recently updated in March 2021. It is available via the National Suicide Prevention Alliance[24], and other websites.

In February 2013, a Welsh version, 'Help is at Hand Cymru', was developed through the Welsh National Advisory Group for suicide and self-harm prevention[25].The resource was revised in 2016, with Welsh Government funding, through Swansea University, led by Professor Ann John, and that version is now available in digital format, in Welsh and English, on a dedicated digital platform[26].

Most of the people who took part in our listening exercise were not offered access to the 'Help is at Hand Cymru' resource at any point during their bereavement. When presented with a copy, many felt that the information would have been helpful, though some felt it would have also been too much to take in, in the first few weeks.

22 https://www.cambridge.org/core/journals/psychiatric-bulletin/article/help-is-at-hand-for-people-bereaved-by-suicide-and-other-traumatic-death/31F927B88A15B09D06717198A1AE9569
23 https://www.gov.uk/government/news/you-are-not-alone-help-is-at-hand-for-anyone-bereaved-by-suicide
24 Help is at Hand – Providing Individual Support – NSPA
25 https://www.cruse.org.uk/news/help-is-at-hand
26 https://sshp.wales/en/help-is-at-hand/

When asked how they thought the resource could be developed, the people we spoke to made constructive suggestions:

- To provide the information in different formats, eg: paper, digital, interactive presentations with video, as having to read it all written down was something they did not feel they could have done in the early days and weeks
- To break down the document, making different parts available at different stages and through the touch point agencies that each section related to
- Updating the design and look so that it is more visually appealing to young people and males.

This would suggest that investment is required to build on this resource, to bring it up to date, break it down into more accessible components, and to develop its appeal to a wider audience. Now that it is digital, the content and format can be continually updated and improved, working alongside experts by experience, to ensure that it meets their needs.

Recognising the needs of those exposed through their work

When someone takes their own life, it can have a profound effect on all those exposed to the death. Some workers may have been caring for the person leading up to the death while others, whether paid or voluntary, may be coming into contact with that person for the first time. The on-line resource 'First Hand'[27] has been developed in England specifically for those people who are exposed to a suicide death of someone they don't know.

The Royal College of Psychiatrists has published guidance on supporting mental health staff following the death of a patient by suicide (December 2022)[28], making particular reference to clinicians. The universities of Surrey, Birmingham, and Keele have published postvention guidance on supporting NHS staff after a death by suicide of a colleague (2023)[29], and the Royal College of GPs has published guidance for GP practices, should a staff member die by sudden death, including suicide[30]. Further guidance has been published by the Intensive Care Society providing an Unexpected Death of a Colleague First Aid Kit[31].

Many other workers may also be affected, including those working in social care, emergency services, prison, probation, and custodial services, social housing, primary and community-based care, rescue volunteer services (e.g.: RNLI, Mountain Rescue), rail and transport workers, funeral directors, hospitality industry, and many others.

All four pillars of this guidance will contribute to a more developed response to the needs of these workers, alongside other workstreams delivering on the objectives of the wider suicide and self harm prevention strategy for Wales.

27 Home – First Hand (first-hand.org.uk)
28 Supporting mental health staff following the death of a patient by suicide: A prevention and postvention framework (CR234) (rcpsych.ac.uk)
29 UoS_NHS Suicide Postvention Guidance.pdf (nhsemployers.org)
30 Sudden Bereavement Support (rcgp.org.uk)
31 Intensive Care Society | Unexpected Death of a Colleague first Aid Kit (ics.ac.uk)

Delivering a compassionate system-wide response

Overview

The accounts of those directly affected by a suicide suggest that bereavement journeys are unique to each individual and for those close to them. This is captured in our 'fingerprint' logo, produced to support this workstream. There are organisations and agencies with whom many of them will come into contact, but their experiences can be very different depending on where they are and the individuals they meet. Our insights work confirmed that some of these experiences can be helpful and supportive, yet others can be disappointing, distressing, or at worst, they can set people back and re-traumatise them.

Where compassion may be viewed as a variable or desirable extra quality in those delivering front-line services, due to the vulnerabilities of people bereaved by possible suicide, a compassionate response is fundamental and essential, even in the briefest and most simple of exchanges.

People bereaved by possible suicide speak of a very specific set of needs that more generalised bereavement services and responses cannot always meet. Emotional responses can be conflicting and evolve over a lifetime. The potential complexity and longevity of the grief calls for a systems-wide response with multiple flexible components so that people have options for finding the right help and support at various points during their bereavement.

Guidance from the National Institute for Health and Care Excellence (NICE) makes it clear that support should be offered proactively, and recurrently[32]. Based on developments across the UK and beyond, and the accounts of people in Wales, these components would include:

- A point of contact immediately following the death, and the personal assistance of someone who can 'come alongside' and keep abreast of people's needs, as they navigate the days and weeks ahead.
- A compassionate response without judgement or stigma, at the interfaces with touch point agencies.
- A further proactive offer of information and support at each agency the bereaved come into contact with, including an understanding from agency personnel, of the role of the other agencies the bereaved are likely to come into contact with.
- Timely availability and access to sources of mental and emotional therapeutic support appropriate to the needs and experiences of the individual, group, or family.
- Appropriate access to medication where pharmaceutical intervention is the right response, in the context of a wider package of support.
- Opportunities to connect with others living with similar experience, specific to a loss from suicide, such as peer support or community network.

32 https://www.nice.org.uk/guidance/qs189/chapter/Quality-statement-5-Supporting-people-bereaved-or-affected-by-a-suspected-suicide

Key Principles

By engaging with individuals with lived experience, and those agencies they encounter, the following principles have emerged to shape our response.

Those offering support:

- Recognise that each individual bereavement journey is different, and the experiences people have with different agencies is also different.
- Are kind and compassionate, and honest about the uncertainty of each journey ahead and how people's needs might change along the way.
- Ensure that they are providing information that is factually correct and reflects the local processes in the area in which those bereaved or affected are based, and the support systems that are available.
- Recognise the limitations of their ability and capacity to support and ensure that they are equipped with the right information to connect with other agencies and organisations who can provide the additional support that might be needed.
- Remain mindful of the multiple risk factors that can lead to a death by suicide, the complexity of people's backgrounds, the contexts in which they live and work, and the potential for them to have experienced previous trauma (see section on trauma informed practice).
- Acknowledge those characteristics protected through the Equality Act 2010[33], that may present particular needs and preferences (eg: they may be experiencing stigma and discrimination in addition to the stigma often associated with suicide; they may have particular requirements relating to their faith or beliefs, or the faith or beliefs of the person who has died, which may be different; or that they are feeling that these faiths and beliefs are being challenged by the nature of the death).
- Come 'alongside' those who are bereaved or affected, arriving at plans and actions that suit each individual (individual needs potentially being different within groups and families), so that things are done 'with' and not 'to' people when they are most vulnerable.
- Acknowledge that support must always be available in Welsh as well as English and all referral information, assessments that may be carried out, leaflets, and support materials should similarly always be available in Welsh and English as part of the core offer to bereaved people in Wales.

