South Australian Suicide Postvention Project

Report to Mental Health Services

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APPENDICES

1. Ethics approval

2. Permission to adapt Norwegian questionnaires

3. Bereaved persons' questionnaire

4. Agencies' questionnaire

5. Service providers' questionnaire

6. Bereaved persons' flier

7. Information flier

8. Agencies: categories relevant to suicide postvention

9. Variables, risk factors and clusters used in analysis of the bereavement data

10. Wilson A., Clark, S. (2004). Desperate to tell: towards improving the care of people bereaved through suicide - a report of work in progress. Published in *RED Snapshots, March 2004, Issue 2: PHCRED-SA State Conference 2003 Proceedings.* www.phcred-sa.org.au/REDSnapshots.htm

11. Wilson A., Clark, S. (2004). Hidden or missing? Suicide postvention services: bereaved persons' perceptions of need. General Practice and Primary Health Care Conference. Sheraton Hotel, Brisbane, 2-4th June 2004.

INDEX TO FIGURES AND TABLES

Executive Summary

Suicide postvention represents an opportunity for mental health services, social services and other health services to collaborate to enhance the quality of care provided to those persons who become bereaved due to the suicide of someone they know. Suicide postvention has recently been recognised as an important part of suicide prevention because those bereaved through suicide are a high risk group for mental ill health and suicide.

Suicide postvention has been researched and supported in other countries such as Norway, New Zealand, Ireland and Belgium. In these countries, suicide postvention has been systematically supported to develop and provide targeted services, professional infrastructure including pathways to care, educational pathways for professionals and professional support. In contrast, Australia appears to lag significantly behind in relation to the recognition and identification of suicide postvention as a suicide prevention strategy. There is opportunity and need to support suicide postvention as a specialised, viable health promotion strategy.

The South Australian Suicide Postvention Project was funded by Mental Health Services, Department of Health, and undertaken by researchers in the Grief Research Unit of the Department of General Practice, University of Adelaide. The project was conducted part-time over two years from November 2002 to December 2004. The project was supported by a Reference Group comprising representatives from mental health services, research, psychiatry and consumers.

The Project's purpose was to examine current approaches to postvention for those bereaved through suicide in metropolitan Adelaide from the perspective of consumers, service providers and organisations.

The Project was based on a concurrent mixed method design, which collected both quantitative and qualitative data. Consequently, the Project contained a number of research activities:

- A review of published and unpublished literature and research from both Australian and international contexts. Some of the literature was obtained through making connections with overseas researchers.

- Survey research of the bereaved through suicide via a postal questionnaire which collected quantitative and qualitative information about the deceased, services received, experience of services and strategies for survival.

- A mailed questionnaire to service providers collected primarily quantitative information about types of services provided, education received on suicide bereavement and professional organisational support. Service providers were contacted through professional associations and through the organisations surveyed.

- A postal questionnaire to service organisations, which collected primarily quantitative information about the range of services currently available to support suicide bereavement. A purposive sample of mental health, community health and social service organisations were surveyed.

- Conduct of a discussion forum to debate the findings of the Project and to form recommendations for Mental Health Services. The findings were work-shopped under the three main sections of the report and the outcomes are presented in a separate chapter.

One of the most salient features of this research was the emphasis placed on ensuring that research data, results and conclusions were grounded in the experiences, beliefs and ideas of the bereaved, service providers and organisations.

The bereaved who participated in this study were self-selected as a result of information about the Project released by the media. Many expressed a view that their participation was the first time they had expressed their inner most thoughts of their experiences. Many indicated it also formed part of their personal healing process. There were numerous spontaneous offers to participate further if required.

An Ideal Model of Suicide Postvention Services (p.162) was developed from the findings to articulate the concepts and components arising from this study. Taken objectively, this model will contribute to the safe and efficient delivery of quality suicide postvention care. To move

toward achieving this, a number of recommendations have been made. These recommendations mainly target the immediate needs for suicide postvention in the next one to two years. The recommendation for a central, co-ordinating agency to be formed may be considered a medium term recommendation for the next three to five years. These recommendations focus on continued sustainability of suicide postvention activities as a resource for health care in South Australia.

Recommendations

The following recommendations for the care and support of those bereaved through suicide are grounded in the research undertaken with bereaved consumers, professionals and service organisations as part of the Project. Brief information is given with each recommendation. More substantial discussion and evidence for these recommendations is presented in the body of the report.

Postvention Policy

1. **Promote the identification and recognition** of suicide postvention as a suicide prevention strategy.

2. **Development suicide postvention policy** to guide best practice procedures and guidelines that address issues for service delivery, support of staff, education for professionals and accreditation of counsellors. South Australian Mental Health Services could lead this.

3. **Establish a steering committee to guide the founding of a central administering agency** and operations policy. Tasks to include:

    3.1. Develop Terms of Reference

    3.2. Investigate examples of best practice postvention practice nationally and internationally

    3.3. Investigate where a central agency fits in the health structure (Recommendation 18)

    3.4. Make connections with national associations and networks to increase capacity

Support for the bereaved

4. **Provide an appropriate and immediate crisis response team** that is consistently highly skilled in the issues of suicide postvention and to include:

    4.1. A trained volunteer as a "been-there" other person (one who has experienced similar trauma) to be part of the emergency response team at the site of a suicide and, to be able to give on-going support to the newly bereaved (buddy system similar to the SIDS and international models)

4.2. The offer of clean-up services to clean the site of the suicide and prevent further distress to the family and relatives.

5. **Establish clearly defined pathways to care including:**

    5.1. A home visiting service following the suicide

    5.2. Co-ordination of services for the bereaved from the time of the suicide and continuing long term.

    5.3. Flexible, co-ordinated approach to service delivery that acknowledges what the bereaved suffers.

    5.4. Easy access to practitioners trained in suicide bereavement such as general practitioners and counsellors.

    5.5. Identified referral pathways for individual needs.

6. **Strengthen support groups with the provision of greater resources e.g.**

    6.1. Co-facilitation by professionals.

    6.2. Training for facilitators and support volunteers in specific issues of suicide grief, group management skills, crisis intervention, pathways etc.

    6.3. Core funding to enable support groups to offer an expanded range of services covering 24 hours, 7 days a week

7. **Provision of an 1800 state-wide 24 hour telephone support service** staffed by experts and bereaved volunteers.

8. **Establish support for non-metropolitan areas that includes:**

    8.1. Outreach to country areas as appropriate to co-ordinate the care of bereaved individuals and communities with local services and professionals.

    8.2. Use of technologies to provide rural outreach e.g. telephone group support similar to that of the Organ Donation Foundation.

    8.3. Special consultative service for establishing supports in country areas.

9. **Create more, and age appropriate services for children and youth**, such as play-centred groups for children and activity groups for youth.

10. **Develop culturally appropriate services for NESB and indigenous peoples** as well as for gay and lesbian groups and others.

Strengthen the actions of service providers

11. Establish adequate and comprehensive education for professionals and all relevant service providers in grief, suicide postvention, trauma, support and self-care for personnel to increase awareness and understanding of inherent issues and to include in:
- under graduate/basic training
- post-graduate training programs
- continuing professional/service provider education

12. Establish support structures for professionals working in suicide bereavement that include:

12.1. Best practice guidelines which are current, adhered to and updated regularly to aid and guide professionals in the conduct of their work.

12.2. Networks and forums to share expertise and seek advice through an identified set of contacts with whom to associate for collaboration and support.

12.3. Policies and procedures for addressing stress in professionals after the suicide of a client and in working with the bereaved, for example, immediate de-briefing provision.

12.4. Recognition through accreditation of skilled professionals based on experience as well as training.

Resources

13. A comprehensive central resource for accurate, appropriate and regularly maintained information available in printed copies, CD and through a postvention suicide website. Information to include:

13.1. Best practice guidelines on how to respond to a suicide death.

13.2. Information to support the personal grief of the service provider in the event of a suicide of a patient or client.

13.3. Directory of skilled service providers in both metropolitan and rural areas to facilitate access by the bereaved and other service providers.

13.4. Pathways to care

13.5. Information for bereaved clients.

14. The current Information and Support Pack (Clark, Hillman & Ministerial Council for Suicide Prevention 2001) to:

14.1. Be updated with information on services not currently detailed such as cleaning up services for the suicide site and other support groups.

14.2. Be more widely available for individuals within families and to 2nd degree relatives and non-relatives.

14.3. Be more widely disseminated from emergency services, community agencies, hospitals, general practitioners, support groups, funeral parlours, cemeteries, educational institutions and service providers.

14.4. Be supported by intra-organisational funding to enable wider dissemination.

14.5. Be regularly reviewed and kept up to date.

Community

15. Raise public awareness and educate on the subject of suicide postvention.

15.1. Informed and appropriate multimedia approach to reduce the community stigma about mental illness, suicide and suicide bereavement.

15.2. Annual theme day to raise awareness about suicide grief in the community and to destigmatise suicide.

Research

16. Research into suicide postvention with specifically reserved funds so this does not become consumed by research in other areas of prevention including.

16.1. The and evaluation of models of care and services

16.2. Accurate statistical data keeping by agencies and service providers of the suicide bereaved population for the purposes of identifying a population at risk and the need for specific services

16.3. Further consultation and research into how to supply the needs of:

- rural and remote populations
- children and young people
- people from non-English speaking backgrounds

Central coordinating agency

17. Establish a central co-ordinating agency with a state-wide focus and underpinned with secure funding to provide:

17.1. An administration base staffed by professionals and experienced volunteers

17.2. A co-ordinator of response and follow-up who monitors the crisis response and ensure home visits and support follow from the initial emergency outreach (Recommendations 4 & 5).

17.3. Co-ordination of volunteers by a facilitator who has experience and or knowledge of suicide bereavement. This person could facilitate recruitment, training, emergency response outreach and follow-up by volunteers.

17.4. Advice and information on policy, processes and practices (Recommendation 13 & 14)

17.5. Facilitate training, networking and support for the experts (Recommendation 11 & 12).

The effectiveness of the recommendations about the service infrastructure will be limited unless there is consideration given to the issues. These issues must be addressed to enable a move towards consistent and high quality health care for persons bereaved through suicide and for suicide postvention. **An Ideal Model of Suicide Postvention Services** (p.159) is described and depicted in model form (p.162) at the end of the report.

Introduction

Aim and objectives

The aim of the study was to examine the current approaches to postvention for those bereaved through suicide in metropolitan Adelaide and to make recommendations to Mental Health Services, Department of Health. Three major objectives sought to fulfil this aim.

1. To examine the needs of people bereaved through suicide;
2. To undertake an audit of existing postvention services;
3. To review the support and educational structures available for service providers of postvention services.

History of the project

The study originated from a proposal in 2000 from the South Australian Suicide Prevention Advisory Group to the Hon Dean Brown, Minister for Human Services, to enhance the services for individuals and families bereaved through suicide in South Australia. The original proposal included three main objectives: to review and make recommendations regarding services for the bereaved; provide outreach services to country areas; and provide support and education to professionals. The current project was redesigned as a two-year pilot research study, limited to metropolitan Adelaide, following funding allocation by the South Australian Department of Human Services.

Limitations of the project

Because of budgetary limitations the study made no direct attempt to include populations in rural and remote areas, aboriginal and Torres Strait islanders, and schools. A limited attempt was made to target people from non-English speaking backgrounds.

Plan of the project

The study was planned in three stages:

Stage 1: Set-Up
Establishment of a Reference Group
Literature review

Stage 2: Research study

Examine the needs of people bereaved through suicide
Undertake an audit of postvention services provided by agencies
Review the support and educational structures for service providers and
professionals

Stage 3
Discussion forum to consider data and form recommendations
Form and review recommendations for final report to Mental Health
Services

The Reference Group is described below. The literature review is a separate chapter of this report. The research study is presented in the chapters: Methodology, Results and Discussion. The recommendations are formed from the Conclusions.

Reference Group

A Reference Group was established to provide support and advice to the research team, increase the understanding of key issues related to the project, act as a point of reference for resolving methodological issues, and assist in liaising with the community. Members of the group were chosen for their research knowledge and/or expertise in the area under study and came from the following areas and disciplines: the Coroners Office, consumers, psychiatry, Department of Human Services, community mental health and research.

It was the decision of the Reference Group to exclude school populations from the study as well as populations in rural and remote areas, Aboriginal and Torres Strait islanders, and for there to be only a limited attempt to target people from non-English speaking backgrounds. Each of these populations was perceived to be a study in their own right.

Terms and Definitions

Postvention: Postvention deals with the traumatic after-effects in the survivors of a person who has committed suicide. It involves offering mental health and public health services to the bereaved survivors. It includes working with all survivors who are in need. (Shneidman, cit Leenaars & Wenckstern 1999).

Suicide: Death designated as suicide by the Coroner.

"Been there" other: refers to a person who has experienced the suicide of a close family member or friend and who is advanced in heir grief recovery.

Bereaved persons: Anyone bereaved as a result of suicide, for example, relatives, friends, peers and colleagues.

Service providers: Specifically, general practitioners, psychologists, psychiatrists, social workers, nurses, religious counsellors and volunteers.

Agencies: Government and non-government agencies whose main objectives included the practical, psychological, physical, social and spiritual care and support for people bereaved through suicide.

Self-nominated option: A response that is nominated by the respondent rather than being one of the listed optional responses. Such an item may carry greater weight than the number indicates: other respondents may have responded to this option if it had been included in the list of options, and therefore the actual number of responses may be an under-estimate.

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Literature Review

Introduction

This literature review addresses the issue of why suicide postvention is important, including the various risk factors and complications associated with bereavement through suicide. It looks at the current knowledge of the needs of the bereaved, the current state of services provided for them and the particular needs of service providers in assisting the bereaved. It focuses on both Australian and international perspectives. Search methods included electronic data bases such as Medline, Psychlit and Pubmed using the key words "suicide", "bereavement", "survivor", "grief", services", and "needs". A journal alert for relevant publications was set up for the duration of the project. In addition the search included grey literature such as books of conference abstracts and proceedings from Australian national conferences and conferences of the International Association for Suicide Prevention. National and international networks known to the Project Manager (SC) were approached for information, including members of Suicide Prevention Australia and the Postvention Taskforce of the International Association for Suicide Prevention.

Background

Suicide is recognised as one of the major issues facing primary health care providers and mental health organisations worldwide. Each year approximately 1 million people die from suicide around the world, representing one death every 40 seconds (International Association for Suicide Prevention 2004). Suicide is a leading cause of death, particularly in younger people. It is sobering that in Australia, over 2000 people every year are so deeply distressed that they end up taking their lives.

There are over 150 people who die by suicide each year in South Australia (Australian Bureau of Statistics 2002). Considering there are many others whose deaths by drugs and single-person motor vehicle accidents may also be a form of self-inflicted death (but cannot be confirmed as such), the extent of the problem of suicide in our State takes on considerable proportions. The highest rates of suicide are among middle aged men, but there are also peaks in the 16-24 year olds and among the elderly (Australian Bureau of Statistics 2002). Strategies over a number of years have combined to reduce considerably the death rates from

other major causes such as motor vehicle accidents and Sudden Infant Death Syndrome (SIDS). For example, in 2002 the number of deaths from suicide just outnumbered the deaths from motor vehicle accidents and were many times the deaths from SIDS.