Understanding Compassion

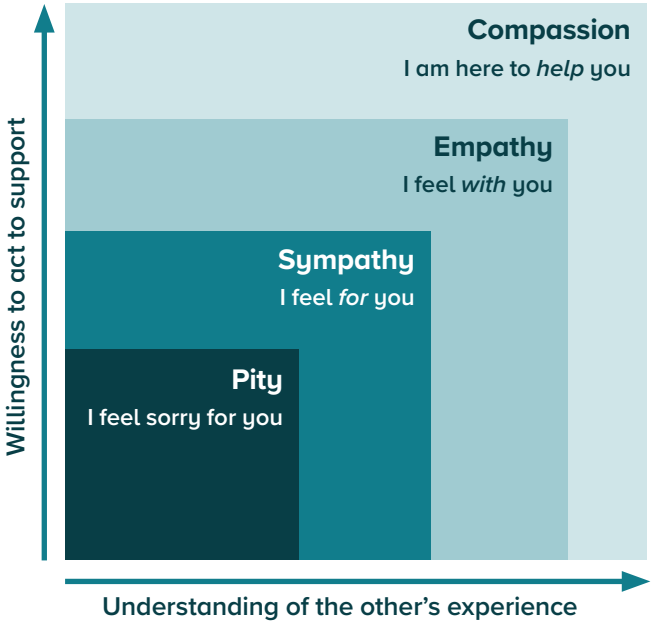
While there are ambitions across Wales to foster compassionate communities, there is currently no clear or shared definition of what compassion is, what it feels like, or how to enact compassion as a way of behaving towards others.

Compassionate Cymru[34] is a national movement whose vision is for everyone in Wales to enjoy the benefits of belonging, to receive help at a time when they need it most, including times when they are dealing with grief, loss, and bereavement, and to give help when they are able.

33 Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)
34 Mission Vision and Values – Compassionate Cymru

The Compassionate Cymru Steering Group[35] recommends a model of compassion set out in the Harvard Business Review[36] which offers a graph explaining how compassion goes beyond empathy and sympathy (see Figure 1)

Figure 1



During the development of this guidance, members of the task and finish group were invited to provide three words that describe how it feels to be met with compassion (see Figure 2). The outcome is captured in the word cloud below where the larger the letters, the more frequently the word was used.

Figure 2

35 https://compassionate.cymru/about/members-and-steering-group/
36 https://hbr.org/2021/12/connect-with-empathy-but-lead-with-compassion

'Compassionate Leadership' is currently gaining traction across the UK public sector[37] [38], identifying four behaviours of compassionate leadership. Whilst framed for the workplace, the components resonate more widely:

- **Attending** – 'listening with fascination' – being present with and focusing on others.
- **Understanding** – 'taking time to properly explore and understand the situations people are struggling with' – valuing and exploring different perspectives.
- **Empathising** – 'feeling the emotions of others without being overwhelmed'.
- **Helping** – 'taking thoughtful and intelligent action' – removing obstacles and providing resources.

Understanding trauma-informed approaches

The impact of a sudden or unexplained death, that is a possible suicide, can induce a trauma response. This may not be limited to those close to the person who has died, but also those who may have been the first person to find the deceased(who they may not know, or who may be a child or young person). They may have been the last person to interact with the person who has died, or impacted by the method used and the immediate care or response required. This can affect family members, members of the public, first responders (eg: emergency services and volunteer rescue teams), public service providers, and health professionals. Indeed, the experience could induce a trauma response in anyone who feels connected to the person who has died or what has happened.

Health and care systems across the UK have been setting out their approaches to trauma-informed practice[39]. The Welsh Government's ambition is for a societal approach to understanding, preventing, and supporting the impacts of trauma and adversity[40]. The recently published Trauma-informed Wales framework (2022) defines a trauma-informed approach as one:

- That recognises that everyone has a role in sensitively facilitating opportunities and life chances for people affected by trauma and adversity.
- Where a person, family, community, organisation, service, or system takes account of the widespread impact of adversity and trauma and understands potential ways of preventing, healing, and overcoming this as an individual, or with the support of others, including communities and services.
- Where people recognise the multiple presentations of being affected by trauma in individuals, families, communities, staff, and others in organisations and systems across society.
- Where knowledge about trauma and its effects are integrated into policies, procedures, and practices.
- That seeks to actively resist traumatising people again and prevent and mitigate adverse consequences, prioritising physical and emotional safety and commits to 'do no harm', and to proactively support and help affected people to make their own informed choices.

37 What is compassionate leadership? | The King's Fund (kingsfund.org.uk)
38 Leadership Principles for Health and Social Care in Wales – Gwella HEIW Leadership Portal for Wales
39 Working definition of trauma-informed practice – GOV.UK (www.gov.uk)
40 Trauma-Informed Wales (traumaframeworkcymru.com)

Acting in a trauma informed way

Trauma can relate to single incidents such as assaults, serious accidents, or events, or through persistent and repeated exposure over time in situations that might be difficult to escape from[41].

People affected by trauma can be less likely than others to seek or receive the help or support they need for a range of reasons. A workforce or community that can recognise where an individual might be affected by trauma can do several things:

- Recognise that people might have experienced various traumatic events and adversity. While being exposed to a sudden death that could be a suicide is a singular traumatic event, it could be in addition to and impacted by previous traumatic experiences.
- Provide a different experience of relationships in which people are offered safety rather than threat, choice rather than control, collaboration rather than coercion, and trust rather than betrayal.
- Minimise the barriers to receiving care, support, and interventions particularly for those whose memories of trauma are triggered by aspects of the service or interactions with staff.
- Recognise that trauma exposure affects people's neurological, biological, psychological, and social development[42].

41 nationaltraumatrainingframework.pdf (transformingpsychologicaltrauma.scot)
42 Supporting documents – Trauma-informed practice: toolkit - gov.scot (www.gov.scot)

Providing an immediate proactive offer of support through a specialist advisory and liaison service

Developing a consistent offer across Wales

Through their discussions, members of the guidance task and finish group agreed that a nationally recognised agency should be identified. The purpose of the agency would be to ensure an immediate and proactive response can be made equitably and consistently across Wales.

This agency would provide a single, straightforward connection between those affected by a suspected suicide, and the police, and other touch point agencies who come into contact with the bereaved or affected at any time along their individual journey. This would also ensure that the NICE guidance to make an early proactive offer of support, with subsequent repeated offers, could be implemented consistently, given how variably the bereaved may be receptive to each offer.

The agency, through suitably qualified and experienced workers (e.g. bereavement liaison officers), would provide a triaging service and facilitate access to the varying forms of support that people bereaved by suicide have told us they need, in whatever delivery format, or geographical proximity is most suitable for them. Some of this might be provided by other organisations, but where there is no obvious provision, the national advisory and liaison service would have the expertise to respond directly to those affected.

Components of an immediate response

Established services specifically designed to respond to people impacted by a suspected suicide across the UK show that the needs of people bereaved by a suicide are often practical in the days and weeks immediately following the death, and these needs were also expressed by those with lived experience in Wales. If someone affected by the death has experienced trauma e.g. they found the deceased person, then they may also need trauma counselling or support from the early stages. However, psychological therapies or counselling can often play their part after several weeks or months have passed. Importantly, there needs to be a process in place for the needs of each person bereaved, affected, or exposed to a suspected suicide to be acknowledged and discussed, so that the right support can be provided at the right time. Essential elements of the initial response are that it is:

- timely (within 24-72 hours in the first instance)
- accessible (immediately, and at various subsequent intervals including longer-term)
- professional (with suitably qualified, skilled, experienced, and supported workers)
- calm and compassionate
- safe
- confidential
- non-judgmental.

There are several roles that provide services for people who need both practical and emotional support when they are going through a challenging experience across different sectors in relation to traumatic events e.g. Family Liaison Officers; Victim Support Officers; Independent Sexual or Domestic Violence Advisors; Macmillan Cancer Support Workers. The offer that these roles have in common reflect the principles underpinning psychological first aid set out by the World Health Organisation (WHO)[43], in providing a humane, supportive response to a fellow human being who is suffering and who may need support.