A conservative estimate is that for every death, at least six others are severely affected by grief (Shneidman, 1972); therefore 1,000 or more people suffer major grief from losing someone close through suicide every year in this State. This poses serious challenges for families, individuals, service providers, researchers, governments and policy makers. It is evident that to address significantly the burden of high and increasingly recognised mental health disorders, there is compelling need to approach intervention from all sides. Promotion, prevention and early intervention (PPEI) comprised a major platform in the Australian Health Ministers 1998 *Second National Mental Health Plan* (Australian Health Ministers 2003). Two goals identified in the plan included reduced numbers of suicides and increased consumer and carer satisfaction with clinicians' responses to early warning signs of mental disorders. Recognising a need for a working document that responded to emerging priorities, the Commonwealth Department of Health and Aged Care produced the *LIFE* Framework for Prevention of Suicide and Self Harm in Australia (National Advisory Council on Youth Suicide Prevention 2000.). The Framework addresses the context for suicide activity, areas for action and building partnerships, and stresses the need to support people adequately to prevent mental illness and suicides. One of these areas for action is that of providing "prompt and effective support for people bereaved or affected by suicide" (p.84), that is suicide postvention. Included are strategies concerning quality, partnerships, protocols, access, information exchange and crisis plans.

Why is suicide postvention important?

Morbidities associated with bereavement

The death of a close relationship is one of the greatest of life's stresses (Holmes & Rahe 1967) and the grieving process may last several years (Zisook & Shuchter 1986). Grief may affect individuals' physical, emotional, cognitive, mental, social and spiritual well being (Corr 1999).

Bereavement carries the increased risks of:

- Mortality and suicide (Brent, Perper, Goldstein, Kolko, Annan, Allman & Zelenak 1988; Szanto, Prigerson, Houck, Ehrenpreis and Reynolds 1997);

- Cardiovascular disease (Hirsch, Hofer, Holland, & Soloman 1984);

- Mental ill health such as depression, anxiety and substance abuse (Clayton 1998; Harlow, Goldberg & Comstock 1991; Jacobs, 1993; Maddison & Viola 1968; Mendes de Leon, Kasl & Jacobs 1994; Mor, McHorney & Sherwood, 1986; Surtees 1995; Wortman & Silver 1989);

- Social changes such as diminished social support and relationship breakdown (McNeil, Hatcher & Reubin, 1988; Tudball, 2001); and

- Somatisation (Clarke, Mackinnon, Smith, McKenzie & Herrman 2000; Mallouh, Abbey, Gillies 1995; Parkes 1964).

The cumulative effects of bereavement can be even more far reaching because diminished cognitive ability may cause poor school performance and work difficulties (Caplan 1990; Seeman, Singer, Rowe, Horwitz & McEwen 1997).

Predictors of poor outcome

There are many factors that have been identified from a variety of controlled studies as predictors of poor outcome from bereavement, and which may result in any of the morbidities mentioned above (Cleiren 1993; Cleiren, Diekstra, Kerkhof & Van der Wal 1994; Parkes 1998; Sanders 1995). Those at particular risk of experiencing these effects are those who are bereaved by the death of a young person. Grief was found by Cleiren (1994) to be highest in females, and in the close kinship groups in the declining order of mothers followed by widowers, fathers, widows, sisters and then by a variety of other kinships. Young widows seemed to fare worse in the short term, but better in the long term. (Sanders 1995). Those with very close, dependent or conflict relationships, as well as those with pre-existing physical or mental illness also appeared worse off. A high severity of grief in the early months was found to be a marker for chronic grief, a condition of continuing severe grief above the norm for the context of the loss (Middleton, Burnet, Raphael &. Martinek1996). In addition, there exist also a number of predictors associated with the dying process: sudden, untimely or unexpected death, and trauma and stigma associated with the death. There are also a number of psychosocial predictors of poor outcome, such as lack of support received after the death, disturbed family relationships, other losses in childhood or adult life, poor coping skills and

financial insufficiency. A recent study found additional predictors of higher psychological morbidity of parents bereaved through suicide, accident and SIDS included withdrawing from others, not having any more children left at home, not working outside the home and lower educational status (Dyregrov, Nordanger & Dyregrov 2003).

The importance of this is that populations bereaved through suicide generally have a higher prevalence of predictors of poor bereavement outcome than groups bereaved through other modes of death. Because the highest rate of suicide is among men aged 25-44 (Australian Bureau of statistics 2002), the most vulnerable groups mentioned above are over-represented and include females, those grieving the death of a younger person and the close kinship groups of parents and widows. There is also an over-representation of psychosocial risk factors, such as the unexpectedness, untimeliness and often traumatic nature of the death. Stigma is present in many cultures and may lead to support not being offered or declined by the bereaved.

The research confirms that people bereaved through suicide are a group at particular risk of depression (Brent, Perper, Moritz, Liotus, Schweers, & Canobbio 1994, Van Dongen 1991; Valente & Saunders 1993) and suicide (Brent, Bridge, Johnson. & Connolly, 1996; Roy, Nielsen, Rylander, Sarchiapone 2000). Causes appear to be gene linkage for suicide or variants of some mental illness such as depression running in families. Additionally, the modelling of certain behaviours, coping skills and completed suicide in families may all have intergenerational effects (Séguin, Lesage & Kiely 1995b). A recent descriptive study demonstrated high levels of complicated grief in bereaved people who were close to the suicide deceased and suggests these are at risk of developing physical and mental health problems (Mitchell, Kim, Prigerson & Mortimer-Stevens 2004).

However, it is important to point out that comparative studies between people bereaved through different modes of death have shown that once these risk factors have been accounted for, there is very little difference in the outcome from bereavement, whatever the mode of death (Barrett Scott 1990; Cleiren 1993; Cleiren, Grad, Zavasnik & Diekstras 1996; Demi 1984; Farberow, Gallagher, Gilewski & Thompson 1987; Farberow, Gallagher-Thompson, Gilewski & Thomson 1992a; Séguin, Lesage & Kiely 1995a & 1995b; Grad & Zavasnik 1996). In other words it is the high prevalence of risk factors and not the mode of death itself that accounts for the higher risk of depression and suicide among those bereaved through

suicide. A suicide therefore identifies a population at risk of the complications of the grieving process as well as of further suicide. Bereavement support is therefore necessary not only as a humanitarian responsibility to relieve suffering and mental illness, but also as suicide prevention.

Service providers

An often forgotten category of people bereaved through suicide is the clinician or service provider him or herself. The effects they may experience after the suicide of a patient or client have been found to be various. They include shock, sorrow and remorse, guilt, anger, a sense of professional and personal failure and fear of facing the family. They may also fear for their reputation, and have difficulty in being objective in dealing with the aftermath of a suicide, physical and mental illness, absenteeism from work, burn out and some may even change their clinical interests or career as a result (Alexander, Klein, Gray, Dewar & Eagles 2000, Andriessen, Delhaise & Forceville 2001; Ellis, Dickey & Jones 1998, Grad 1996, Grad, & Zavasnik 1998, Hodgkinson 1987, Michel, Armson, Fleming, Rosenbauer & Takahashi, 1997). Not all reports, though, are negative as there is evidence that providers identify changes to their practice and improve professionals' standards, which may lead to career development (Alexander, Klein, Gray, Dewar & Eagles 2000; Hendin, Lipschitz, Maltsberger, Pollinger Haas & Wynecoop 2000).

However, postvention education and support for the service provider have been found lacking. In a review of psychiatry training programs in the United States, Ellis, Dickey & Jones (1998) found that only 46% provided any training in postvention, 19% had policy relating to managing a completed suicide and a mere 14% provided emotional support for the trainee psychiatrist. In Australian universities, any postvention training was provided in only 70-85% of psychology courses, 50-69% of medical, nursing and social work curricula and less than 50% of theology programs (Hazell, Hazell, Waring & Sly 1999). Evaluation of the educational needs of general practitioners and community health personnel in the 'Keep Yourself Alive' national suicide prevention educational initiative found that postvention education rated third highest after skills in recognising the signs of suicide and general counselling skills (Clark, Martin & Beckinsale 1998). Further, a survey of bereaved persons and service providers attending a postvention forum at an Australian national conference

indicated that educational and attitudinal improvements were needed for more appropriate support of the bereaved (Clark 2001; Grad, Clark, Dyregrov & Andriessen, 2004).

The apparent lack of preparation of clinicians and service providers for the suicide of a patient or client appears to be an anomaly given the severe effects such an event may have on the individual, especially considering that this is a professional hazard for those who work in any area of mental health. Service providers must also be considered as bereaved or potential bereaved and their needs must also be considered.

The need for support

There is increasing recognition that people bereaved through suicide grieve differently and have different needs from those bereaved through other modes of death (Clark & Goldney 1995; Clark & Goldney 2000; Dunn & Morrish-Vidners 1987; McNeil, Hatcher & Reubin 1988; Ness & Pfeffer 1990; Séguin, Lesage & Kiely, M.C.1995a). Some of the grief themes that the bereaved may have to deal with include feelings of guilt, why the suicide occurred, blame of others, anger at the deceased and the medical system, the waste of the life of the deceased, a crisis of values and relief after a suicide has finally occurred following repeated suicide threats. All these issues require insight, specific knowledge and sensitivity from the supporting professional.

A further difference following a suicide is the lack of support that may be perceived relative to the amount received after deaths from other causes (Farberow et al 1992b, Knieper 1999; McNeil et al 1988). There are differences of opinion in the literature as to whether support is actually lacking, is perceived to be lacking or perceived to be inappropriate. Lack of support is usually attributed to stigma, which, in turn, depends on the culture. As a result help may not be offered and the bereaved may withdraw and even refuse help. Other reasons given include that the bereaved feel too shocked, exhausted, lose confidence to reach out for help or merely lack information or availability of services.

Social support is important because it has been identified as a major factor in reducing psychological morbidity (Andrews, Tenant, Hewson & Schonell 1978). This also appears true for the aftermath of suicide (Leenars & Wenckstern 1998). In a comparative study of psychological reactions and help received by parents bereaved through suicide, SIDS and

accident, Dyregrov et al (2003) found that the parents of a young suicide and accident victims experienced more severe psychological reactions compared to the SIDS group at 1-1.5 years post death. The study also identified that the needs for support by the SIDS group had been met more completely than for those in the other two groups. At the time of the study Norway had a national support network for parents bereaved by SIDS only, and the authors concluded that the lower psychological morbidity for the SIDS bereaved was related to the high level of support received. Further, positive correlations were found between need, psychosocial complaints and complicated grief reactions.

Evaluation of bereavement interventions

There is evidence that bereavement programs overall have proved benefit (Murphy, Johnson, Cain, Gupta, Dimond & Lohan 1998; Woof & Carter 1997). In a review of 11 controlled trials of general and suicide bereavement support groups, Woof and Carter (1997) and found that in seven trials the subjects showed significant improvements on one or more measures compared to controls. A randomised controlled trial of a ten week group program for parents bereaved by traumatic death of their children, including by suicide, found that participants reported strongly the benefits of such a program but that outcome scores on mental health and grief measures did not altogether support this (Murphy et al 1998). Changes in scores indicated that, compared to controls, highly distressed mothers benefited most, whereas those less distressed and fathers generally appeared worse off. A controlled trial of a group intervention for children bereaved by suicide found that anxiety and depression levels were less for subjects compared to controls who did not receive the intervention but that no significant differences were found for post-traumatic stress and social adjustment (Pfeffer, Jiang, Kakuma, Hwang & Metsch 2002).

Further, in an controlled evaluation of an intervention using a manual on children bereaved through suicide Pfeffer, Jiang, Kakuma, Hwang & Metsch (2002) found that anxiety and depression levels were lower in the group of children who received the intervention compared to children who did not, but there were no significant differences for measures of post traumatic stress, social adjustment or parental depression. Keeping a grief journal has also been found to decrease levels of anxiety, depression, subjective distress and increase accommodation to the loss (Range, Kovac & Marion 2000). These findings clearly have implications for further evaluation of postvention programmes.

Research perspective

Our current knowledge of the needs of the suicide-bereaved comes not only from clinical reviews (Knieper 1999), but also from the recent pioneering studies overseas in this area. These include telephone interviews of bereaved people in New York (Provini, Everett & Pfeffer 2000); a questionnaire study in Flemish Belgium (Andriessen, Delhaise and Forceville 2001); questionnaire and in depth interview data of bereaved of young suicides from Norway (Dyregrov 2002, 2003); interviews with family survivors of young suicides in the United States (Kalischuk and Hayes 2004); and questionnaire and interview data from survivors of elderly suicides in the United Kingdom (Harwood, Hawton, Hope and Jacoby 2002). A broad research and consultative process undertaken by the ministry of Youth Development in New Zealand resulted in a range of recommendations including political leadership in the provision of support for those bereaved through suicide, proactive outreach and better grief services for the bereaved, improved training for relevant professionals, coronial consultation and public education about grief (Beautrais (2004). A workshop at a national Australian suicide prevention conference identified issues consistent with the results of the overseas studies (Clark 2001).

All studies identified that many of the bereaved received no help at all, ranging from 15% in Norway (Dyregrov 2002) up to 76% in New York (Provini et al 2000). A mapping exercise of supports for people bereaved through suicide in New Zealand found appropriate services were "virtually non-existent" (Health Innovations Management Services 2004). Several of these studies pointed to the need for early, (in the first week) and repeated offers of help for a minimum of one year (Dyregrov 2002; Provini et al 2000). Dyregrov makes the point that the needs of the bereaved increase rather than decrease over the first year of bereavement and that the bereaved wanted continued care throughout this time. Help of a professional standard was needed, with appropriate attitudes and knowledge and should be one of outreach to the bereaved person in his or her home. The additional need of support by a bereaved peer who may form a 'buddy' type of relationship is also recognized (Clark 2001, Dyregrov 2002). Various types of assistance are required, such as counselling, legal and financial advice, and practical assistance (Clark 2001; Dyregrov 2002). Information is an important need and should include a directory of the various services available, what types of help they provide, information about the administrative issues to do with the death, including coronial matters, and facts about the grieving process (Andriessen et al 2001; Clark 2001; Dyrgrov 2002).

Children were identified as a group in need but for whom few services existed (Clark 2001; Dyrgrov 2002; Provine 2000). Other needy and under serviced groups, such as youth, immigrants, people in rural and remote areas and the gay and lesbian community were also identified in Australia.

Specific criticisms relating to inappropriate attitudes, knowledge, skills or services were made against police, coronial proceedings, the media and medical services (Andriessen 2001; Clark 2001; Harwood et al 2002; van Dongen 1993). Some authors even reported that bad support can be harmful (Kneiper 1999). Barriers to receiving help included family disagreements about need for help, language, time, money and transport.

Dyregrov (2002) found that communities with a coordinator, crisis team and written routines offered the best support in terms of what the bereaved regarded as ideal. Further recommendations from these studies included the design of postvention policy for service providers and professionals, which importantly should include relevant education and training. Suggestions were made for increasing the availability of a wider range of services and information, especially with early outreach and backed by increased funding. Specific services for children, education of the general public and the media to raise their awareness of the needs of the bereaved and increased research into postvention were additional proposals.

Needs of service providers

There is need for more appropriate training, written guidelines and support for service providers relating to the management of the aftermath of a suicide (Andriessen 2001; Clark 2001; Dyregrov 2001; Ellis et al 1998). There was a perceived need for education about the emotional reactions experienced by the bereaved service provider, and strategies to assist with them. The provision of time to deal with emotions, increased coordination between services, attention to emotional and physical needs of the service provider, time away from the job, and debriefing were all seen as important (Andriessen et al 2001; Clark et al 1998; Ellis et al 1998). In particular, support in the workplace not linked with clinical review was found to be the most supportive (Ellis et al 1998; Hendin et al 2000). Other strategies include defined standards of care, guidelines for the aftermath of a suicide, accreditation & supervision.