These include:

- Non-therapeutic but empathetic support, information, and advocacy.
- Review of needs, risks, and concerns to ensure safety and wellbeing.
- Development of plans working alongside individuals to meet identified needs.
- Facilitated access to services and agencies, and connection to information that can help with practical issues and emotional support.
- Listening to people without pressuring them to talk.

A similar role, particularly focused on supporting people who are bereaved by a possible suicide has been outlined in the appendices.

Expectations set out in the National Bereavement Care Pathway for Wales

The national bereavement care pathway for Wales model specification sets out the need for multi-disciplinary and multi-agency integrated support pathways for those bereaved[44]. The pathway recommends that support should always be tailored to meet individual needs following an appropriate assessment, rather than assuming people's needs according to the 'type' of bereavement. It also suggests that incremental assessments of need might need to be available, over time, rather than over-loading individuals with a fuller assessment at their first contact.

An over-arching national service for sudden unexplained deaths, with established links across all forms of potential support, specialised and more general, will enable the delivery of the standards set out in the national bereavement care framework and pathway for Wales, offering choice to the bereaved and ensuring equity in that offer. The agency could also facilitate collaboration and connectivity between the touchpoint agencies identified in the journeys of those living with bereavement by suicide in Wales, and the statutory and third sector agencies providing different elements of support, and inform shared training and development for workers from different sectors and organisations.

43 https://www.who.int/publications/i/item/9789241548205
44 National bereavement care pathway | GOV.WALES

Additional benefits of a 'Once for Wales' approach

A specialist advisory and liaison service would also establish a national overview and directory of more localised provision, the strengths, and the gaps, informing continual improvement in delivering equitable access to the right support at the right time. It could facilitate an 'asset based' approach, engaging with the existing and variable range of offers that respond to differing needs, while working to shared service outcomes and quality standards.

Learning can be taken from other parts of the UK. Research reviewing services across England has been published, emphasising the importance of in-built evaluation[45], and Scotland has now completed the second consecutive year of evaluation of their service, which includes aspects such as quality assurance, receiving and allocating referrals, and contributing to staff training and development.[46] The evaluation report provides valuable insight into the benefits to the people accessing the service, and how the service enables them to explore different offers as their needs change over time.

Through the engagement of an over-arching national service, issues regarding data protection and data disclosure agreements will be simplified helping to ensure the protection of the personal information of those affected, in the immediate hours and days following an unexplained death that could be suicide. If there is a central agency and point of contact, it may also be clearer to those impacted, who they can expect to contact them soon, at a time when multi-agency engagement might be overwhelming.

From a commissioning perspective, performance management will be more straightforward, against clear expectations around efficiency, timeliness, consistency, evaluation, and engagement of those with lived experience in the continual improvement of services.

45 Evaluating Postvention Services and the Acceptability of Models of Postvention: A Systematic Review – PubMed (nih.gov
46 Suicide Bereavement Support Service: evaluation report – year 2 – gov.scot (www.gov.scot)

Developing a consistently compassionate response through the 'touch point' agencies and the wider community

What agencies at the different 'touch points' can do

Delivering trauma informed compassionate services requires a move away from process-led medical models[47], to being person-led, giving the service user choices, and offering appropriate support and interventions, understanding the widespread occurrence and nature of trauma and loss. Collaboration and multi-agency working is essential to delivering holistic (whole person) care and support.

In relation to a bereavement journey following a possible suicide, the 'touch point' agencies such as the police, mortuaries and coroners have clear processes that need to be followed in the scope of their statutory duties. These partners work very closely together, and part of the compassionate response is that the bereaved are helped to understand the role of each of these services or agencies; how they will be concerning themselves with the details regarding the deceased; and the opportunities and limitations regarding their level of engagement with the bereaved individuals and families in any kind of supportive capacity.

In trauma-informed compassionate practice, irrespective of the limits of the scope of any given service, all daily interactions (spoken and written) with another person (service user and co-workers) are kind and considerate. Sentences are framed positively. The well-being of the individual is given precedence. This includes being aware of culture and language, gender, disabilities, and individual differences. Physical environments also need to be trauma informed. They need to be accommodating, comfortable and safe. Services should strive to provide spaces that are designed to give service users a sense of belonging and normalisation.

Through the listening exercise we learned from those bereaved by a suicide that funeral directors are particularly helpful about practical issues relating to a death, with capacity to spend time with the bereaved, and the skills to show kindness and compassion. Funeral directors are themselves first responders to the scene of a death, working closely with police, mortuaries, and coroners, as well as offering funeral services, and part of our efforts to foster a compassionate community response would be that each of these agencies share the responsibility to help the bereaved to understand the roles of the different agencies and services, and how, when, and why they will feature along the bereavement journey.

47 Living with grief – The Lancet

Agencies at the first point of contact

Police

Current guidance

Suicide and bereavement response (college.police.uk)

Adaptations to service delivery

The police play an active role in helping those agencies with statutory responsibilities to help vulnerable people. At a strategic level there is an NPCC (National Police Chief Constable) lead for suicide and bereavement care, who works alongside the lead for Mental Health.

At an operational level, police officers and staff come across people at risk of suicide in their everyday duties. Police have an important part to play in taking immediate safeguarding action.

Data sharing through appropriate channels will further assist in ensuring these individuals receive the care they need.

Police, along with the Welsh Ambulance Services NHS Trust (WAST), are most likely to be the first emergency services on the scene following a suspected suicide. The above guidance document (Authorised Professional Practice College of Policing) sets out the policing response that officers will provide.

Welsh Ambulance Services NHS Trust (WAST)

Current guidance

JRCALC Plus – Class Professional Publishing

Up to date guidance can be found on the JRCALC Plus app as well as through existing WAST policies.

Adaptations to service delivery

From call handlers working in the 999-contact centre, through to nurses working in the 111 service, and paramedics and technicians working in ambulances, most have spoken with someone who has been affected by suicide. Many will have been involved in efforts to resuscitate people and to support newly bereaved families. WAST has a major focus on suicide in their training programme, delivering Suicide First Aid across the organisation. E-learning modules are available to all staff through the WAST Learning Zone on suicide intervention, and a culture of compassionate communication is emphasised for all of their interactions.

This guidance will help WAST to work with partners across Wales to improve the response to people who are bereaved by suicide. Support is available to staff affected via TRiM practitioners or the Wellbeing Team.

Funeral Directors

Current guidance

Funeral directors are governed predominately by two professional bodies but some of the smaller, independent firms may not be part of either organisation and act independently.

UK Independent Funeral Directors (saif.org.uk)

Home – National Association of Funeral Directors (nafd.org.uk)

Adaptations to service delivery

If a death is sudden or unexpected, funeral directors are usually one of the first to attend the scene. They are called by the police and attend to both move the deceased from the place of deathto the mortuary; and provide the family with immediate support and information on next steps. The family will usually have provided the name of the funeral director they wish to use, but in cases where the family do not have a nominated funeral director, the police will contact a funeral director on their behalf.

Funeral directors are often well placed to provide immediate support to the family. They predominantly arrange all things relating to the funeral of the deceased, and then support with the funeral or ceremony (religious or non-religious), dependent on the wishes or preferences of the family, or the bereaved, in relation to their cultural practices, faith or beliefs, or their wish for a natural or humanist ceremony.