Existing models of service

Information about existing postvention services worldwide is limited. There are few international reviews and guidelines, and language is a major barrier. An email request for information about national postvention strategies to the 15 members of the Postvention Taskforce of the International Association for Suicide Prevention, resulted in only one response, other than the existing contacts with Norway & Belgium. Any written guidelines tend to be country, culture and geographically specific, and with the additional limitation that publications appear only in the language-specific journal of the relevant country. One exception is the World Health Organisation's publication on starting a survivor group (World Health Organisation 2000). Similarly the 'Survivors of Suicide Support Group Guidelines" of the American Association of Suicidology (American Association of Suicidology 1992) and the Oxford Bereavement Pack (Hill, Hawton, Malmberg & Simkin 1997) are among documents that have been used world-wide, the latter forming the basis of Australia's own Bereavement and Support Pack (Clark, Hillman & Ministerial Council for Suicide Prevention 2001).

Few countries have a postvention policy. Exceptions include Norway (Dyregrov & Hauge unpublished); Ireland (Begley 2003; Living Links undated), Germany, Flemish Belgium (Andriessen, Clara & Beuckx 2002); and England (Department of Health 2002). Many other countries have policies created by and for the local communities, such as the one in the Helsinki district of Finland (Maenpaa 2004). However, New South Wales has developed draft postvention guidelines for health staff (New South Wales Health 2001).

Audits of suicide bereavement support groups have found them to be sparse in America (Farberow 1998; Campbell 1997) and Europe (International Association for Suicide Prevention 2002)

In a rare international review of postvention activities coming out of the member countries of the IASP Postvention Taskforce, Andriessen (2004) noted that most activity occurs in Europe, and within the continent itself is most prominent in the north and north-west for socio-economic and cultural reasons. Here the focus was on the use of service directories, and services and support groups in adult bereavement, with little attention being paid to the needs of children and the bereaved clinician.

Published accounts of national and local postvention activities provide some similar themes. Following a completed suicide in Ireland, the family is visited at home on six occasions by a trained volunteer (Living Links undated). This person provides the initial emotional support and advice and bridges the gap to existing health and welfare services and to the local support group. The Baton Rouge Crisis Intervention Centre in Los Angeles has an active postvention model with a first-response team consisting of professionals, and trained volunteers who themselves had been bereaved through suicide (Campbell, Cataldie, McIntosh & Millet 2004). Support of the family and others is initiated at the scene of the suicide and continues in various forms. Evaluation has shown the model provides a reduced death-help seeking time interval for the bereaved, more appropriate and beneficial support for the bereaved and positive psychological benefit for the bereaved volunteers compared to controls. A similar system is in place in the Noosa Suicide Bereavement Project of Queensland (Fisher 2003), except that the link is a single trained professional, who is on call to respond immediately to a family after a suicide and this person also coordinates local support groups. This use of a specific suicide bereavement-trained crisis coordinator or service which provides entry into existing community networks and suicide-specific support groups is also a feature of the supports provided under the Norwegian strategy (Dyregrov & Hauge unpublished).

A number of novel innovations have been established in Flemish Belgium such as a manual of good practice (in Flemmish), a national Suicide Survivor Day, a Charter 'The Rights of Suicide Survivors' (De Fauw & Andriessen, 2003) and a directory of services. Further, support groups are supported by funding, professional co-facilitation, training workshops for the facilitators. Additional strategies are a media award for the sympathetic reporting of suicide bereavement issues, a theatre play to educate the public in the issues and a website where the bereaved can seek information.

Schools and higher educational institutions seem to be the exception in having well described recommendations for forming guidelines in the event of a student (Leenars & Wenckstern 1998; Streufert 2004).

Conclusions

The 1000 or more people bereaved through suicide each year in South Australia may be subject not only to the general effects of bereavement, but also be at increased risk of mental ill health and suicide. The grief that ensues is particular to the mode of death. From the

discussion in this review it follows that interventions not only need to have a mental health approach, including suicide risk assessment, and a generic grief approach, but also a specific suicide grief focus. This needs to be delivered appropriately and in a timely fashion by skilled and experienced providers. Clinicians and service providers who experience the suicide of a patient or client are also subject to morbidities and burn out and their needs are too often neglected. Suicide postvention therefore needs to have a two-pronged approach, firstly, in providing support for the bereaved, and, secondly in providing appropriate measures to assist the professionals and service providers who provide postvention services. Suicide postvention is still a neglected and under-serviced area the world over and is a new area of research and development.

Methods

Study design (Figure 1)

The research approach was a Concurrent Mixed Method Design (Creswell 2003), chosen for its ability to best address the project objectives within the given time parameters. This is a multi-strand design in which both qualitative and quantitative data are collected by the same method and analysed to answer a single type of research question.   Both numerical and text data are collected and alternative tools of statistical and text analysis are applied.   The final inferences are based on analysis of both data sets.   The two types of data are collected independently, at the same time or with a time lag.

This study was conducted by a half time research officer over two years to allow adequate time for data collection and follow up. Questionnaires were developed and piloted for the three target groups of persons bereaved through suicide, agencies, and service providers. Data were analysed by SPSS Version11.0 (SPSS Inc.) for statistical analysis of quantitative data and QSR NVivo2 (QSR International 2002) for narrative analysis of text. A research journal was maintained in NVivo and was systematically coded. Themes emerging from the data analysis were explored through a discussion forum and helped towards forming the final recommendations.

Permission was granted from the University of Adelaide Human Research Ethics Committee to proceed with the study **(Appendix 1).**

Services	Bereaved	Service providers
Advisory group	**Literature**	**Literature**
↓	↓	↓
Questionnaire	**Questionnaire**	**Questionnaire**

Pre-test/Pilot

↓

Q'aire Distributed

↓

Data collection
& analysis

↓

Discussion Forum

↓

Data collection
& analysis

↓

Report &
recommendations
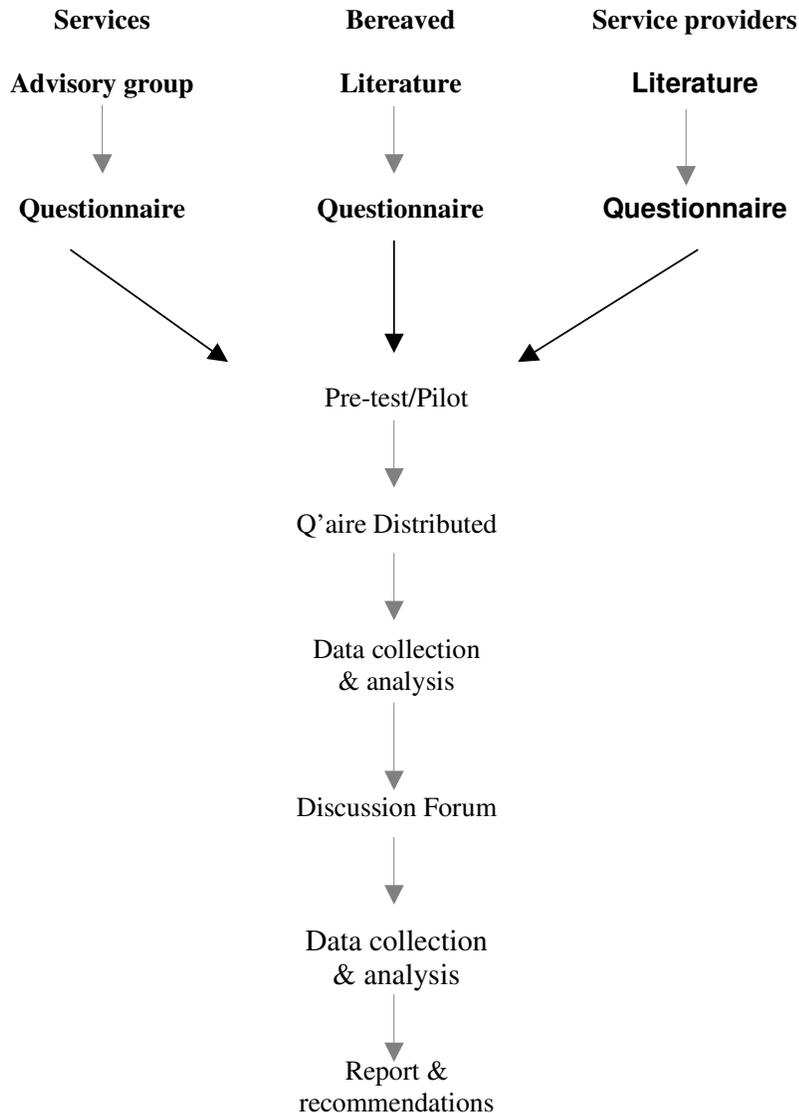
Figure 1: Study design for the three sample groups

Questionnaire development

Topics for exploration in the questionnaires were determined following a literature review as well as by the personal local knowledge of the researchers and advisory group. Following a search for existing instruments and personal communication with international postvention experts, a number of relevant task-specific questionnaires were obtained from overseas. Some required translation in order to ascertain their usefulness. Questionnaires from Norway (Dyregrov, Nordanger & Dyregrov 2002), were found to most suit the study's objectives as they too focused on postvention in similar areas of interest, and were officially translated. It was then adapted, with permission of the authors (**Appendix 2**), to suit the South Australian

context and needs. Both closed and open-ended questions were applied to maximise available information. Each questionnaire was pre-tested and piloted prior to distribution (McLennan 1999).

The bereaved persons' questionnaire

The bereaved persons' questionnaire **(Appendix 3)** aimed to determine the demographics of the respondent, establish relevant facts relating to the person who suicided, determine their need for help following the death, establish and evaluate the usefulness of the services received (if any) after the suicide, and provide opportunity for suggestions for improving support for the bereaved.

The agencies' questionnaire

The purposes of the agencies' questionnaire **(Appendix 4)** was to audit the services relevant to suicide postvention in metropolitan Adelaide, identify the gaps, and assess the experience, education and professional support relevant to postvention of the agency workers and to elicit their suggestions for improving the support of those bereaved by suicide.

The service providers' questionnaire

The service providers' questionnaire **(Appendix 5)** aimed to assess the services provided by individual service providers relevant to suicide postvention, evaluate their experience, education and professional support relevant to postvention, and elicit their suggestions for improving the support of those bereaved by suicide.

Selection of subjects

Bereaved persons

Ideally, a random sample of bereaved next of kin from the records of the Coroner's Office over the previous 10-year period would have provided the most representative sample of bereaved persons. However, this opportunity was not forthcoming and alternative methods of recruitment were necessary.

Two different methods were therefore used to engage subjects in the study. Firstly, a series of radio interviews and newspaper and internet articles invited persons bereaved through suicide, whatever their kinship and social relationship to the deceased, to register by telephone and

receive a postal questionnaire. In order to access people from non-English speaking backgrounds, announcements were also made on ethnic radio programs. Secondly, bereavement support groups informed members of the study through their newsletters and mailed questionnaires to all on their mailing lists. An informational flier for bereaved volunteers **(Appendix 6)** was developed to accompany the questionnaire. These processes resulted in 172 (48.7%) questionnaires being received (total mailed N=353), of which 166 (47%) were sufficiently complete to be included. This method made provision for other than the immediate family to participate in the study, such as second degrees relatives, friends, workmates and colleagues

Agencies:

A list of agencies relevant to suicide postvention in metropolitan Adelaide was drawn up from existing databases, web sites and from sources known to the reference group. They included, government organisations as well as non-government agencies, volunteer organisations and churches. Non-responders were followed up by telephone. From the 170 questionnaires sent out, there were 71 valid returns (valid return rate=41.76%). A general information flier was sent to agencies and service providers with the questionnaires **(Appendix 7).**

Agencies were categorised for their appropriateness for suicide postvention (Table 1). A full list and diagrammatic representation showing their relevance to suicide postvention are shown in **Appendix 8**.

Category 1: Specific suicide bereavement agencies:
        1 suicide specific support group

Category 2: Generic grief-related agencies:
        39 agencies, such as funeral parlours, cemeteries, generic mode-of-death grief-related support groups and bereavement services

Category 3: Agencies targeting specific grief-related populations at risk of suicide
        30 agencies such as Aboriginal corrections, gay and lesbian services and alcohol and drug services.

Category 4: General counselling agencies:
        100 agencies that provide generic counselling services such as Child and Adolescent Mental Health Services, South Australian Metropolitan Fire Service and community health centres.

Table 1: Classification of categories

| Category | Questionnaires | | |
	Mailed out N	Returns N & (% of mail out)	% of returns
1 Suicide bereavement agencies	1	1 (100.00)	1.4
2 Generic grief-related agencies	39	9 (23.07)	12.7
3 Agencies targeting specific populations	30	13 (43.33)	18.3
4 General counselling agencies	100	48 (48.00)	67.6
Total	**170**	**71 (41.76)**	**100**

The returns were examined to ascertain whether the returned sample represented those agencies most pertinent for suicide postvention and whether the non-returns were less relevant. The highest return rate was from specific suicide bereavement agencies (N=1; 100%), followed by the general counselling agencies (N=48; 48%) and agencies targeting specific populations category (N=13; 43.33%). The lowest returns were among those agencies targeting generic grief-related populations. Entries in the research journal recorded that several agencies in the generic grief-related agencies category notified the project by telephone or mail that they would not make a return because their agency did not provide any postvention services or because they perceived that their agency was not relevant to postvention. Some agencies in the general counselling agencies category also notified intent to not participate, as they felt frustrated and disillusioned by the lack of effort to improve services in the past.

Although the return rate of 42% is high compared to other similar recent studies, it is still below the desired level for obtaining a true picture of postvention among the listed agencies.

Service providers:

The aim was to access specific professional and service provider disciplines most relevant to suicide postvention. The list of these is shown in the left hand column of Table 2.

Two different methods were used to distribute the questionnaire. Multiple copies of questionnaires were posted to the service agencies in the list in **Appendix 8**, with the request to distribute to individual providers within the agency. For some disciplines, sufficient numbers of respondents were obtained by this method. For those disciplines insufficiently sampled by the method described above, samples were obtained through their professional

bodies. Personal contact was made with key administrative personnel of these bodies for assistance with distribution of questionnaires by random selection through their membership.

Table 2: Postvention service provider disciplines

Discipline N=90; n=89	Sources of disciplines surveyed	Questionnaires		
		Sent out	Returned	
		F	F	%
General Practitioner	Metropolitan divisions of general practice, Uni of Adelaide Department of General Practice GP listing,	177	30	33.7
Social Worker	Community health centres, Child &	)	16	18.0
Nurse	Adolescent Mental Health Services, Anti-	)	9	10.1
Counsellor	cancer Foundation, Anxiety Disorder	)	3	3.4
Community Health Worker	Foundation, Counselling & Support	)	2	2.2
Psychologist	Services, Julia Farr Services, National	169	2	2.2
	Association for Loss & Grief, DETE,	)		
	Second Story Youth Health, Community	)		
	Mental Health, Emergency Department,	)		
	Noarlunga Health Services, Palliative Care	)		
	and other agencies	)		
Psychiatrist	RANZCP, Private psychiatric hospital psychiatrists listing	40	9	10.1
Religious Counsellor	Hospital chaplains Selected churches	35	9	10.1
Volunteer	Suicide-specific support groups	15	5	5.6
Police Officer	Victim of Crime Officers	14	2	2.2
Manager/team leader	Community agencies		1	1.2
Other doctor	Community health centre		1	1.2
Total		450	90	100.0

Repeated approaches were made until all reasonable effort had been made to try to achieve twenty participants from each profession or discipline. This method can be criticised in that it cannot give a sufficiently representative picture of each profession or discipline, both because of the small sample sizes and because of self-selection of respondents. However, it can provide a picture across service provision, as the intention had been to gather perceptions from a cross-section of service providers rather than to individual provider groups.

From the 450 questionnaires sent out, 90 valid returns were received (response rate=20.0%).

Data analysis

A data analysis table for each questionnaire was drawn up listing the analyses for each question and reasons. In the following description, each questionnaire will be dealt with separately.

Bereaved persons' questionnaire

Variables, risk factors and clusters (identified from the literature review) and that were considered in the analysis are shown in **Appendix 9.** In considering the time since the suicide, the question arose of what time limit of experience is relevant to the study.