In the early days the funeral director can assist with paperwork, provide advice about finances and legalities, as well as signpost families for bereavement support, however signposting families for further support can be inconsistent, and dependent on the individual company or person. It is not a requisite of the role, and some funeral directors may only know where to signpost to if they have previous experience or research sources of support on behalf of the family. Having up-to-date information readily available would optimise the opportunities presented at this point of contact. Families will often return to the same funeral director time and time again, for any further bereavements, and often keep up contact long after the funeral has taken place providing ongoing opportunities to signpost to support that is available.

Royal National Lifeboat Institution (RNLI)

Current guidance

Drowning Prevention Strategy – National Water Safety Forum

Royal National Lifeboat Institution (RNLI) – NSPA

The RNLI has noted an increase in their response to incidents of self-harm which, while not resulting in loss of life, can have a traumatic and lasting effect on the first responders. In other instances, cases of repeated self-harm often signal later incidents of suicide which can have a traumatic impact on the RNLI volunteers.

Adaptations to service delivery

Regarding the public and loss of life, it might be that the bereaved may wish to engage with those RNLI first responders to achieve greater understanding of the circumstances of the incident surrounding the death of the person they have lost, and this support could be offered by a TRIM (Trauma Risk Incident Management) trained member of their team.

Mortuaries and hospital end of life or care after death services

Current guidance

https://gov.wales/national-framework-delivery-bereavement-care

Adaptations to service delivery

In most Health Boards there is a team offering bereavement support to families when a patient dies in hospital. This team sometimes has a dual role, working within the mortuary, or a separate service altogether. Some Health boards do not have a dedicated bereavement service, which is something that is being supported through the National Bereavement Framework.

Within each Health board, there will usually be a nominated mortuary site which serves as the Public Mortuary, into which all sudden or unexpected Coronial deaths, including suicides or suspected suicides, will be brought. This places either the bereavement team or mortuary team at the epicentre. The team will be aware of the deceased person, and the circumstances, very early on and be well placed to provide immediate support. This team usually works in close collaboration with the Coroner's Office and Police, and usually also has significant contact with the family, especially if there needs to be an identification performed at the mortuary.

Often, families will also want to visit their loved one, especially in this type of circumstance, and this again is facilitated by the mortuary team or the bereavement support team. This level of care and respect will include establishing their faith/belief and that of the bereaved family. In some cases, some interventions will be traumatic (for example, some faiths require burial or cremation within 24 hours and delay adds to trauma; some faiths oppose invasive examination of the deceased's body and overriding this deeply held belief will add to trauma).

Some mortuary or bereavement teams do not offer dedicated support for the family or relatives of Home Office or Coronial deaths[48], only hospital deaths. However, they are in an excellent position to do so if they have the right training, and many teams will respond to all deaths in the same way.

Prison Services

Current guidance

https://www.gov.uk/government/publications/managing-prisoner-safety-in-custody-psi-642011

Adaptations to service delivery

Prisons will appoint a Family Liaison Officer (FLO) in the event that a prisoner dies or becomes seriously unwell during their time in custody. The Family Liaison Officer will often attend the family address to break the news of the death in person to the family. They act as the point of contact between the prison and the family, providing information and practical support where appropriate. FLO's will stay in contact with the family, dependent on the family's wishes until the conclusion of the Coroner's Inquest. They are available to attend the individual's funeral and can support with returning the prisoner's property to the family. They will signpost families to relevant local support services as and when the need arises.

Staff and other prisoners may also be affected by suspected suicides within the custodial estate. Staff are provided with support from the local Care Teams as well as being provided access to Trauma Risk Management Assessments (TRiM). In collaboration with the Samaritans HMPPS in Wales has recently rolled out its Postvention offer. As well as sensitive handling of the news of the death, including face-to-face communication with as many prisoners as possible, there is an offer of support from the Samaritans Listeners (selected prisoner volunteers who provide emotional support to their fellow prisoners) who have undergone additional training to be able to provide proactive support in these circumstances.

48 What to do after someone dies: When a death is reported to a coroner – GOV.UK (www.gov.uk)

Agencies involved in the Inquest

Coroner's Services

Current guidance

Guide to coroner services – GOV.UK (www.gov.uk)

Adaptations to service delivery

The work of the coroner's office exposes the staff to the full community impact of a death, including those by suicide. The impact observed by coroners around suicide is that it can include further deaths by suicide, amongst friends and family members traumatised by a suicide. Advice provided by those providing coroners services include:

- Use of available resources to help people to understand in what circumstances a death will be referred to the coroner's office (eg: 'Help is at Hand' Cymru), and that if referred, that the coroner's office will contact the bereaved.
- The provision of contact details for local agencies likely to be involved and who can support the bereaved, and this information also being consistently provided by police, ambulance services, funeral directors, GPs, and hospital bereavement services.
- Support for the provision of an independent person for the bereaved to talk to, and for that support to be available as rapidly as possible, and available for as long as is required. The practical support that this person offers should include practical guidance concerning the inquest and all that it involves.
- That postvention is recognised as relevant across the life-course, as coroner's offices receive reports of suicide amongst the elderly often in relation to the loss of their lifetime partner, loss of good health, status, self-worth and loneliness. Coroners would encourage GPs and community nurses to be vigilant to the emotional welfare of their elderly patients who live alone.
- Recognising the wider 'ripple effect' of a suicide across a community and over time, ensuring the visibility and availability of support services without stigma so that people can seek and find support as and when they need it.
- With regard to suicide prevention, coroners have observed a frequency in the link between suicide and drug and alcohol use, highlighting the need for wider policy to address suicide, and broader prevention interventions and support for people using drugs and alcohol.
- Recognising those attending an inquest who may represent the media or press, and reminding them of the need to be responsible in any reporting in relation to an unexpected or unexplained death.

Press and Media

Current guidance

Industry guidance:
Reporting on suicide for journalists (ipso.co.uk)

NICE (National Institute for Health and Care Excellence) guidance:
Quality statement 3: Media reporting | Suicide prevention | Quality standards | NICE

Samaritans media guidance:
Samaritans' Media Guidelines

PAPYRUS media guidance:
Guidance on Reporting Suicide – Papyrus UK | Suicide Prevention Charity (papyrus-uk.org)

World Health Organisation (WHO) resource:
Preventing suicide: a resource for media professionals

Adaptations to service delivery

An inquest is a public hearing, and the press and media are entitled to attend to report on unexplained or unexpected deaths, in the public interest. There is a delicate balance to strike to serve this public interest, while ensuring respect and compassion is shown to the family or those close to the person who has died, and indeed to be respectful to the deceased.

A journalist's role at an inquest is to report matters of public interest and serve the principle of open justice, that is ensuring justice is seen to be done before the wider public. Journalists will not attend every inquest, but they will decide which cases to hear based on their perceived news value, whether they serve the interests of the community, or perhaps where there is a fault that the coroner will attribute. Sometimes relatives of the deceased can find journalists' presence at an inquest intrusive, but a good journalist will not seek to sensationalise or exaggerate their reporting. Some families can find the support of the press helpful in exposing failings among public bodies and feel able to work with the press to share their stories.

Journalists work to ethical standards that aim to minimise media intrusion into bereaved relatives' grief when a death is due to suicide, and these standards are reflected in the guidance referenced above, for people working in the media.

Coroner teams may find opportunities to draw this guidance to the attention of those attending the inquest on behalf of press and media outlets, at the time of the inquest.

Agencies that provide additional support

GPs and Primary Care Teams

Current guidance

Suicide Postvention:
Support Pack for General Practice in Derbyshire (derbyandderbyshireccg.nhs.uk)

Experiences of suicide bereavement:
a qualitative study exploring the role of the GP – PubMed (nih.gov)

Experiences of support from primary care and perceived needs of parents bereaved by suicide:
a qualitative study – PubMed (nih.gov)

Adaptations to service delivery

Primary Care services are an integral part of supporting the health and wellbeing of our communities. People affected by suicide will often come into contact with primary care services at various points in time following bereavement from suicide. However, with over 400 GP practices in Wales, there is likely to be significant variation in the capacity and nature of what practices are able to offer in support. Primary Care clusters and their constituent GP practices should ensure that their teams have the capacity, capability, and support to provide a meaningful and compassionate response when in contact with people affected by suicide.

Whilst primary care does not in general provide specialist or dedicated bereavement services, primary care staff and teams should be able to describe the variety of support available to individuals within their teams. This is especially important given the increasingly multi-professional nature of primary care services. As primary care staff, especially reception/care navigation staff, will often be resident within the communities in which they work, any training to support staff to provide a compassionate response following bereavement should also address the emotional impact and pastoral care of the staff themselves.

Employers and workplaces

Current guidance

Guidance is available from several sources including the Chartered Institute of Personnel and Development; the Advisory, Conciliation and Arbitration Service (ACAS); and on the GOV.UK website regarding entitlements following a bereavement.

https://www.gov.uk/time-off-for-dependants

https://www.gov.uk/parental-bereavement-pay-leave

Responding to suicide risk in the workplace: a guide for people professionals (cipd.co.uk)

Reducing the risk of suicide: a toolkit for employers – SASP (supportaftersuicide.org.uk)

Responding-to-Suicide-A-Guide-for-Employers.pdf (hospicefoundation.ie)

https://www.nhsemployers.org/articles/suicide-prevention-and-postvention

bitc-wellbeing-toolkit-PHESuicidePreventiontoolkit-Feb2020.pdf

https://www.acas.org.uk/time-off-for-bereavement/supporting-an-employee-after-a-death

Your Workplace | Time to Change Wales

Crisis Management In The Event Of A Suicide: A Postvention Toolkit For Employers – Business in the Community (bitc.org.uk)

Adaptations to service delivery

There are currently no UK laws obliging employers to grant leave entitlement for death in the family, however employees have a right to time off to deal with an emergency involving a dependent. Since April 2020, employees are also entitled to statutory parental bereavement pay and leave.

Many employers have a clear plan or bereavement policy on how they will support employees when someone dies, that provides for bereavement leave, pay during leave, and other considerations such as managing the return to work, and what offers are available to support the employees ongoing health and wellbeing.

A bereavement following a possible suicide can present particular challenges and support needs, as the death may be followed by an inquest, and might be of interest to the local or wider media and enter the public domain. This may require a range of responses, and recognition of the length of time it might take for the full repercussions of the death to play out.

Some of those living with bereavement by suicide who participated in the listening exercise explained how they experienced stigma and a lack of understanding around their experiences amongst work colleagues. Others found that their employers showed compassion and went over and above legal requirements to ensure they were supported. Time to Change Wales is an anti-stigma campaign with an organisational pledge to support employers in combatting stigma in the workplace[49].

49 https://www.timetochangewales.org.uk/en/employers/

Samaritans Cymru have developed a bilingual toolkit 'Working with Compassion'[50] to help people in Wales to develop compassionate approaches at work and improve interactions between staff, customers, clients, or services users. Healthy Working Wales[51] also provides guidance to employers and businesses on supporting employee mental health and wellbeing.

Psychological, counselling or 'talking' therapies for mental and emotional support and skills development

Current guidance

Matrics Cymru (CM design – DRAFT 15).pdf (wales.nhs.uk)

Adaptations to service delivery

The Matrics Cymru guidance for delivering evidence-based psychological therapies in Wales defines psychological therapies as treatments and interventions that are derived from specific psychological theories and formulated into a model or treatment protocol[52]. The guidance recognises that the quality of the relationship between therapist and service user is an essential component in the delivery of effective psychological interventions.

Peer Support Groups

Current guidance

Volunteer opportunities, rights and expenses: Volunteers' rights – GOV.UK (www.gov.uk)

Guidelines for Delivering Bereavement Support Groups – Support After Suicide

Adaptations to service delivery

Peer support resonates strongly with people bereaved by suicide, providing potentially indefinite comfort and companionship.
Many of the agencies already providing suicide bereavement support in Wales are led and staffed by people on their own bereavement journeys, who make themselves available to others, to provide much needed understanding. Some of these agencies also provide signposting to other forms of support, or access to a range of therapies.

50 https://www.samaritans.org/how-we-can-help/workplace/working-with-compassion-a-toolkit-for-wales/
51 Healthy Working Wales – Public Health Wales (nhs.wales)
52 Matrics Cymru (CM design – DRAFT 15).pdf (wales.nhs.uk)

Other considerations for ensuring a compassionate response

Ensuring equitable access to support

Health Inequalities

The suicide and self-harm prevention strategy for Wales presents a clear gradient between the rates of suicide, and residence-based deprivation, with rates of suicide being highest in the most deprived communities. In 2017 Samaritans commissioned a report 'dying from inequality'[53], followed by 'socioeconomic disadvantage and suicidal behaviour: finding a way forward for Wales'[54] from Samaritans Cymru. Both reports recognise that people living in the most disadvantaged or under-served communities face the highest risk of dying by suicide with income, unmanageable debt, unemployment, poor housing conditions, and other socioeconomic factors contributing to risk.

It is important to ensure that people impacted by suicide have equal access to bereavement support across communities, particularly where numbers of suicides may be lower than in highly populated areas, but rates per 100,000 might be higher eg: in more rural regions. The Samaritans Cymru report identified that those experiencing poverty are unable to access some forms of bereavement support due to lack of resources, recommending that GPs, coroners, and funeral directors present possible opportunities for signposting and linking bereaved individuals to appropriate sources of support. The provision of a national advisory and liaison service will help to overcome gaps in services and provide support for underserved communities.

Intersectionality

The protected characteristics set out in the Equality Act (2010)[55] (age, disability – which could include neuro-diverse conditions, gender, marital or civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation), are often considered separately, failing to recognise how multiple social identities can intersect at an individual level, compounding the impacts of marginalisation and disadvantage[56, 57]. Individuals and families impacted by a death by suicide may have multiple characteristics that lead to them experiencing several barriers to accessing services, and which may also make them more vulnerable to suicide within their communities. The Support After Suicide Partnership (SASP) has recently commissioned research on the particular needs of LGBTQ+ communities[58] setting out recommendations for improvements in our response and across touch point agencies. SASP has also published a guide on supporting people bereaved by suicide

53 Samaritans_Dying_from_inequality_report_-_summary.pdf
54 Socioeconomic disadvantage and suicidal behaviour | Samaritans
55 Protected characteristics | Equality and Human Rights Commission (equalityhumanrights.com)
56 Neurodiverse conditions are found in people with differences in the way their brains work and develop, and include autism spectrum disorder (ASD), and attention deficit hyperactive disorder (ADHD), Dyslexia, Dyscalculia and Dyspraxia (Neurodiversity – Oxford Health NHS Foundation Trust)
57 https://www.thelancet.com/journals/lancet/article/PIIS0140-6736(21)02801-4/fulltext
58 LGBTQ+ Bereavement by Suicide Research Study – SASP (supportaftersuicide.org.uk)

who are neurodivergent[59], in collaboration with Ambitious about Autism, the ADHD Foundation, and Autistica.