Specific methodological issues

The bereaved sample

Bereaved persons who had experienced more than one suicide were asked to respond in relation to the most recent suicide, because the recent experiences of services rather than distant past experiences were most relevant to the project. Although the study was not aimed at rural and remote areas, the method of advertising for bereaved respondents was not limited to metropolitan Adelaide. In view of the level of grief shown by the respondents, it was decided it would be callous to refuse anyone who volunteered to participate in the study. Results from respondents outside the metropolitan area were therefore included in the study and formed one of the subgroups of respondents. Another subgroup consisted of persons from non-English speaking backgrounds. Other methodological issues are detailed in the paper 'Desperate to tell: Towards improving the care of people bereaved through suicide – A report of work in progress. Wilson A. & Clark SE. (2004). RED Snapshots 2:75-85 (010) **(Appendix 11)**.

Responses from agencies

The numbers and percentages of responses to some questions were necessarily limited by the number and percentages of the different categories of respondent organisations (refer to the sample group of this study). For example, the numbers of responses to religious support and their percentage expressed in relation to the total number of responses is markedly determined by the number of religious institutions surveyed.

Incomplete responses

Not all respondents answered every question and some topics addressed in the questionnaires have considerable numbers of missing responses. To address this issue, the numbers of the

total population eligible to answer a question is shown by N, the number who answered the question is indicated by n, and the frequency of responses by F.

Profile of Bereaved Subjects

Demographics

This section reports on section A of the Questionnaire (Appendix 3). The demographics of the N=166 respondents are presented here. Participants found out about the study from different sources (Table 3).

Table 3: Sources of information about study

Source of Information n=161	F	Percent
Newspaper	75	46.6
Support Group	40	24.8
Radio	21	13.1
Family or friends	18	11.2
Internet	6	3.7
Hospital nursing staff	1	0.6

The median age of subjects was 50.0 years (mode 43; median 50; range 20-78) (Figure 2).

Bereaved Participants in age groups

Respondents (n=163)

Age groups (years): 16-24, 25-34, 35-44, 45-54, 55-64, 65-74, 75-84, Total

☐ Number of respondents
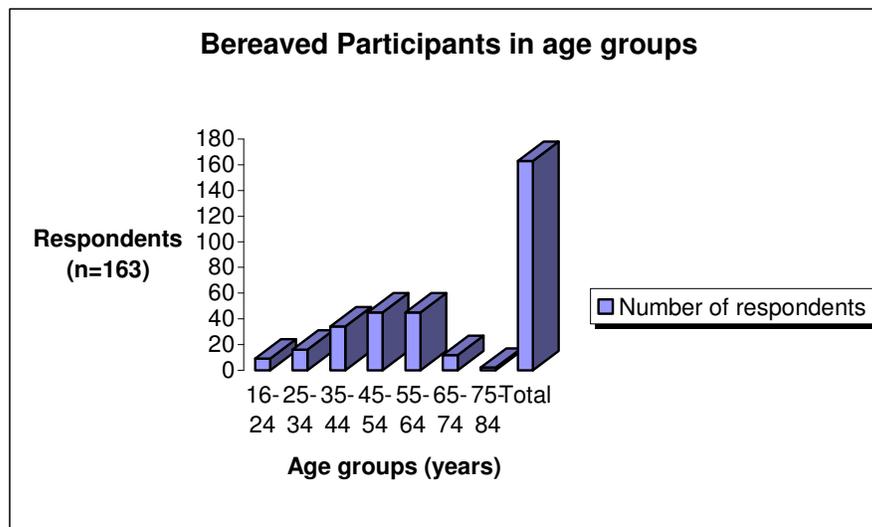
Figure 2: Bereaved participants in age groups

Three quarters of the subjects (75.6%) were females (Table 4). Sixty percent were in married or de facto relationships and the remaining 40% were fairly evenly distributed between the three categories of being separated or divorced, never married, and widowed. Half of the

subjects had received University or higher education, a third had left school and done no further study and only small percentages were either still studying, or had received trade or apprenticeship training. Almost a third of subjects were employed full time and a further third were employed part time. The remaining third were either involved in home duties or retired. Only 3% were unemployed, with the remaining 4% being students. Almost half of the subjects were Health Care Card holders. Three quarters identified as being from Australian culture. Another large group included those from English, Irish or Scottish backgrounds (17%) and only a few individuals came from various European, Asian, or South African backgrounds. One subject identified as being Aboriginal/Afghan. For almost all subjects the main language spoken at home was English, which is consistent with the predominant cultural backgrounds. About a third of participants had children under the age of 16 at home at the time of the suicide. The mean number of children was 1.7 (mode=1; range 1-4).

Table 4: Frequencies (F) and percentages for subjects' demographic variables.

Variable (Subjects N=166)	Level	F	Per Cent	Variable	Level	F	Per Cent
Gender				**Employment**			
n=164	Male	40	24.4	n=163	Full time	51	31.3
	Female	124	75.6		Part time	52	31.9
Marital status					Unemployed	5	3.1
N=163	Married/De facto	97	59.5		Home duties	24	14.7
	Divorced/separated	20	12.3		Retired	35	15.3
	Never married	22	13.5		Student	6	3.7
	Widow / er	24	14.7	**Culture**			
Education				n=158	Australian	118	74.7
n=156	Left school no further study	55	35.3		English/Irish/ Scottish	27	17.1
	In school/ Further study	9	5.8		European	9	5.7
	Trade qualification /apprenticeship	14	9.0		Asian	2	1.3
	University/ Higher education	78	50.0		Aboriginal/ Afghan	1	0.6
Health care card holder					South African	1	0.6
n=160	Yes	67	41.9	**Socio-economic advantage**			
	No	93	58.1	n=163	Low-medium	35	21.5
Main home language					Medium	28	17.2
n=164	English	160	97.6		Medium-high	38	23.3
	English + other	3	1.8		High	62	38.0
	Chinese	1	0.6	**Accessibility**			
Children <16 at home				n=163	Highly accessible	152	93.3
n=163	Yes	55	33.7		Accessible	6	3.7
	No	108	66.3		Moderately accessible	1	0.6
					Remote	4	2.5

Residency

Postcodes were used to define socio-economic wellbeing of subjects using the Socio-Economic Indexes for Areas 2001 (SEIFA) (Australian Bureau of Statistics 2003). Of these indexes, the index of Relative Socio-Economic Disadvantage is an index derived from the summary of various social and economic variables (income, education, unemployment, occupation, divorce rate and indigenous population) by the technique of principle components analysis. Sixty percent of participants were from areas of high and medium-high advantage and the remaining 40% were from medium and low-medium areas.

Postcodes were also used to estimate the accessibility of subjects to services as defined by the Accessibility/Remoteness Index for Australia 2001 (ARIA) (Department of Health and Aged Care and the National Key Centre for Social Applications of Geographical Information Systems (GISCA). This index calculates remoteness based on accessibility to 201 services centres based on road distances. Five categories span a range of values of 0-12. Over 90% of the bereaved respondents were from the category classed as most highly accessible, which is consistent with the aims of the project of focussing on metropolitan Adelaide, all of whose areas are classed as highly accessible.

The mean length of residence at postcode was 12.1 years (mode=6years; median 8.5years; range 1 month-61 years. The mean number of times participants had moved since the death was one (mode=0; standard deviation 0.15; range 0-12). The majority of participants (n=104; 64.4%) had not moved residence following the suicide. Thirty (n=30; 18.4%) had moved once; twenty (n=20; 12.9%) between 2 and 5 times, and seven (n=7; 4.2%), between 6 to12 times (Table 5).

Table 5: Stability of the bereaved population

Variable (Subjects N=166)	Level	F	Per Cent	Variable (Subjects N=)	Level	F	Per Cent
Time at postcode (years) n=162				**Times moved since death the n=163**			
	Mean		12.08		0	105	64.4
	Median		8.5		1	30	18.4
	Mode		6		2	9	5.5
	Standard deviation		11.28		3	6	3.7
	Range		61		4	4	2.5
	Percentiles	25	4		5	2	1.2
		50	8.5		6	1	.6
		75	18.25		7	3	1.8
					8	1	.6
					9	1	.6
					12	1	.6

Variables relating to the suicide

This data reports on information related to the suicide in section B of the questionnaire. The mean time since the suicide was 5.8 years (mode 2 years; SD=7.94; range: 1 month-62 years) (Figure 3). In cases where there had been more than one suicide, respondents were requested to report on the most recent suicide.

Time since death in yearly groups
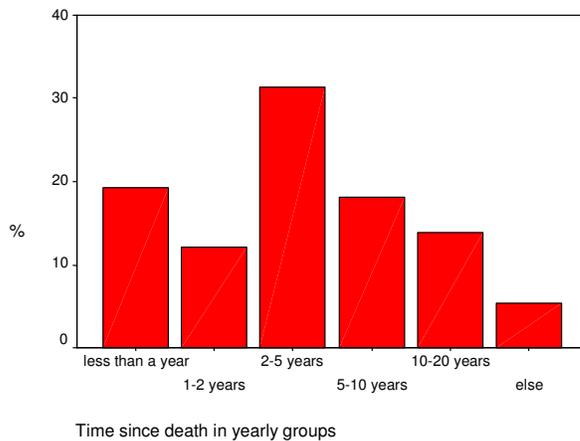
Figure 3: Time since death (in yearly groupings)

Eighty-five percent of participants had been bereaved once through suicide (Table 6). It is notable that 15% had lost 2 or more close people to suicide and that one (not the Aboriginal respondent) had been bereaved six times. Fourteen percent had experienced the trauma of discovering the suicide, and a third of respondents had been present at the site of the suicide, another very distressing experience. That three quarters of the deceased were male is consistent with national statistics (Australian Bureau of Statistics 2002). Nearly three quarters of the deceased fell into the 16-24 year age group.

Table 6: Frequencies (F) and percentages for variables about the suicide.

Variable (Subjects N=166)	Level	F	Per Cent*	Variable (Subjects N=)	Level	F	Per Cent*
Times bereaved by suicide				**Gender of deceased**			
n=160	Once	136	85.0	n=163	M	118	72.4
	Twice	15	9.4		F	45	27.6
	X3	7	4.4	**Age of deceased**			
	X4	1	0.6	n=163	14-15	45	27.6
	X6	1	0.6		16-24	72	71.8
Discovered the suicide?					25-34	36	22.1
n=164	Yes	23	14.0		35-44	10	6.1
	No	141	86.0				
Present at site of suicide?							
n=164	Yes	55	33.5				
	No	109	66.5				

Kinship

Respondents were divided into three kinship groups as indicated in the table below. Parents formed the largest group of respondents at 35%, with two thirds of these being mothers. This was followed by spouses and partners at 22%. Siblings of the deceased formed 16% and children of the deceased formed a further 14% of respondents. Twenty-one (13.4%) respondents were second-degree relatives and non-relatives (Table 7). As a result of the small numbers of subjects in these two groups, conclusion must be guarded about any generalisations drawn from their analyses.

Table 7: Kinships to the deceased and kinship clusters.

Variable (Subjects N=166)	Level	F	Per Cent	F	Per cent	Cluster	F	Per Cent
Kinship						**First degree relative**	142	86.6
n=164	Father	20	12.2	Parents	34.8			
	Mother	37	22.6					
	Son	14	8.5	Children	14.0			
	Daughter	9	5.5					
	Brother	8	4.9	Siblings	15.9			
	Sister	18	11.0					
	Spouse/de facto	32	19.5	Partners	21.9			
	Same-sex partner	4	2.4					
	Aunt/uncle	4	2.4			**Second degree relative**	9	5.5
	In laws	3	1.8					
	Boy friend/ Fiancé	2	1.2					
	Godparent	1	0.6			**Non-relative**	13	7.9
	Foster child	1	0.6					
	Friend's child	2	1					
	Friend	9	5					

Risk Clusters

Three risk clusters were generated from the high suicide risk variables in Appendix 9: a high risk cluster consisted of:

Risk cluster components:

1. high – first degree relatives of young suicides (14-24;
2. medium – 2nd degree relatives of older suicides (>45)
3. low – non-relative of suicide of any age

Profile of Agencies

Agencies surveyed were restricted to the Adelaide metropolitan area because of the brief of the study. All agencies scored as 'highly accessible' on the access ability and remoteness indicator of Australia (ARIA). Agencies participating in the study were spread throughout the metropolitan area with the majority in the central eastern region, as indicated in Table 8. Agencies were also analysed to determine their socio-economic advantage (Australian Bureau of Statistics 2003)) with fairly even distribution across the socio-economic areas. The majority of agencies provided services in metropolitan only areas (55%; n=33), while 43.3% (n=26) of agencies serviced both metropolitan and country areas, and one agency located in metropolitan Adelaide serviced country areas only. Financial support for services was primarily from government sources (67.2%; n=41).

Table 8: Profile of agencies

Variable (Subjects N=71) Level	F	Per Cent*	Variable (Subjects n=71) Level	F	Per Cent*
Socio-economic distribution (n=67)			**Geographical area (n=67)**		
High area of advantage	20	29.9	Central Eastern	26	38.8
Medium-high area of advantage	18	26.9	Western	13	19.4
Medium area of advantage	9	13.4	Northern	11	16.4
Low-medium area of advantage	20	29.9	Southern	9	13.4
			North Eastern	8	11.9
Funding (n=61)			**Areas covered by agency (n=61)**		
Government funded	41	67.2	Metropolitan	33	55.0
Non-government funded	11	18.0	Both areas	27	45.0
Mixed funding	9	14.8	Country	1	1.4

Profile of service providers

Analysis of the service providers illustrated that one third were from central or eastern suburbs (Table 9), which are districts of high advantage, and almost 80% were from areas of high or medium-high advantage with few from areas of low-medium advantage. Almost all service providers were from highly accessible areas, with one (Murray Mallee) being classed as accessible.

Two thirds of respondents reported they covered the metropolitan area (64.4%; n=58), nearly a third covered metropolitan and country areas (29.1%; n=25) and only 3.5% (n=3) had services in the country (Table 9).

Table 9: Profile of service providers

Variable Subjects N=90	Level	F	Per Cent	Variable Subjects N=90	Level	F	Per Cent
Accessibility (n=84)				**Geographical area (n=84)**			
	Highly accessible	83	98.8		Central/eastern	31	36.9
	Accessible	1	1.2		Western	15	17.9
Socio-economic index (n=60)					North-eastern	14	16.7
	High advantage	26	43.3		Northern	11	13.1
	Medium-high advantage	21	35.0		Southern	11	13.1
	Medium advantage	10	16.7		Murray Mallee	1	1.2
	Low-medium advantage	3	5.0		Adelaide Hills	1	1.2
Geographical areas covered (n=86)							
	Metropolitan	58	67.4				
	Metro+country	25	29.1				
	Country	3	3.5				

The majority of respondents were employees of an agency (n=50; 56.8%), approximately a third were independent service providers (38.6%) and four were volunteers (4.5%) (Table 10). Respondents were mostly experienced in their discipline with nearly half having more than 20 years of service.

Reasons given for becoming a volunteer (multiple responses) were because of: personal experience of bereavement from suicide (n=4; 4.5%), experience of other type of bereavement (n=2; 2.3%), saw a need (n=4; 4.5%), and due to personal interest (n=3; 3.4%).

Table 10: Position as service provider

Variable (Subjects N=)	Level	F	Per Cent*	Variable (Subjects N=)	Level	F	Per Cent*
Position of employment (n=88)				**Length of time as service provider/volunteer (n=85)**			
	Employee	50	56.8		0-2 years	4	4.7
	Independent provider	34	38.6		3-5 years	8	9.4
	Volunteer	4	4.5		6-10 years	14	16.5
					10-15 years	12	14.1
					15-20 years	11	12.9
					>20 years	36	42.4

Discussion forum process

Copies of the draft report were circulated to the Reference Group members for discussion at a workshop. The purpose of the review was to:

1. Provide comments on the text and data of the report that would lead to improvement of the report
2. Consider the main issues raised by the report
3. Form recommendations about postvention.

Members who could not be present were asked to provide written comments before the meeting for consideration.

In the workshop participants were asked to respond, from their reading of the report, to the three questions below:

1. What is already there?
2. What is missing?
3. What is required?

Participants worked in small groups and recorded their responses in writing. Each question was discussed in turn with the whole group and the draft recommendations formed.

Results: Bereaved persons' questionnaire

Bereaved persons' perceptions of need for services

This reports on the perceived needs for services and actual services received after the suicide by the 166 bereaved respondents who made valid returns (Section B questions 18 & 19 and Section C of the questionnaire, **Appendix 3**).

Help was needed by 94% but was received by only 44%. Sixty percent of respondents needed a great or significant degree of help (Table 11).

Table 11: Bereaved persons' perceptions of need for services compared to help received

Help received from services				Help needed from services			
Help received n=163	**Level**	**F**	**%**	**Help needed n=160**	**Level**	**F**	**%**
	Yes	71	43.6		Great degree	47	29.4
	No	92	56.4		Significant degree	48	30.0
					Some degree	38	23.8
					Small degree	18	11.3
					Not at all	9	5.4

Analysis of need by kinship cluster showed, as expected, that first degree relatives had the greatest degree of need as nearly 60% indicated a great or significant degree of need. However, second degree relatives and non-relatives also demonstrated need of help but of a lesser level (Table 12).

Table 12: Perceptions of need by kinship group

Variable (Subjects N=)	First degree		Second degree		Non-relative	
	F	**Percent***	**F**	**Percent***	**F**	**Percent***
Great	46	28.8	0	0.0	1	0.6
Significant	44	27.5	2	1.3	2	1.3
Some	27	16.9	6	3.8	5	3.1
Small	13	8.1	1	0.6	4	2.5
None	8	5.0	0	0.0	1	0.6
Total	138	86.3%	9	5.6%	13	8.1%

Analysis of need by age of deceased showed that need is high whatever the age of the deceased and was not higher for youth suicides. Eighty percent of bereaved for each age category indicated great, significant or some degree of need (Table 13).

Table 13: Perceptions of need by age of deceased

Variable n=160	14-24 years		25-44 years		45-64 years		65-84 years	
	F	Percent*	F	Percent	F*	Percent*	F	Percent*
Great	9	20.5	24	34.8	10	27.8	4	40.0
Significant	11	25.0	22	31.9	14	38.9	1	10.0
Some	13	29.5	13	18.8	8	22.2	3	30.0
Small	7	15.9	7	10.1	3	8.3	1	10.0
None	4	9.1	3	4.3	1	2.8	1	10.0
Total	44	100.0	69	100.0	36	100.0	10	100.0

Correlations between those who needed help and those who received help indicated that those who needed help received it (0.32: $p<0.01$). Significant correlations were also found between receiving help and being present at the site of the suicide (0.158: $p<0.05$) presumably because of the help provided by the on-site crisis services. No associations were identified between need and gender of respondent, nor between need and having children under 16 at home at the time of the death.

Information and services received after the suicide

This section of the questionnaire sought to gather information relating to how the bereaved found out about support services, whether they received information or were offered assistance, the type of help they received and from whom they might have preferred help. Participants were also asked if they had found any particular contacts unhelpful.

Information about support services

Ninety-eight percent of participants responded to the question that asked whether they had received information about support services and 48.5% indicating that they had (Table 14). Of those who did not receive information (51.5%), 90.7% stated that they would have liked information. Information was received from a range of persons, the most frequent being the Coroner's Office, followed by friends, funeral parlours, police, general practitioners and families. Less frequent sources of information were churches, workplaces, counsellors, neighbours and hospitals (Table 15). Forty percent were offered assistance from any support service after the death.

Table 14: Frequencies and percentages for information received about support services

Variable	Level	F	%	Variable	Level	F	%
Received information				**Would have like information**			
n=163	Yes	79	48.5	**n=86**	Yes	78	90.7
	No	84	51.5		No	8	9.3
Offered assistance							
n=160	Yes	64	40.0				
	No	**96**	**60.0**				

Table 15: Sources of information about support services

Information from (n=163 (multiple responses)	F	Percent
Coroner's Office	36	**21.7**
Friends	26	**15.7**
Funeral Parlour	24	**14.5**
Police	21	**12.7**
General Practitioner	21	**12.7**
Family	17	**10.2**
Church	6	**3.6**
Workplace	5	**3.0**
Counsellor	4	**2.4**
Neighbours	3	**1.8**
Hospital	3	**1.8**

There is clearly a deficiency in bereaved people obtaining information about services. The services involved in the immediate aftermath of the death, as well as family, friends and the GP, appear the most common vehicles for dissemination.

Contacts with support services

Subjects were offered three options with regard to how contact with support services was established: they were contacted by the services, they made contact, or others assisted them to do so. The response rate to the question was 51.8%. The majority (58.2%) had to make contact themselves and in only 18.6% of cases was the contact initiated by the services (Table 16: Making and receiving supportive contact).

For most participants (64.0%), contact was made within one month of the death, and 85% within three months (Table 16). Less than a third of respondents (29.3%) had made or received contact from support services within a week.

The most widely held view was that offers of services should be made in person (52.7%), with telephone (33.1%) and postal information (33.7%) being the less popular options (Table

16). A specific bereavement service and the GP were considered to be the most appropriate to make contact with the bereaved (Table 16). Other appropriate persons or services included general practitioners, the coroner's office, funeral parlours and support groups.

Table 16: Making and receiving supportive contact

Variable	Level	F	Per Cent*	Variable	Level	F	Per Cent*
How contact was made n=86				**How services should be offered n=163 (multiple responses)**			
	I made contact	49	57.0		In person	69	42.3
	Others assisted				Telephone/post/person		
		21	24.4			15	9.2
	I was contacted	15	17.4		By telephone	30	18.4
	All 3 ways	1	1.2		By post	38	23.3
					Telephone/post	9	5.5
How soon after the death contact was made n=75					Person/post	2	1.2
	Within 1 day	6	8.0	**Who is appropriate to make contact n=159 (multiple responses)**			
	Within 3 days	10	13.3		GP	22	13.8
	Within 1 week	6	8.0		Coroner's office	18	11.3
	Within 1 month	26	34.7		Coroner + specific service	13	8.2
	Total within 1 month	48	64				
	Within 1-3 months	16	21.3		GP + specific service		
						9	5.7
	Within 3-6 months	8	10.7		All three	6	3.6
	Within 6-12 months	2	2.7		GP + Coroner	4	2.5
	Within 12-24 months	1	1.3		Funeral parlour	2	1.3
					Support group	1	0.6

Help received and desired

Bereaved persons were asked to provide information about the types of help they received from support services following the death and from who help was acquired. Four professional groups, psychiatrist, psychologist, nurse and other counsellor, were merged to form one variable 'counsellors'. As such this group formed the largest number of responses to this question (n=77) (Table 17). Of the individual professionals nominated, general practitioners were by far the highest nominated profession (n=71). This was followed by funeral parlours, support groups, religious institutions, police, and telephone counselling services, mental health services, legal services and crisis teams.

The table also shows the options that respondents selected as services they would have liked to have received but did not. Help from a support group and counselling topped the list, with

support from a crisis team, mental health services, telephone counselling and legal advice also being in demand. There appears to be little further demand for some of the highly used services - the GP and funeral parlour - whereas for counselling and support groups there is still considerable need.

Table 17: Sources of help for bereaved persons

Variable	Sources of help received n=166 (multiple responses)		Desired service n=166 (multiple responses)	
	F	Per Cent*	F	%
Counsellors	77	46.5	55	33.1
GP	71	42.8	11	6.6
Funeral parlour	48	28.9	8	4.8
Support group	47	28.3	59	35.5
Religious institution	33	19.9	7	4.2
Police	27	16.3	12	7.2
Mental health services	24	14.5	24	14.5
Telephone counselling	19	11.4	20	12.0
Hospital	15	9.0	6	3.6
Legal services	11	6.6	17	10.2
Crisis team	4	2.4	32	19.3
Other services	8	4.8	8	4.8

The types of help received from each of the above sources are shown in Table 18, and was often a mix of counselling, medical assistance, information, and financial and practical help rather than of only one type. This illustrates the complexity of the work, especially for individual providers such as general practitioners.

Table 18: Types of help received from support services

Variable	Level	F	Per Cent*	Variable	Level	F	Per Cent*
Type of help from hospital n=15				**Type of help from GP n=71**			
	Medical help	5	33.3		Medical help	34	47.9
	Practical help	2	13.3		Practical help	3	4.2
	Counselling	1	6.7		Counselling	7	9.9
	Information	2	13.3		Information	3	4.2
	Combination of above	5	33.4		Combination of above	24	33.8
Type of help from Religious Institution n=33				**Type of help from Support Group n=47**			
	Medical help	4	12.1		Medical help	2	4.3
	Practical help	7	21.2		Practical help	3	6.4
	Counselling	12	36.4		Counselling	16	34
	Information	1	3.0		Information	8	17
	Financial	1	3.0		Combination of above	18	38.3
	Combination of above	8	24.3	**Type of help from Funeral Parlour n=48**			
Type of help from Counsellors n=77					Medical help	1	2.1
	Medical help	7	4.2		Practical Help	11	22.9
	Practical help	2	1.2		Counselling	5	10.4
	Counselling	49	29.4		Information	25	52.1
	Information	2	1.2		Combination of above	6	12.6
	Combination of above	16	9.6	**Type of help from Legal advice n=11**			
	Financial	1	0.6		Practical help	4	36.4
Type of help from Mental Health Services n=13					Counselling	1	9.1
	Counselling	4	30.8		Financial	1	9.1
	Information	5	38.5		Information	5	45.5
	Combination of above + medical + practical	4	30.8	**Type of help from Telephone counselling n=19**			
Type of help from crisis team n=4					Medical help	1	5.3
	Practical help	1	25.0		Practical help	1	5.3
	Counselling	1	25.0		Counselling	12	63.2
	Combination of above + information	2	50.0		Information	2	10.5
Type of help from police n=27					Combination of above	3	15.8
	Practical help	5	18.5				
	Counselling	1	3.7				
	Information	14	51.9				

Duration and frequency of contact with services

Responders indicated the number of contacts they had had with services from the first week following the death to more than 2 years afterwards (Table 19). The mean is provided as the average number of contacts made with services by the responding number of participants in the given time period. Table 19 shows that a mean of 2.02 contacts were made or received in the first week by the 57 participants who responded to the item about the first week. The

range of responses indicates that some participants had no contacts with services and others had up to 10. The response rate to this question is low and may be related to difficulty recalling the practical details when experiencing deep emotion, particularly when the death occurred a long time ago. Despite the consequent difficulty in interpreting the responses, it can be seen that respondents had contact with services from the very first week up to 4 years after the death. Contacts were more frequent at first: a mean of two in the first week, two in the following three weeks and 4-5 in the following 5 months. In the first and second six month periods in the second year after the death there were 7 contacts. After that the number of contacts fell away and no one recorded contacts after more than 4 years.

Table 19: Number of contacts received from services after the death

Time since death	Respondents		Contacts	
(multiple responses) N=166	n	%	Mean	Range
1st week	57	34.3	2.02	0-10
Next 3 weeks	42	25.3	2.4	0-18
1-6 months	60	36.1	4.6	0-48
6-12 months	32	19.3	6.31	0-48
12-24 months	25	15.1	7.2	0-24
After 24 months	18	10.8	4.83	0-24

Desired duration of help

Table 20 shows that respondents felt that professional assistance was required for considerable time following the death. Twenty seven percent indicated they required support for at least twelve months and a further 20% for at least 2 years. Although not specifically asked in the question, twenty-three participants (17.4%) pointed out that support should be for as long as required or, as one respondent wrote, "until the pain has subsided".

Table 20: Length of time help is needed

Variable	Level	F	Per Cent*
How long would have like help n=132			
	At least 1 month	10	7.6
	At least 2 months	6	4.5
	At least 3 months	8	6.1
	At least 6 months	22	16.7
	At least 12 months	35	26.5
	At least 2 years	25	18.9
	At least 5 years	3	2.3
	As long as needed*	23	17.4

* self-nominated item

Home Visits

A third of participants (30.5%; n=47) reported receiving home support visits and two thirds (69.5%; n=107) reported they had not. Depending on their individual circumstances, subjects provided a range of sources from which they had received these visits (Table 21). Most commonly they were from general practitioners (29.8%), religious/spiritual institutions (19.3), hospitals (12.3%), funeral parlours (10.5%), and support groups, police and counsellors (7% each).

Of the 107 (69.5%) who indicated they had not received a home visit, the majority (67.3%; n=68) indicated that they would have liked to have received this service from a range of personnel, including support group (24.1%), counsellor (20.4%), religious institution (13.0%), specific bereavement service or person with experience in the area (9.3% each respectively) (Table 21).

Table 21: Home visits received and desired

Variable	Level	F	Per Cent*	Variable	Level	F	Per Cent*
Home visits received from: (n=47) multiple responses				**Would have liked home visit from: (n=68) multiple responses – all self nominated items**			
	General practitioners	17	29.8		Support group	13	24.1
	Religious institution	11	19.3		Counsellor	21	20.4
	Hospital	7	12.3		Religious institution	7	13.0
	Funeral parlour	6	10.5		Specific bereavement service	4	9.3
	Support group	4	7.0		Person bereaved through suicide	5	9.3
	Police	4	7.0		General practitioner	3	5.6
	Counsellor	4	7.0		Psychologist	6	3.7
	Mental health services	1	1.8		Psychiatrist	1	1.9
	Salvation Army	1	1.8		Crisis team	1	1.9
	Army	1	1.8		Police	1	1.9
	Deaf society	1	1.8		Funeral parlour	1	1.9

Satisfaction with help received

Analysis of participants' satisfaction with the help they received showed that only 40% of respondents received much satisfaction with the services (Table 22). It is noteworthy that a third of participant only felt some or a small degree of satisfaction and that a quarter were not satisfied at all.

Table 22: Satisfaction with help received

Satisfied with the help received n=134	F	%	Unhelpful contact received n=121	F	%
Great degree	21	15.7	Yes	42	34.7
Significant degree	32	23.9	No	65	53.7
Some degree	28	20.9	Don't know	14	11.6
Small degree	18	13.4			
Not at all	35	26.1			

Unhelpful support

Half of the respondents 65 (53.7%) had found contact with services to be helpful compared with a third of respondents (42; 34.7%) who indicated they had not (Table 22). Written comments explaining what they found to be unsatisfactory have been classified into nine categories (Figure 4).

Lack of appropriate training in relation to knowledge and skills as well as attitudes of the service provider formed the majority of responses and included examples such as "*Some seemed fearful of my grief, eg GP wanted to give me sleeping tablets and said 'Don't start crying I don't know how to help you'*"; "*Church seemed uneducated about suicide and its impact. Appeared too busy to listen; appeared to be judgemental and quick to draw inaccurate conclusion; very insensitive to family needs*"; "*I found on several occasions that professionals who had not themselves lost a loved one through suicide, to be quite damaging to me*". Lack of immediate and on-going follow up by services was also a major disappointment for respondents. Most comments relating to support groups described the group process as unhelpful as typified by the following response "*(Support) group was overwhelming because the number of newly bereaved in the room seemed hopeless*". Other reasons for dissatisfaction were in difficulties accessing help, for example "*I wanted support from a professional but when we went we got the royal run around*", and dissatisfaction with the quality of particular services such as financial advice and children's support.