A compassionate response to all those affected by suicide should ensure that all aspects of people's needs, and preferences are acknowledged, whether financial, cultural, social, related to aspects of their identity or sexuality, their physical or mental capacity, or their overall health and wellbeing.Faith and belief can be important at such a time, recognising that the faith or beliefs of the deceased may not be shared by all those bereaved, and the faith or beliefs of the bereaved may be challenged or changed by the experience. The VCSE (voluntary, community, and social enterprise) Health and Wellbeing Alliance in England has recently published guidance on Faith and Suicide Prevention, produced by FaithAction[60], which raises the need for front-line workers to provide cues and opportunities for people to talk about their faith, if it is important to them.

The Human Rights Act (1998) is underpinned by five principles that guide public authorities: F – fairness, R – respect, E – equality, D – dignity, A – autonomy (FREDA) Commitment to these principles is driven either by the desire to build a fairer, more inclusive society, or to improve services for the most disadvantaged or vulnerable[61]. The application of these principles also informs approaches taken by inspectorate organisations such as Care Inspectorate Wales[62].

While intersectionality is an emerging concept, with an under-developed evidence base, it is gaining traction as a way of encouraging approaches that are sensitive to subgroup inequalities and the processes that generate them[63].

The development of real-time suspected suicide surveillance will enable us to monitor those factors and characteristics relating more closely to intersectionality in the future.

Cultural Competence

Cultural awareness, knowledge, and sensitivity create the capacity to provide effective services that consider the cultural beliefs, behaviours, and needs of individuals and communities across a diverse society.[64]

With regard to culturally sensitive bereavement support, a guide for practitioners has been produced by agencies serving boroughs across London[65], recognising that culture, faith and religion can have a significant impact on the grieving process, and the importance of not acting on the basis of one's own assumptions and beliefs.

Regarding bereavement specific to suicide, a recent report published by the Support After Suicide Partnership (SASP) acknowledges the increased vulnerability to suicide among Gypsy, Roma and Traveller communities across the UK[66]. The report describes particular traditions and conventions that surround a death within these communities, emphasising the benefits of offering a single point of contact for bereavement support; recommending that thought is given to how information is provided due to language and literacy barriers; and highlighting the need

59 https://supportaftersuicide.org.uk/neurodivergence-guide/
60 Talking faith in suicide prevention — Produced by FaithAction
61 https://www.equalityhumanrights.com/sites/default/files/the_impact_of_a_human_rights_culture_on_public_sector_organisations_0.pdf
62 https://www.careinspectorate.wales/sites/default/files/2019-08/190501-human-rights-en.pdf
63 https://health-policy-systems.biomedcentral.com/articles/10.1186/s12961-021-00742-w
64 Cultural-Competency-Toolkit.pdf (diversecymru.org.uk)
65 JC0323_Good_Thinking_Bereavement_v3.pdf (good-thinking.s3.amazonaws.com)
66 Understanding Gypsy, Roma and Traveller communities: A Support Guide – SASP (supportaftersuicide.org.uk)

to connect with local organisations who have the expertise and trust of those communities. Guidelines for improving Roma health have also been published in England.[67]

Welsh Language

The Welsh Language (Wales) Measure gives the Welsh language official status in Wales. Communicating with individuals in their own language is a key component of delivering good care. It is important that anyone bereaved by a sudden death or suicide is able to access support services, including touch point agencies in the language of their choice. This should include information at the first point of contact, any referral conversations and information collected, leaflets, materials, and support sessions whether provided face to face or virtually.

Mwy na geiriau/More than just words is the Welsh Government's strategic framework to strengthen Welsh language provision in health and social care. At the core of the framework is the principle of the Active Offer. It places a responsibility on health and social care providers to offer services in Welsh, rather than on the individual or service user to have to request them.

Workforce Development

As set out in the Senedd Inquiry report (2018), suicide prevention is 'Everybody's Business'[68], calls to action transcend geographical and organisational boundaries, requiring all sectors to recognise their part in fostering a compassionate Wales, recognising when others may need help, and being kind to one another. Specific competencies related to postvention are set out in the HEE/UCL/NCCMH guidance[69].

The particular needs of people who are bereaved, exposed, or affected by a sudden or unexplained death, that could be a possible suicide, need to be more widely understood, and people need to feel confident, and capable of recognising and responding to those needs, or in helping those affected to find the right help.

Professionals, front-line workers, volunteers, and members of the public will all interface with individuals, families and communities who are exposed or directly affected by a suicide. A national survey of suicide prevention training needs across sectors was conducted in Wales in July 2023, with responses from over 2045 people, mostly front-line workers. When asked about their levels of confidence in different circumstances, they reported their lowest levels of confidence related to supporting those bereaved or affected by suicide[70]. Training and development programmes across sectors should create opportunities for conversations about bereavement, loss, and grief to take place, and for learning about the particular nature of bereavement by suicide to be understood, including the importance of compassion and kindness.

A package of accredited training and development offers are currently in development using a co-production approach. These will build understanding and skills to manage different interactions with people exposed, affected, or bereaved by suicide, that particularly reflect the response in Wales, and in the context of the wide range of support available in Wales. These learning units will be informed by the national competency frameworks that are available to guide curriculum development[71].

67 Improving Roma health: a guide for health and care professionals – GOV.UK (www.gov.uk)
68 https://senedd.wales/laid documents/cr-ld11947/cr-ld11947-e.pdf
69 https://www.ucl.ac.uk/clinical-psychology/competency-maps/self-harm/Working with the public framework/Postvention/Postvention.pdf
70 https://sshp.wales/en/
71 Self-harm and Suicide Prevention Competence Framework | UCL Psychology and Language Sciences – UCL – University College London

Communication, accessible information, and digital platforms

While the agencies represented in this guidance might do all that they can to reach out to those individuals they come into contact with, the impact of a sudden death by suicide can be far reaching, and many who will be affected by the death may not come into contact with key agencies at all.

It will be important to ensure that bilingual information about bereavement support agencies is made available at other places where it may come to the attention of those experiencing grief and loss e.g.: through workplaces, front-line health and local authority services, libraries, general bereavement services, social media feeds, places of worship.

Knowing when we're responding in the right way

What outcomes are we seeking for the people of Wales?

At a population level

For the citizens of Wales, the vision is that anyone impacted by a sudden or unexplained death that might be a suicide, receives an offer of support from a suicide bereavement specialist agency, as soon as possible after the death. This offer is not universally available at the moment, and so we would expect to see a significant increase in the number of people accessing this provision when it becomes available.

Ultimately, we want to ensure that people directly impacted by suicide, have access to robust sources of support, for as long as they might need it, to help them through the practical and emotional challenges, and to guard against the pain of their loss increasing their vulnerability to self-harm and suicide.

The quality measures set out in the NICE quality statement provides the metrics that could be used to monitor progress. The development of a timelier surveillance system for suspected suicides in Wales will support a timelier response to those bereaved or impacted by each death.

Quality Measures		
Structure	**Process**	**Outcome**
Evidence of local arrangements to use rapid intelligence gathering to identify people (data sharing and reporting agreements).	Proportion of people who are given information (**metric**: number of those affected compared to the number given information).	Proportion of people satisfied with the information or support (the number of people affected compared to the number satisfied).
Evidence of local processes to give information to people and ask if they need help (local protocol).	Proportion of people who are asked if they need help (**metric**: the number affected compared to the number who were asked).	Number of suicides among people bereaved or affected by suicide (local data collection/rapid intelligence).
Evidence of local service that can provide support to people (local directory and service specification).	Proportion of people who accessed tailored support (**metric**: number of people affected compared to the number who accessed support).	Proportion of people affected whose experience of support was sufficiently beneficial that support was extended to wider groups.

For individuals, families, and groups

At a more personal level, the aim is that people impacted by a possible suicide, feel noticed, and feel that their particular practical, social, emotional, spiritual and language support needs are acknowledged, assessed and met through the concerted and compassionate actions of others, from the time of the death to the build up to, and conclusion of, the inquest, and beyond.

The published report 'Evaluating local bereavement support services'[72] suggests some of the types of information that is of most interest to suicide bereavement services:

Quality Measures	Examples
Service level operational data: overall	Number of calls to a helpline, number of people attending a group session, number of visits to a service's website.
Service level operation data: individual	For each client: types of support received from the service, length of contact with the service, source of referral, support also received from other services.
Demographic data	Age, gender, preferred language, ethnicity, place of residence, relationship to the person who has died, length of time since the death.
Client experience	Feedback on how useful the service has been: What was good about the service, what could be improved? Would they recommend the service to others?
Outcome measurement	Using a standardised assessment tool or tools to measure whether there have been any changes for people using the service.

Tools to measure outcomes for individuals being supported are available, including the Warwick-Edinburgh Mental Wellbeing Scale[73] (WEMWBS), WEMWBS short[74], or other tools. The important factor being consistency in the use of the tool of choice.

The Support After Suicide Partnership (SASP) has developed standards for suicide bereavement services[75], including those for monitoring, measurement, and evaluation to ensure service delivery continues to meet the needs of those using the service and to inform future developments.

72 NSPA_Evaluating-Local-Bereavement-Support-Services.pdf (suicidebereavementuk.com)
73 About WEMWBS (warwick.ac.uk)
74 WEMWBS: 14-item vs 7-item scale (warwick.ac.uk)
75 Measurement and Evaluation Standards – SASP (supportaftersuicide.org.uk)

Glossary

Belief or philosophical belief	The Equality Act says that a philosophical belief must be genuinely held and more than an opinion. It must be cogent, serious and apply to an important aspect of human life or behaviour. The Equality Act also covers non-belief or lack of religion or belief[76]. In the context of the Act, religion or belief can mean any religion such as Christianity, Judaism, Islam or Buddhism, Rastafarianism or Paganism, as long as it has a clear structure and belief system.
Bereavement	In its broadest sense bereavement is the state or fact of being deprived of something or someone. The Etymology (origins) of the word relate to depriving someone or taking someone away by violence, to seize or rob, and relating to sorrow from the loss or deprivation of hope, loved ones. People bereaved or affected by a suspected suicide include children, young people and adults who are relatives, friends, classmates, colleagues, other prisoners or detainees, as well as first responders and other professionals who provide support[77].
Compassion	Showing kindness, caring and willingness to help others. Compassion is a positive emotion and about being thoughtful and decent.
Compassionate communities	Communities who build compassion as a major value in life, based on how we treat each other and the world around us. Compassionate communities are built on a combined ethos of a public health approach to palliative and end of life care, and community development[78].
Culture	The mix of beliefs, values, behaviours, traditions, and rituals that members of a cultural group share[79].

76 https://www.equalityhumanrights.com/en/advice-and-guidance/religion-or-belief-discrimination
77 Quality statement 5: Supporting people bereaved or affected by a suspected suicide | Suicide prevention | Quality standards | NICE
78 Compassionate Communities UK (compassionate-communitiesuk.co.uk)
79 Understanding Grief Within a Cultural Context | Cancer.Net

Cultural competence	The capacity to provide effective services taking into account the cultural beliefs, behaviours, and needs of people. It is therefore made up of cultural awareness, knowledge, and sensitivity as well as the promotion of anti-oppressive and anti-discriminatory policies[80].
Disenfranchised grief	Where a person's grief may remain hidden because they feel it is not accepted or acknowledged by others[81].
Grief	Comes from the Latin 'gravare' meaning 'to burden', from gravis, meaning 'heavy'. Use of the term over time has related to hardship, suffering, mental pain, injustice (aggrieved), afflicted, sorrow.
Health Inequalities	Health inequalities are avoidable, unfair, and systematic differences in health between different groups of people. Inequalities might be based on socio-economic factors (eg: income); geography; specific characteristics (eg: ethnicity); and social exclusion, and the effects of inequality are multiplied for those with more than one type of disadvantage[82].
Intersectionality	The concept of intersectionality describes the ways in which systems of inequality based on gender, race, ethnicity, sexual orientation, gender identity, disability, class, and other forms of discrimination 'intersect' to create unique dynamics and effects. For example, when a Muslim woman wearing the Hijab is being discriminated, it would be impossible to dissociate her female from her Muslim identity and to isolate the dimension(s) causing her discrimination[83].
NICE	National Institute for Health and Clinical Excellence is an organisation that seeks to improve outcomes for people using the NHS and other public health and social care service through the production of evidence-based guidance and quality standards and performance metrics[84].
Pharmacological Therapies	Pharmacology and therapeutic professionals promote and ensure the safe, economic, and efficient use of medicines or drugs[85].

80 Cultural-Competency-Toolkit.pdf (diversecymru.org.uk)
81 National framework for the delivery of bereavement care [HTML] | GOV.WALES
82 Health inequalities in a nutshell | The King's Fund (kingsfund.org.uk)
83 what is intersectionality (intersectionaljustice.org)
84 National framework for the delivery of bereavement care [HTML] | GOV.WALES
85 Clinical pharmacology and therapeutics | Health Careers

Post-Traumatic Stress Disorder (PTSD)	Post-Traumatic Stress Disorder (PTSD) can result from traumatic events, either experiencing or witnessing single, repeated or multiple events. People with PTSD will experience avoidance; hyper-arousal; re-experiencing; dissociation; negative alterations in mood and thinking[86].
Postvention	Activities developed by, with, or for people who have been bereaved by suicide, to support their recovery and to prevent adverse outcomes, including suicide and suicidal ideation[87].
Psychological therapies	Sometimes referred to as 'talking therapies' for mental and emotional problems like stress, anxiety and depression. There are lots of different types of talking therapies which can be one-to-one, in a group, online, over the phone, with families, or with partners[88].
Spirituality	A consensus on the definition of spirituality is difficult to find, and the understanding and interpretation of spirituality has evolved over time. Descriptions of spirituality include: • A sense of seeking the best relationship with ourselves, with others and with what might lie 'beyond'. • A way to find meaning and purpose in life. • A sense of hope. • A support in times of suffering and loss[89].
Suicide	The Office for National Statistics (ONS) includes deaths from international self-harm for persons aged 10 years and over, and deaths caused by injury or poisoning where the intent was undetermined for those aged 15 years and over[90].
Suicide bereavement	Suicide bereavement is a risk factor for complicated or prolonged grief. Loss by suicide can have serious and lasting psychosocial effects on bereaved individuals and communities. Their needs are complex and varied requiring a concerted provision of support[91].

86 Recommendations | Post-traumatic stress disorder | Guidance | NICE
87 support_after_a_suicide.pdf (publishing.service.gov.uk)
88 Types of talking therapy - NHS (www.nhs.uk)
89 https://www.rcpsych.ac.uk/mental-health/treatments-and-wellbeing/spirituality-and-mental-health
90 Suicides in England and Wales – Office for National Statistics (ons.gov.uk)
91 Suicide Postvention Service Models and Guidelines 2014–2019: A Systematic Review (nih.gov)

Tailored support	Support that is focused on the person's individual needs. As well as professional support it could include i) support from trained peers who have been bereaved or affected by a suicide or suspected suicide, ii) adjustments to working patterns or the regime in residential custodial and detention settings, iii) other support identified in bereavement guidance documents focusing specifically on bereavement by suicide.
Traumatic bereavement	Whether a bereavement is traumatic or not relates to the way in which the person affected experiences or understands the death, and the meaning they make of it. It can affect people of any age, and any type of death can result in a traumatic bereavement. It causes distress and difficulties, over and above a more typical grief, that impact everyday life. Sudden deaths, like suicide, can increase the likelihood of traumatic bereavement[92] .
Trauma informed practice	A model that is grounded in and directed by a complete understanding of how trauma exposure affects peoples neurological, biological, psychological and social development[93].
Vicarious Trauma	A process of change resulting from empathetic engagement with trauma survivors. Anyone who engages empathetically with survivors of traumatic incidents is potentially affected, including health and other front-line professionals[94].