More information about dissatisfaction with the help received may be found in the chapter RESULTS: QUALITATIVE DATA BEREAVED QUESTIONNAIRE.
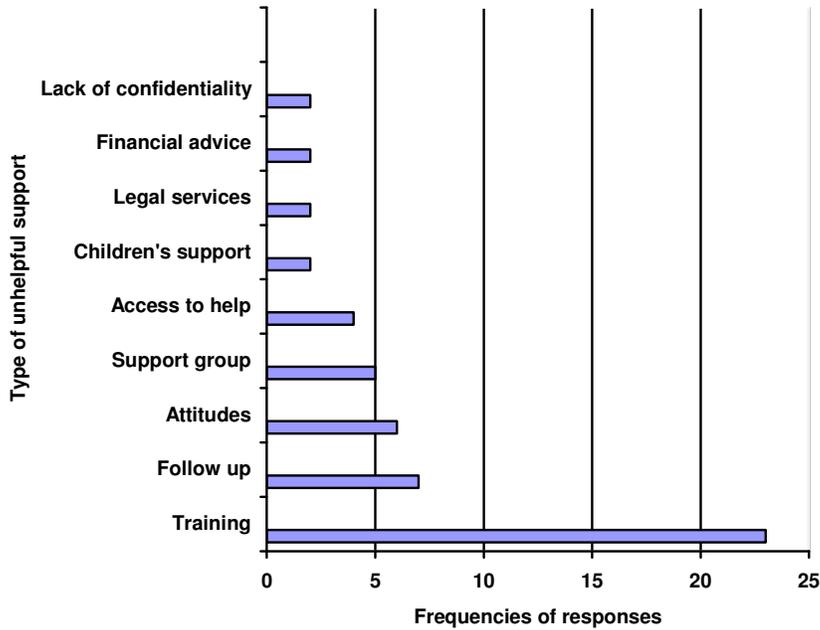
Figure 4: Unhelpful support

Barriers to help

Barriers that hindered receiving or accessing help are listed in Table 23.   Not having information about services was clearly an issue represented by lack of available information (25.3%), lack of awareness of available services on the part of participants (23.5%) and did not think anyone could help (18.7%)

Table 23: Barriers to receiving or accessing help and support

Barriers to help and support n=158 (multiple responses)	F	Per Cent*
Yes	115	72.8
No	43	27.2
Type of barrier		
Lack of information	42	25.3
Not aware of services	39	23.5
Help not offered	38	22.9
Did not think anyone could help	31	18.7
Distance	25	15.1
Cost	24	14.5
Depression*	23	13.9
Privacy needed	17	10.2
Shame	13	7.8
Family pressure*	2	1.2

* self nominated

Other barriers in the text data included:

"I wanted support from a professional but when we went we got the royal run around. Now I just want to leave things where they are. I get upset and don't want to stir things up inside".

"I am still on a waiting list for counselling through (named) mental health services it has been 2 years".

"Three children to care for. I was pregnant at the time of his death".

"Never having experienced a suicide in the family I did not know that I needed some help. Its only after you come out of the grief that you realise you needed help".

Services for bereaved children

A separate section in the questionnaire requested information about services for bereaved children. Information was requested regarding the type of assistance received, satisfaction with assistance, preferred services and specifics about the help received. Fifty-five respondents (33.7%) indicated there were children under the age of 16 years in the household at the time of the death. Because of the small numbers of subjects, the numbers of responses in the different categories are small and any conclusions drawn from these results must be guarded. Also compliance with this part of the questionnaire was poor with inconsistent numbers of respondents answering the questions within the section.

Specific services for children

Of the 55 respondents who had children at home after the suicide, eleven (20%) specified that the children had received special assistance or support from children's services after the death (Table 24), whereas 41 had not. The types of help received are shown in Table 24 below. Counselling and information were the only types of help received. No-one indicated that children received help from a hospital, nurse, psychiatrist, crisis team, police, funeral parlour, telephone counselling or legal advice. Schools were not a group separately investigated by this study and are therefore notably absent as a service.

Children's participation in adult programs

Of 21 who responded to whether children had received help from adult services only 2 indicated that children participated in adult programs. One of these participated up to 3 times and the other on more than 10 occasions.

Length of contact with children's services

Sixteen participants indicated the length of time for which services had been received by children. The most frequent response was 12 months (mode=12 months; range 1 month-5 years).

Satisfaction with services for children

Ratings of satisfaction with the help received for children indicated a third were not satisfied, a third were satisfied to some degree and a further third to a significant or great degree (Table 24).

Services desired

Only 18 respondents replied to the question asking about services they would have liked for their children. Support groups, child health services and psychology were the type of assistance most desired but not received for children.

Table 24: Children's services

Variable	Level	F	Per Cent*	Variable (Subjects	Level	F	Per Cent*
Help received N=55				**Satisfaction with help N=18)**			
n=52	Yes	11	21.2		Great degree	3	20.0
	No	41	78.8		Significant degree	2	13.0
					Some degree	5	33.3
					Not at all	5	33.3
Help received (multiple responses) N=11				**Help desired (multiple responses) N=55**			
n=11	Child Health service	5	3.0	**n=18**	Support group	8	4.8
	Other Counsellor	5	3.0		Psychologist	7	4.2
	Psychologist	3	1.8		Child health	7	4.2
	Mental Health	2	1.2		Child welfare	4	2.4
	Support Group	2	1.2		Crisis team	3	1.8
	Religious	1	0.6		Mental health	3	1.8
	GP	1	0.6		School assistance	2	1.2
	Child Welfare	1	.6		GP	2	
					Psychiatrist	2	
					Religious support	1	
					Hospital	1	
					Anyone	1	0.6

Community Support

This section of the questionnaire refers to support participants received from community groups and individuals.

Grief support groups

Sixty-eight (n=68; 41%) participants indicated they attended a grief support group. For the majority, the group was run by volunteers with others being government or non-government (for example, Church) supported (Table 25). Perceived benefit was generally positive and only two respondents (2.9%) found no benefit from the support groups.

Table 25: Support Groups

Variable	Level	F	Per Cent*	Variable	Level	F	Per Cent*
Grief support group run by (n=68) Multiple responses				**Organisations conducting support groups (n=53**			
	Volunteers	54	79.4		BTSSG*	35	66.0
	Government	7	10.3		SFSBG*	8	15.1
	NGO	7	10.3		Funeral Parlour	4	7.5
Benefit from Support Group (n=70)					Church	2	3.8
	Great degree	20	28.6		Family wellbeing	1	1.9
	Significant degree	18	25.7		Compassionate friends	1	1.9
	Some degree	16	22.9		Rainbow	1	1.9
	Small degree	14	20.0		Carelink	1	1.9
	Not at all	2	2.9	*** BTSSG = Bereaved Through Suicide Support Group. *SFSBG = Southern Fleurieu Suicide Bereavement Group**			

Non-professional assistance

Help was received from non-professional persons by 94.9% of participants (N=150). Friends (n=135) and families (n=134) were the non-professional groups most highly nominated as being sources of help. These were followed by colleagues (n=78), neighbours (n=59), religious institutions (n=35), clubs, teams and social groups (n=28) and schools and educational facilities (n=25). The types of support received were of an emotional, social, practical and financial nature, and frequently involved a complex combination of all (Table 26).

Table 26: Types of community help received

Variable (Subjects N=)	Level	F	Per Cent*	Variable (Subjects N=)	Level	F	Per Cent*
Help from family (n=134)				**Help from friends (n=135)**			
	Emotional support	59	44.0		Emotional support	41	30.4
	Emotional/social	11	8.2		Emotional/social	27	20.0
	Emotional/social/practical	27	20.1		Emotional/social/practical	40	29.6
	Emotional/social/practical/financial	13	9.7		Emotional/social/practical/financial	10	7.4
	Emotional/social/financial	2	1.5		Emotional/social/financial	1	0.7
	Emotional/practical/financial	4	3.0		Emotional/practical	6	4.4
	Social/practical	1	0.7		Social/practical	2	1.5
	Emotional/financial	3	2.2		Emotional/financial	1	0.7
	Emotional/practical	12	9.0		Social contact	7	5.2
	Practical/financial	1	0.7	**Religious help (n=35)**			
Help from neighbours (n=59)					Emotional support	12	34.3
	Emotional support	15	25.4		Emotional/social	2	5.7
	Emotional/social	10	16.9		Emotional/social/practical	8	22.9
	Emotional/social/practical	15	25.4		Emotional/practical	2	5.7
	Social/practical	2	3.4		Financial help	1	2.9
	Practical/financial	1	1.7		Emotional/social/practical/financial	1	2.9
	Emotional/practical	4	6.8		Emotional/financial	2	5.7
	Social/practical	2	3.4		Social contact	4	11.4
	Social contact	8	13.6		Practical help	3	8.6
	Practical help	4	6.8	**Help from school/education facility (n=25)**			
Help from colleagues (n=78)					Emotional support	12	48.0
	Emotional Support	32	41.0		Emotional/social	3	12
	Emotional/social	23	29.5		Emotional/social/practical	2	8.0
	Emotional/social/practical	14	17.9		Emotional/practical/financial	1	0.6
	Emotional/social/practical/financial	1	1.3		Emotional/practical	3	12.0
	Practical help	2	2.6		Emotional/social/financial	1	4.0
	Emotional/practical/social	14	17.9		Social contact	3	12.0
	Social contact	4	5.1	**Other help received (n=5)**			
	Emotional/practical	2	2.6		Mood Disorder Association	1	16.7
Help from club/team/social group (n=28)					Compassionate Friends	2	33.3
	Emotional Support	7	25.0		Yungiass Therapist	1	16.7
	Emotional/social	7	25.0		Funeral Director	1	16.7
	Emotional/social/practical	5	17.9				
	Social/financial	1	3.6				
	Social contact	8	28.6				

Satisfaction with non-professional assistance

Satisfaction with the help received was felt by the large majority of participants (99.3%) and half the participants (52.9%; n=73), reported they had not wished for support from any other non-professional personnel. However, 46.4% of participants indicated they would have liked to have received assistance from a variety of non-professional people, including family (16.6%), religious personnel (10.9%), friends (6.5%), educational institutions (3.6%) and

neighbours (3%). One respondent said they would have liked help from a family who had experienced suicide (1%). This was not given as an option on the listing and therefore may carry greater weighting.

Further information about the need for help by someone who has been through a similar experience ("been-there" other) is given in the chapter: RESULTS: QUALITATIVE DATA BEREAVED QUESTIONNAIRE (p.106).

Table 27: Satisfaction with community help

Satisfaction with community help (N=150		
	F	**%**
Great degree	60	40.0
Significant degree	49	32.7
Some degree	33	22.0
Small degree	7	4.7
Not at all	1	0.7

Activities and experiences following the death

Helpful activities

Participants provided information on those activities which they had found helpful to engage in after the death. Physical activity (83.3%; n=125;) was the most highly nominated activity, followed by workplace activity (76.4%; n=107), hobbies (73.1%; n=106) and lastly by religious activities (42.4%; n=59) (Table 28).

Personal experiences

Participants were asked about their experiences with others since the death. Eighty five percent (n=136) reported they perceived that others had felt sorry for them and 36.5% (n=57) felt that others had looked down on them. More participants felt that family members had become closer to each other (n=108; 67.9%) compared to 66 (41.5%) who felt they had become more distant. However, distancing from others was certainly a feature of bereavement with 106 (66.2%) participants feeling that others had distanced themselves from them and 93 (58.4%) feeling that they had kept away from people.

Table 28: Activities and experiences since the death

Activities (Subjects N=)	Level	F	Per Cent*	Personal experiences (Subjects N=)	Level	F	Per Cent*
Religious activities helpful (n=139)				**Others feel sorry for me n=160)**			
	Large degree	25	18.0		Large degree	45	28.1
	Some degree	34	24.5		Some degree	91	56.9
	No	80	57.6		No	24	15.0
Physical activities helpful (n=150)				**Others look down at me (n=156)**			
	Large degree	47	31.3		Large degree	9	5.8
	Some degree	78	52.0		Some degree	48	30.8
	No	25	16.7		No	99	63.5
Hobbies helpful (n=145)				**Others distance themselves from me (n=160)**			
	Large degree	29	20.0		Large degree	22	13.8
	Some degree	77	53.1		Some degree	84	52.5
	No	39	26.9		No	54	33.8
Workplace/educational activities helpful (n=140)				**I have kept away from people(n=159)**			
	Large degree	49	35.0		Large degree	24	15.1
	Some degree	58	41.4		Some degree	69	43.4
	No	33	23.6		No	66	41.5
I have come closer to people (n=156)				**Family members have become more distant from each other (n=155)**			
	Large degree	26	16.7		Large degree	25	16.1
	Some degree	77	49.4		Some degree	41	26.5
	No	53	34.0		No	89	57.4
				Family members-have become closer to each other(n=159)			
					Large degree	42	26.4
					Some degree	66	41.5
					No	51	32.1

Support from a confidant

Three quarters of respondents reported having someone who really understood their situation and in whom they could confide (73.5%; n=119). Of these, 80% had a significant or great degree of satisfaction with the support received from them. However over a quarter of respondents did not have a confidant.

Table 29: Support received from confidant

Variable (Subjects N=)	Level	F	Per Cent*	Variable (Subjects N=)	Level	F	Per Cent*
Have a confidant (n=162)				**Degree of support (n=124)**			
	Yes	119	73.5		Great degree	65	52.4
	No	43	26.5		Significant degree	37	29.8
					Some degree	15	12.1
					Small degree	4	3.2
					Not at all	3	2.4

Change in opinion of importance in life

Eighty percent of respondents had experienced a great or significant degree of change in what was important in life, as a result of their bereavement. Only 3% reported they had not experienced any change in their priorities. No association was found between time since death and change in priorities.

Table 30: Perceptions of change of what is important in life

Change opinion (N=161)	Level	F	Per Cent*
	Great degree	92	57.1
	Significant degree	36	22.4
	Some degree	23	14.3
	Small degree	5	3.1
	Not at all	5	3.1
	Missing	5	3.0

Some comments indicate that the suicide was a life-changing experience. Most of these indicted some heightened awareness of self and life as typified below:

"…*The wellbeing and happiness of my family and other people is as important to me now as it was before my son's death, however, now I think that for me true happiness has flown out the window. It is more about learning to live in a different way. Each day I try to prioritise what is important and what needs attention. It is not that I feel I am alone in my sorrow. I think I have developed an even more acute sense of for human suffering. I am affected daily with the awareness of the more subtle and quite damaging injustices that are present in our community and our world at large. I am much less tolerant of the general apathy, the lack of fair attention and some people's attitude and behaviour towards important issues, particularly those in responsible positions that affect people's lives. But at times I am not surprised because for many it is often too overwhelming to think deeper and attempt to bring about some change*".

"*Nothing really seems important any more except keeping the rest of us alive so we don't see it again*".

"*Accept your loved ones as they are, love them as though there may be no tomorrow because as we found out in a sad way there wasn't.*"

"*Everything I do now is underpinned by my belief that I must make the rest of my life mean something, to make some meaning out of Mark's death. The death of my son has probably emphasised more of what is NOT important in life, actually. …There is a*

greater sense of the spiritual, of something beyond this life filled with compassion and joy, a Higher Power, whatever that may mean to each person. Whereas I used to wonder about such things, now have absolutely no doubt at all. I don't need religion to interpret this for me, to clog it up with dogma and superstition and judgement: it just is, and I have no need to justify myself. I feel liberated."

However, some comments indicated a sense of hopelessness and helplessness.

"*My heart is broken forever; I'm not the same person. I used to be happy and carefree; I've spent 2 years on anti-depressants with no sign of feeling that much better.*"

Discussion

Any conclusions from this research should be taken in context due to the nature of the sample and also of the retrospective nature of the research. The sample is a self-selected sample and the respondents may have had particular personal agendas in wishing to participate in this study, which is not uncommon in research. The valid return rate of 47% indicated yet another layer of selection of the sample. The research journal indicated several telephone calls from bereaved people wishing to participate but finding the questionnaire too labour-some or emotionally traumatic for their current state of mind. Written comments in some completed questionnaires also indicated the difficulty for participants and one specified that the respondent was having someone help with answering the questions. However there were many other comments including that participating in the study had been helpful to their healing and provided something constructive from the death of their loved one as well as endeavouring to help others who became bereaved through suicide.

The demographics indicate that there are several features of this sample that may not be representative of the general population bereaved through suicide. That most participants were female is consistent with trends in self-selection of samples in bereavement research and with the gender differences in suicide. The high percentage of respondents who had completed University or higher education is consistent with the methods used in the selection of the sample, i.e. newspaper, internet and profile of the radio stations hosting the programs. The fact that 40% were health care cardholders despite the majority living in high socio-economic areas is interesting. The question arises as to whether a suicide changes the financial status of families and if so, to what extent. More research is necessary to clarify the reasons. It may indicate that this is a disadvantaged group and financial considerations are

important for servicing those bereaved through suicide. Two thirds had no more children at home after the death – a risk factor for severe psychological reactions - and a third were not working outside the home –also a risk factor (Dyregrov 2003). High proportions of the subjects also have other better known risk factors, such as being bereaved parents and having deceased of a young age. Some sub-groups are not sufficiently sampled, such as people from non-English speaking backgrounds, migrant populations, young people, the elderly and second degree relatives and non relatives. No attempt was made to find the opinions of rural and remote residents (although this sample contains a few) and the views of children themselves. Further, more research needs to be done to find the specific needs of males, gays and lesbians and other special groups.

The retrospective nature of the research is an important consideration, especially as the mean length of time since the death was 5 years. Another factor that may affect the accuracy of recall is the high level of distress experienced over the period of time that is the subject of this study. One further consideration that needs to be borne in mind is the mental state of participants at the time of completing the questionnaire. From the written comments and phone calls recorded in the research journal, many were clearly in a distressed state, either because of the extant severity of their grief, or because of the distress caused by revisiting their grief experiences. This may account for the anomalies in the quantitative results.

The results are consistent with those of other studies examined within their contexts (Andiessen, Delhaise & Forceville 2001, Dyregrov 2003; Provini Everet & Pfeffer 2000). For example 85% of persons bereaved through suicide received some sort of help from services in the socialist hierarchically structured health and welfare system of Norway. In contrast with that only 24 % received help in the US, a country in which access to health services is determined by the individual's financial means. In South Australia, the finding that 44% received help is consistent with a health system that falls between these two extremes. Other features in common with other studies are that help is required for up to 1-2 years or more following the death, and that it should be offered immediately and regularly afterwards. The desirability of home visits, support groups and children's services are also similar. The lack of satisfaction with help is also a common feature as also noted in another Australian study (Clark 2001).

In contrast to the British study (Harwood, Hawton, Hope & Jacoby 2002), discontent with the Coronial system was not a major feature of our study, presumably because an inquest is not a usual procedure after suicide in South Australia.

This study has identified new areas of inquiry, such as possible change of financial status after a suicide in the family, possible similarities of perceptions of need whatever the age of deceased, the nature and role of a confidant and details of specific needs for certain sub-groups.

Summary

Conclusion from this study must be taken in context because of the nature of the sample, the retrospective nature of the study and the traumatising affect on the respondents of completing the questionnaire.

There is a large amount of unmet need in terms of service provision; less than half of those who needed help received it. The degree of need is greatest for first-degree relatives but does not vary according to the age of the deceased. Receiving help was related to needing help and to being present at the site of the suicide.

There is a deficiency in bereaved people obtaining information about services. Half of all participants received information and 90% of those who did not would have liked information. The most frequent sources were those services involved in the immediate aftermath of the death, such as the Coroner's Office, funeral parlours and the police, as well as family, friends and the general practitioner.

Most frequently, contact was made with services by the bereaved themselves rather than through others or by outreach the services. Contact was usually established early after the death: for 2/3 contact was made within a month and 85% by 3 months. The most widely held view was that follow up should be made in person by a specifically designated service or the GP.

A complex range of different forms of help including counselling, medical assistance, information, and financial and practical help, was received from a wide variety of

professionals.   Counselling and general practitioner services were the most frequently received.

There was also a large unmet need for home visiting. Only a third had received a home visit from any service and most of those who had not, would have like home visiting. Support groups and counsellors were the services most desired to visit.

Contact with services was frequent in the first few weeks following the death, diminished over time, particularly by 2 years after the death, and continued for up to 4 years. The desired duration of help demonstrates a similar time frame, in that help was required for at least 12 months to 24 months and that there was a sharp fall off after that.

Home visits were received by a third of respondents. The majority of those who had not had home visiting wished that they had received this service. General practitioners and religious institutions were the providers who most frequently made home visits. Support groups and counsellors were the providers of which home visits were most desired.

Sixty percent of respondents had some or much dissatisfaction with the services they received. One third found that the services themselves were not helpful. This is important considering that bad help has been found to be harmful (Kneiper 1999). A major issue seemed to be the lack of training and appropriate attitudes of the providers themselves. Another issue was the lack of appropriate services provided by a variety of agencies, including immediate follow-up after the death. The most frequently experienced barriers to receiving help were lack of information about available services, help not being offered, believing that no-one could help, distance, cost and depression.

A third of respondents had children under the age of 16 at home at the time of the suicide. Only a quarter of these received any help from services - 20% from children's services and a further 4% from adult services. Contact most often lasted for 12 months and the services most frequently used were child health services and children's counsellors. Satisfaction was mixed. Unmet need was a need for a children's support group and for child psychology and child health services.

Forty percent had attended a bereavement support group. Satisfaction with support groups was generally high, although some found the group experience overwhelming and not helpful and others found that the group did not have the specific counselling or telephone facilities they needed. Volunteers ran most groups. Community support was important for providing emotional, social, practical and financial help. Family and friends were rated the most frequent sources of help followed by colleagues, which demonstrates the relevance for many of returning to work after the death. Other community sources of help were neighbours, religious institutions and social groups. Satisfaction with help from these sources was generally high, although some indicated that they missed out on help from family, religious institutions and friends.

Experiences since the death found several common themes. Physical activities, work and hobbies were found to be helpful for the majority of respondents following the death and religious activities were found helpful by just under half the participants. The death appears to have changed the dynamics within the family: about a third found the family had become closer since the death and one third found relationships had become more distant. Distancing from others was a feature for the majority of participants – a risk factor for severe psychological reactions (Dyregrov 2003). Three quarters of respondents had at least one person who understood their situation and in whom they had been able to confide. However one quarter had had no confidant. It would have been useful to know who this confidant had been for respondents for the purpose of improving support of bereaved people in the future. Specific professional disciplines and non-professional support may be identified from future research and specific materials prepared to assist them. The suicide had been a life-changing experience for most participants with some respondents finding a heightened awareness of self and of life but others feeling helpless and hopeless.

Conclusions

The sample studied may not be wholly representative of the total population of persons bereaved through suicide in South Australia but is sufficiently large and varied to lead to valuable learnings. Moreover, these conclusions are consistent with the few existing studies done overseas, taken within their sociological contexts.

Although the suicide-bereaved already access help to a certain degree, the study identifies a large amount of unfilled need, in adults as well as for children. This applies to close family,

second degree relatives and non-relatives. This need is for information and services immediately after the death and for up to 2 years or more following the death. Specific needs are for more services, more appropriate attitudes and education for service providers that identify the complexity of service provision required. The main specific services needed are crisis services, service directories (the study was undertaken since the distribution of a national Information and Support Pack (Clark, Hillman & Ministerial Council for Suicide Prevention 2001) in South Australia), immediate follow up after the death, continuity of care, home visits, counselling support groups and the help from others who have been bereaved through suicide. One of the most important barriers to help, apart from lack of information, distance and cost, is depression, which is consistent with the "inertia" identified in Dyregrov's (2003) study, and which highlights the need for pro-active follow-up by services immediately after the suicide. Depression was a self-nominated barrier, which perhaps speaks for how much depression is seen as interfering with getting help. Derogatory community attitudes and social withdrawal are experiences frequently encountered. Finally, high proportions of bereaved with risk factors for poor outcome, helpful activities after the death and new areas of inquiry have all been identified by this study.

Results: Questionnaire to Agencies

This section reports on the responses given by the 71 agencies that returned valid questionnaires. This represents 41.8% of the 170 agencies to which a questionnaire was sent.

Profile of clientele bereaved through suicide

Agencies were asked how many people bereaved through suicide the agency had seen in each of the previous two years. Numbers for each year asked were very similar as can be seen in the table below. The response rate to this question was very low. Only around 12% agencies were able to provide a figure. About a third of those who answered this question indicated they did not know and, as this was a self-nominated response, the actual number who did not know may have been higher, and may have explained the high non-response rate to this question.

It is interesting that two or three agencies recorded assisting high numbers of bereaved (≥20). This included one suicide specific grief related service (support group) and two general counselling services (Table 31).

Table 31: Number of bereaved persons seen by organisations

Year		Number of bereaved seen (Subjects N=71)						
		1-10	11-20	21-30	31-40	41-50	Unknown	No response
2002	**F**	9	0	1	0	1	6	54
n=17	**%N**	12.7	0.0	1.4	0.0	1.4	8.4	76.1
2003	**F**	8	3	1	1	0	5	53
n=18	**%N**	11.3	4.2	1.4	1.4	0.0	7.1	74.6

Service Provision

Types of services

This section reports on the types of services the organisations offered to bereaved persons after the suicide of someone they knew. Agencies were asked to indicate services they provided under the two headings of general grief services and suicide-specific services. The range of areas is listed in Table 32 in descending order of frequency and are categorised as general grief only, suicide-specific only or both.

All 71 agencies that returned valid questionnaires indicated they provided general grief services. Twenty (28.2%; N=71)) agencies provided any sort of suicide specific service other than referral. Of these, only two (2.8%; N=71) provided solely specific suicide grief services. These were a volunteer led support group and the Coroner's Office.

The frequencies of general grief services obtained by summing the "general grief only" and "both" columns, indicate the most frequent service provided was referral to other organisations (F=54; 76.1% of the total sample), followed by counselling (F=41; 57.8.6%), provision of printed information (F=30; 42.3%), telephone counselling (F=25; 35.2%), home visiting (F=18; 25.4%), services for bereaved children (F=14; 19.7%), financial advice (F=14;19.7%) and medical help (F=13; 18.3%). Religious support, bereavement education, library, drop in centre, support groups and legal services are offered by few of the respondent agencies.

The frequencies of suicide-specific grief services obtained by summing the "specific suicide" and "both" columns, show that the commonest service provided is also referral (F=22; 31.0%) agencies, followed by the provision of printed information (F=19; 26.8%) and counselling (F=18; 25.4%). Other services have few providers: telephone counselling (F=9; 12.7%), services for bereaved children (F=7; 9.9%), home visiting (F=6; 8.5%), bereavement education (F=5; 7.0%), library (F=4; 5.6%), support groups (F=2; 2.8%) and religious support (F=2; 2.8%). There were no suicide-specific services in the areas of financial and legal advice – areas where there exist suicide-specific issues.

Of the 22 agencies that indicated they provided referral, eight offered solely referral for any grief-related issue and the remaining 14 offered referral as part of their service provision in conjunction with their continued care for the client. Five agencies indicated in their written responses that referral was the only service they provided. Explanatory comments provided by six agencies indicated that the function of their organisation was other than supporting people bereaved through suicide (i.e, providing emergency relief, cancer support, carer support and cemetery) but said that should one of their clients be bereaved through suicide, they would refer that client on. Some agencies clearly did not see assisting the bereaved through suicide relevant to them: "*We would search on a person's behalf for services in their area. If needed we would make the initial contact on their behalf. Following questions not*

answered as not part of our role" and "*We are unable to assist as we do not generally deal with families in the area of grief counselling…*"

Other agencies perceived that they could provide a generic form of support for those bereaved through suicide, for example, victim contact officers stated they provided "general support only", another agency offered "emergency relief" and another commented "*Our services are general grief services and not aimed specifically towards suicide related bereavement*".

Several of the text comments indicated suicide-specific counselling was provided as part of the wider context of counselling such as mental health, funeral, aboriginal and Coronial services. For example, "*Usually it is because the person who suicided was a consumer of the service. We therefore offer debriefing, support, listening to a family etc*". Suicide-specific information distributed by some agencies included listings of support services and groups, brochures and suicide bereavement literature. Two suicide-specific support groups were identified.

Table 32: Types of services offered

Variable (Respondents N=71) (multiple responses)		General grief services only	Specific suicide grief services only	Both type of services	Neither service
Referral n=57	F	35	3	19	14
	%	49.3	4.2	26.8	19.7
Counselling n=43	F	25	2	16	28
	%	35.2	2.8	22.5	39.4
Printed information n=32	F	13	2	17	39
	%	18.3	2.8	23.9	54.9
Telephone counselling n=27	F	18	2	7	44
	%	25.4	2.8	9.9	62.0
Home visiting n=18	F	12	0	6	53
	%	16.9	0.0	8.5	74.6
Services for bereaved children n=14	F	7	0	7	57
	%	9.9	0.0	9.9	80.3
Financial advice n=14	F	14	0	0	57
	%	19.7	0.0	0.0	80.3
Medical help n=13	F	11	0	2	58
	%	15.5	0.0	2.8	81.7
Religious support n=9	F	7	0	2	62
	%	9.9	0.0	2.8	87.3
Bereavement education n=8	F	3	1	4	63
	%	4.2	1.4	5.6	88.7
Library n=6	F	2	1	3	65
	%	2.8	1.4	4.2	91.5
Support group – professional n=3	F	3	0	1	67
	%	4.2	0.0	1.4	94.4
Support group non professional n=3	F	2	1	0	68
	%	2.8	1.4	0.0	95.8
Drop in centre n=3	F	2	0	1	68
	%	2.8	0.0	1.4	95.8
Legal advice n=1	F	1	0	0	70
	%	1.4	0.0	0.0	98.6

Hours of service provision

Of the 62 (87.3%) agencies that responded to this question, 27 (43.6%) reported they offered some type of out-of-hours service. Written comments by a funeral service and public services such as the police, hospital accident and emergency departments, and some mental health services indicated they provided out of hours support for those bereaved through suicide as part of their normal services.

Only 11 (15.4%) agencies provided any out of hours services specific to suicide bereavement including three that provided solely suicide specific out of hours services. These were a non-professional led support group, a mental health service and the Coroner's Office

Table 33: After hours service provision

Services after-hours N=71; n=62		General Grief Services only	Specific Suicide Grief Services only	Both type of services	Neither service offered
None n=35	F	30	0	5	36
	%	42.3	0.0	7.0	50.7
Outside 9am-5pm n=25	F	15	2	8	46
	%	21.1	2.8	11.3	64.8
Weekends n=22	F	13	3	6	49
	%	18.3	4.2	8.5	69.0
Public Holidays n=20	F	11	3	6	51
	%	15.5	4.2	8.5	71.8

Charges for services

Of the 43 (60.6%) agencies who responded to the question about charges for services, only 6 (14%) indicted that they did so with two (2.8%) others indicating they did for some services (Table 34). Written comments indicated the charges were for such services as funerals, Medicare 'gaps', or were means-tested.