92 What is Traumatic Bereavement? – UKTC (uktraumacouncil.org)
93 Trauma-Informed Practice: A Toolkit for Scotland (www.gov.scot)
94 Vicarious trauma: signs and strategies for coping (bma.org.uk)

Bereavement Liaison Officer

(NB: These workers would be employed as part of an integrated service and would not be employed as isolated single workers).

Generic Role Descriptor

Indicative salary: c. £25,000 +

Purpose of the Role

- To make a proactive approach to individuals impacted by a sudden death that could have been a suicide, who are referred to the service via Police, or through self-referral.
- Engage with those affected to establish where they are in their bereavement journey, and for them to express their support needs and vulnerabilities.
- Collaborate with those affected to identify providers who can meet their needs eg: those who can offer practical or emotional support, including citizens advice bureau, government websites, health professionals eg: GP, third sector agencies, immediate sources of support through friends and family, faith or belief groups.
- Support those affected to navigate the different agencies they are likely to encounter, such as the police, mortuary staff, funeral directors and other celebrants, coroner's officers, press/media, and to understand the roles and responsibilities of each of these agencies.
- Support those affected to navigate the ambiguities and uncertainties that often accompany a bereavement journey related to a suspected suicide, and help them to understand the processes involved, and the variability of timelines.
- Provide a timely response, as part of a team or service, with availability in the evenings or on weekends, depending on the urgency of referrals to respond to the needs of those affected.

Key skills required

- Ability to communicate with individuals, families and groups with compassion, demonstrating sympathy and empathy.
- Demonstrable counselling skills evidenced through experience of working with clients on a one-to-one basis in a therapeutic and multi-disciplinary setting.
- Ability to develop productive relationships and partnerships with key agencies and first responders to engender a compassionate response to those affected by a suicide, and to signpost to the most appropriate service/provision to the needs of the bereaved.

Knowledge, qualifications, and registrations

- An in-depth understanding of grief and trauma associated with bereavement.
- A thorough understanding of the particular needs of people who have been bereaved following a sudden or unexplained death that may have been a suicide. If specialising in the support of particular groups e.g.: children and young people, people with learning difficulties, refugees or asylum seekers, then the requisite experience and expertise relating to their needs and how they respond to support.
- A degree (or equivalent attainment at level 6[95]) in a relevant area eg: counselling, psychotherapy, psychology and professional membership or accreditation such as BACP (British Association for Counselling and Psychotherapy).
- Local protocols for referrals and record keeping associated with case management.
- A clear understanding of the data protection implications of the work, and how to communicate with the bereaved about the meaning of consent, and how their information will be stored, used, and protected.
- An understanding of the importance of the Welsh language and culture in a bilingual Wales with an appreciation of the Welsh Government's policies and strategies for the language.

Clinical Supervision and continuing development

- Ensure attendance at regular (monthly or more frequent) clinical/management supervision meetings, engage in self-care regarding one's own resilience and mental and emotional health needs.
- Contribute to local training and development programmes that might be developed to improve people's understanding of bereavement by suicide.
- Attend opportunities for further learning to ensure confidence, and effective evidence-based practice and raise the need for this to be made available if not accessible.
- Contribute to service evaluation activities and provide insights to inform continual service improvement.

Compliance with legal and ethical requirements

- Up to date with statutory and mandatory training in information governance, equality and diversity, Welsh language, health and safety, record keeping and risk management, to ensure all practice complies with best practice and due diligence.

Ref: **Job-Description-Suicide-Bereavement-Service-Co-ordinator-Nov-2019-1.pdf (every-life-matters.org.uk)**

Ref: **Bereavement Support Liaison Coordinator – Thames Valley Police (tal.net)**

Ref: **https://hub.supportaftersuicide.org.uk/standards/**

95 **What qualification levels mean: England, Wales and Northern Ireland – GOV.UK (www.gov.uk)**

Levels of exposure for different groups

Potential types of individuals in categories of suicide exposed, affected, bereaved short-term, and bereaved long-term

Exposed	Affected	Suicide-bereaved, short-term	Suicide-bereaved, long-term
First responders	First responders	Family members	Family members
Anyone who finds the deceased	Anyone who finds the deceased	Therapists	Therapists
Family members	Family members	Friends	Close friends
Therapists	Therapists	Close work colleagues	
Close friends	Close friends		
Healthcare workers	Classmates		
Community members	Co workers		
School communities	Team members		
Workplace acquaintances	Neighbours		
Fans of celebrities			
Community groups (eg: sporting clubs)			
Rural or close-knit communities			

Source: **The Continuum of Survivorship: Definitional Issues in the Aftermath of Suicide (wsimg.com)**

Logic Model for the delivery of a systems response to those affected or bereaved by suicide

Input	Activities	Outputs	Short-term outcomes	Longer-term outcomes
National liaison and advisory service linked to wider/ local provision	Procure a national service from an experienced provider through a competitive tender process	Rapid/real-time response or contact from an agency that can assess immediate needs and identify corresponding provision to make a 'proactive offer'	• Clarification of availability and sustainability of existing offers • Better understanding of needs being expressed from service users	• More equitable and accessible suite of support offers available across Wales to all those affected or bereaved
Compassionate and trauma-informed responses from touch-point agencies	Engage key workers with and across the touch-point agencies to identify opportunities to offer a compassionate, trauma-informed response	Materials, links, and information to enable appropriate signposting to different sources of support to continue the 'proactive offer'	• Better multi-agency understanding of the potential impact of sudden deaths that are suspected suicides, and better-informed response from front-line workers	• Reduced occurrences of re-traumatising experiences

Input	Activities	Outputs	Short-term outcomes	Longer-term outcomes
Digitised Help is at Hand Cymru	Convert the 2016 pdf to an interactive digital offer Develop corresponding options for non-digital availability of the information	An interactive version of the 'Help is at Hand' resource for Wales that can continually evolve and improve through co-production with specific groups eg: men, children and young people Collateral and materials that provide information to those affected or bereaved in non-digital format	• Improved accessibility to relevant information both universally and to specific groups on how we respond to loss, both practically and emotionally, following a sudden death that could be a suicide	• Widespread recognition and signposting of a digital support offer across multi-agency front-line public sector services, and in workplaces and other settings, to support those affected or bereaved
Development of nationally accredited learning and development offers to support workforce development	Identify learning and development needs and preferred modes of training delivery Work with front-line workers and people with lived experience to develop learning offers Engage a national training accreditation agency to build quality assurance into the training offers	Co-produced suite of learning and development offers to inform and up-skill front-line workers across sectors, that can be delivered by a range of training providers who meet the accreditation agency quality assurance standards	• Wider range of front-line agencies with a working understanding of the impact of a sudden death that could be a suicide on families, communities, and front-line workers (colleagues/peers)	• Reduced stigma, better understanding, and more compassionate and trauma-informed services and communities regarding the broad impact of deaths by suicide