Table 34: Charges for services

Costs for services	Category classification of organisation				
	Suicide specific	Generic grief	Target population	General counselling	Total
No	1	3	0	31	35
Yes-all	0	2	1	3	6
Yes-some	0	2	0	0	2
Total	1	7	1	34	43

Contact with agencies

Of the 41 agencies who responded to how contact was made with them by bereaved clients, most (n=34; 82.9%; 47.9% of total sample N=71), indicated they are contacted by the bereaved themselves, rather than by others making contact on behalf of the bereaved (n=15; 35.5%; 21.1% of total sample) or the agencies themselves contacting the bereaved (n=11; 26.8; 15.5% of total sample).

Less than half the returns responded with further details of these services. Most contact appears to be initiated soon after the suicide (Table 35), mainly within the first week. Text comments varied in their reasons for the timing of the contact. Early contact came from

referral by funeral services and crisis intervention services. Reasons for delayed contact included the length of waiting lists, bereaved clients not knowing about the services and delay in the emergence of grief symptoms precipitating the need for help.

Contact by agencies was reported to most commonly last for as long as required by the client. As this was a self-nominated item there may be other agencies that also continue care for as long as necessary but which did not think to indicate this. Of those agencies that stated a specific time for follow-up, most indicated they did so for only 6 months, with a small percent continuing for longer. Written comments indicated that the length of contact depended on the aims and policies of the agency, for example "*The service is referral only (police)*".

Table 35: Contact with services

Variable (Respondents N=71)	Level	F	Per Cent*	Variable (Respondents n=71)	Level	F	Per Cent*
How long after suicide contact is made (n=36)				**How long intervention lasts (n=33)**			
	Within 1 day	6	8.5		At least 1 month	5	7.0
	Within 1 week	13	18.3		At least 3 month	3	4.2
	Within 1 month	7	9.9		At least 6 month	10	14.1
	Within 1-3 months	2	2.8		At least 12 month	2	2.8
	Within 3-6 months	2	2.8		At least 2 years	1	1.4
	Within 6-12 months	1	1.4		At least 5 years	0	0.0
	Within 12-24 months	1	1.4		As required*	12	16.9
	Depends on circumstances	4	5.6				

* self-nominated item

Shared Care

Participant organisations were surveyed for the type of services they might provide on a shared care basis with other agencies. Of the 40 (56.3%) agencies that responded to this question, 28 (70.0%; 39.4% of the total sample, N=71) agencies indicated they did not provide shared care services. Of the 12 agencies (30.0%; 16.9% of total sample) which indicated they provided shared care, the most common activity was that of occasional phone calls or letters (n=8; 18.6%), followed by undertaking specific care activities (n=4; 9.3%) (Table 36). Two written comments indicated shared and coordinated care was undertaken either within the organisation itself or with external providers such a general practitioners, FAYS or DECS.

Table 36: Shared care services

Variable Respondents N=71; n=12	F	Per Cent*
Occasional phone calls/letters (n=8)	8	11.3
Undertake specific care activities (n=4)	4	5.6
Shared management tasks (n=2)	2	2.8
One set of notes shared (n=1)	1	1.4
Shared patient held notes (n=1)	1	1.4

Professional groups providing care

Information about which professional groups within an agency provided care for those bereaved through suicide, indicated the most frequent groups were social workers, followed by counsellors, non-psychiatric nurses, psychologists, doctors and psychiatrists (Table 37). Fewer agencies had services provided by psychiatric nurses, religious counsellors, volunteers, crisis teams and police. Most services were for general grief support compared to suicide-specific grief support. Similar orders of frequency were found for both general grief support and suicide-specific support.

The frequencies of the professional groups within agencies that provided general grief services were determined by summing the "general grief" and the "both" data. This indicated a similar order of frequency: social workers (41), counsellors (36), non-psychiatric nurses (26), psychologists (25), doctors (17) and psychiatrists (12). The frequencies of the professional groups within agencies that provided suicide-specific grief services were determined by summing the "suicide-specific grief" and the "both" data. This showed the most frequent to be counsellors (16), followed by social workers and psychologists (each 14), non-psychiatric nurses (9) and psychiatrists and psychiatric nurses (5each).

A range of other professional providers of care was self-nominated by 14 agencies (Table 38) of which the community aboriginal or NESB worker was most prominent.

Table 37: Professional groups providing care

Professional group (multiple responses) Respondents N=71		General Grief Services only	Suicide Specific Grief Services only	Both type of services	Neither service
Social Worker	F	28	1	13	29
n=42	%	39.4	1.4	18.3	40.8
Counsellor n=36	F	20	0	16	35
	%	28.2	0.0	22.5	49.3
Non-psychiatric	F	17	0	9	45
nurse n=26	%	23.9	0.0	12.7	63.4
Psychologist n=26	F	12	1	13	45
	%	16.9	1.4	18.3	63.4
Doctor n=17	F	14	0	3	54
	%	19.7	0.0	4.2	76.1
Psychiatrist n=16	F	11	1	4	55
	%	15.5	1.4	5.6	77.5
Psychiatric	F	8	1	4	33
Nurses n=13	%	11.3	1.4	5.6	46.5
Religious	F	7	0	3	61
Counsellor n=10	%	9.9	0.0	4.2	85.9
Volunteer n=8	F	6	0	2	63
	%	8.5	0.0	2.8	88.7
Crisis Team=5	F	4	0	1	66
	%	5.6	0.0	1.4	93.0
Police n=4	F	2	0	2	67
	%	2.8	0.0	2.8	94.4
Don't know=1	F	0	0	1	70
	%	0.0	0.0	1.4	98.6

Table 38: Other professional providers of care

Other care provider Respondents n=14	F
Community aboriginal/NESB workers	8
Coronial services officers	1
Teacher/school support officer	1
Welfare worker	1
Information officers	1
Funeral consultant	1
Occupational therapist	1

Co-ordination of care

A third of respondents (n=24; 33.8%), provided information about which professional groups co-ordinate the care for people bereaved through suicide (Table 39). It is evident that social workers, counsellors, psychologists and nurses are often the professional groups who co-ordinate care.

Table 39: Professional groups providing co-ordination

Professional group (multiple responses) Respondents N=71; n=24	F	Per Cent*
Social worker	14	58.3
Counsellor	14	58.3
Psychologist	11	45.8
Non-psychiatric nurse	9	37.5
Psychiatric nurse	4	16.7
Psychiatrist	3	12.5
Religious counsellor	2	8.3
Volunteer	2	8.3
Police	2	8.3
Doctor	1	4.2
Crisis team	1	4.2
Don't know	1	4.2

Services provision for bereaved children

A separate section of the questionnaire asked for information on services provided for bereaved children. Of the sample population of 71 agencies, 58 (81.7%) stated they provided care for bereaved children or young people less than 16 years of age.

The most common generic grief services provided by the agencies included counselling (F=21; 36.2%), referral (F=17; 29.3% and telephone counselling (F=13; 22.4%). Only a few agencies provided other services such as home visiting, bereavement education, school assistance and support groups (Table 40).

Suicide-specific grief services were fewer than generic grief services but in a similar order of frequency to generic grief services. The most frequent services were counselling (F=7; 12.1%), referral telephone, counselling and home visiting (all F=5; 8.6%).

Written comments gave more information on the nature of these services: weekend camps, pocket books for grieving children and adolescents, grief and loss groups, and individual and family therapy.

Table 40: Grief service provision for bereaved children

Variable Multiple responses Respondents N=58		General Grief Services only	Specific Suicide Grief Services only	Both type of services	Neither service
Counselling n=21	F	14	0	7	50
	%	24.1	0.0	12.1	70.4
Referral n=17	F	12	0	5	41
	%	20.7	0.0	8.6	70.7
Telephone counselling n=14	F	9	1	4	44
	%	15.5	1.7	6.9	75.9
Medical help n=5	F	5	0	0	53
	%	8.6	0.0	0.0	91.4
Home visiting n=10	F	5	0	5	48
	%	8.6	0.0	8.6	82.8
Bereavement education n=6	F	3	0	3	52
	%	5.1	0.0	5.2	89.7
School assistance n=2	F	2	0	0	56
	%	3.4	0.0	0.0	96.6
Support group professional n=2	F	1	0	1	56
	%	1.7	0.0	1.7	96.6
Support group non professional n=2	F	1	0	1	56
	%	1.7	0.0	1.7	96.6
Crisis Team n=1	F	1	0	0	57
	%	1.7	0.0	0.0	98.3
Religious support n=2	F	0	0	2	56
	%	0.0	0.0	3.4	96.6
Drop in centre n=1	F	0	0	1	57
	%	0.0	0.0	1.7	98.3

Of the 58 agencies that indicated they provided care for bereaved children, only 31 provided information about the professional groups who rendered the services. The professional groups most commonly providing services (

Table 41) are social workers (18; 31%), counsellors (15; 25.9%), psychologists (11; 19%), and psychiatrists (10; 17.2%).

Table 41: Professional groups providing service within agencies

Professional group N=58		General Grief Services only	Suicide-Specific Grief Services only	Both type of services	Neither service
Social Worker n=18	F	12	2	4	40
	%	20.7	3.4	6.9	69.0
Counsellor n=15	F	9	1	5	43
	%	15.5	1.7	8.6	74.1
Psychologist n=11	F	7	1	3	47
	%	12.1	1.7	5.2	81.0
Psychiatrist n=10	F	7	1	2	48
	%	12.1	1.7	3.4	82.8
Non-psychiatric Nurse n=8	F	8	0	0	50
	%	13.8	0.0	0.0	86.2
Doctor n=7	F	6	0	1	51
	%	10.3	0.0	1.7	87.9
Psychiatric Nurse n=6	F	3	1	2	52
	%	5.2	1.7	3.4	89.7
Volunteer n=6	F	4	1	1	52
	%	6.9	1.7	1.7	89.7
Religious Counsellor n=2	F	1	0	1	56
	%	1.7	0.0	1.7	96.6
Police n=2	F	0	0	2	56

%	0.0	0.0	3.4	96.6

Postvention strategies of agencies

Postvention management guidelines

Agencies were asked about written guidelines for the management of the aftermath of suicide. Of the 39 (54.9%) agencies that responded, only 11 (28.2%; 15.5% of the total sample N=71) of these, indicated that the organisation possessed guidelines. Further, only a third of those that did have written guidelines responded about compliance with those guidelines. Only 7 agencies (63.6%; 9.9% of the total sample indicated they complied with the guidelines to a great degree (Table 42).

The low numbers of responses make conclusions difficult. Considering only those 39 agencies that provided responses to this question, just under one third have written postvention guidelines of which about two thirds comply with these to a great degree. In other words, only 18.0% possess and comply a great deal with those guidelines. The reasons for the low response are unclear even from the written responses. However we can conclude that only 9.9% of all agencies had a respondent to the questionnaire that was confident that postvention guidelines were complied with to a great degree, although the actual percentage which does comply well may be higher than this.

Table 42: Practice guidelines

Postvention guidelines				Compliance with guidelines			
Respondents N=71 n=39	F	%n	%N	Respondents N=71 n=11	F	%n	%N
Yes	11	28.2	15.5	Great degree	7	63.6	9.9
No	28	71.8	39.4	Some degree	3	27.3	4.2
No response	32		45.1	Small degree	1	9.7	1.4
				No response	60		84.5

Postvention support for staff

Agencies were asked about the types of support they provided for staff should a client or colleague take their life (Table 43). Of the 53 (74.6%) and the 55 (77.5) respectively that responded, immediate debriefing and counselling appeared to be the most commonly available options in both situations and were carried out by high percentages of agencies.

There were few written comments to this question and varied from "*No staff member is directed to do anything. No formal policy. Staff would be monitored and concerns discussed*" to referral to external professional counselling services such as an Employee Assistance Program or an incident case review.

Table 43: Type of support for staff

Support after suicide of client (Multiple responses)				Support after suicide of colleague (Multiple responses)			
Respondents N=71, n=53	F	%n	%N	Respondents N=71, n=55	F	%n	%N*
Immediate debriefing	49	92.5	69.0	Counselling	48	87.3	67,6
Counselling	44	83.0	62.0	Immediate debriefing	46	83.6	64.8
Case review	36	67.9	50.7	Case review	7	12.7	9.9
None	1	1.9	1.4	None	3	5.5	4.2
Peer & Mentor*	5	9.4	7.0	Assistance program*	2	3.6	2.8

*Self nominated response

Postvention training for staff

Of the 48 agencies (67.6% total sample) that provided valid information about grief support training, 41 (83.7%; 57.8% of total sample N=71) indicated that they provided general grief training for their staff. A smaller percentage (65.0%; 36.6% of total sample N=71) provided specific suicide grief support training for staff (

Table 44).

Only a few agencies provided information about the numbers of hours of grief training they provided (

Table 44). Those agencies that provided more than 20 hours over the past 5 years included a funeral service, a bereavement education service and an agency for gay and lesbian people.

Written comments indicated there was a general lack of knowledge about grief training: "*Am aware that a number of service providers have attended staff development re grief – provided elsewhere. Not aware of any particular focus from within this agency*".   One comment misunderstood the area of training and described suicide prevention training. Two further comments indicated that in-house training was provided.

From the responses given we can only be sure that two thirds of agencies provide suicide postvention training, but considering the low response rate this may be much lower, and may be as low as one third of agencies.

Table 44: Grief training for service providers

N=71, n=48		Yes	No
General Grief training n=41	F	41	8
	%	83.7	16.3
Specific suicide Grief training n=39	F	26	13
	%	65.0	32.5

Table 45: Hours of grief training provided in past 5 years

N=71		Hours					
		1-10	11-20	21-30	31-40	41-50	>50
General grief training n=23	F	12	4	1	1	1	4
	%	54.5	18.3	4.5	4.5	4.5	13.7
Specific suicide grief training n=13	F	8	2	2	1	0	0
	%	61.5	15.4	15.4	7.7	0.0	0.0

Difficulties encountered

Current difficulties in caring for people bereaved through suicide fell into three main categories; issues relating to service provision by the agency, issues for the provider within the agency and community attitudes.

Some of the problems for the agency concerned a perceived lack of appropriate services and resources and a lack of knowledge of existing services and relevant referral networks. Other problems concerned the workplace culture, for example that grief was "*not a part of organisations core business*" (#13) and there was a need to have "*a workplace culture that accepts grief*". A further example:

> "*Current services focussed on suicide prevention/crisis management. Grief and loss issues may not get a high priority in relation to service delivery*". (#53)

> "*only occasional occurrence – we rely on general mental health skills to deal – probably not adequate". (#42)*

Practical difficulties in providing an appropriate service included lack of protocols, waiting lists, time constraints, costs time limited contact policy with clients and fear of litigation.

Specific needs of the bereaved that the agencies perceived were not currently being met included a lack of immediate support at the site of the suicide by a trained trauma counsellor, lack of a clean-up service at the site and lack of follow-up and continuity of care.

Difficulties for the service providers in the agency were perceived to be a lack of expertise and training in suicide postvention:

> *"Need specific knowledge/skills related to bereavement through suicide – have not been aware of specific training/workshops available". (#23)*

> *"Most of the staff don't know how to deal with the problem and tend to' shy' away from it" (#60).*

A further issue of the provider was the personal trauma of working in such a difficult area in which the client required support with stigma, guilt, anger, shame and blame, and the consequent feelings of helplessness of the provider him or herself.

A lack of appreciation by the community of the length and nature of suicide grief as well as stigma were seen as difficulties. Further family separation, either geographical or because of relationship breakdown were also named as difficulties.

Service improvement

Future service provision plans

Organisations were asked if they had any plans to change the care offered for those bereaved through suicide. Sixty-one (85.9%) responded. Of those, 10 (16.4%) responded in the affirmative indicating a very small interest in improving services for people bereaved through suicide.

Many of the text comments indicated that the agency had no plans to improve services for those bereaved through suicide because suicide grief was not the core business of the agency and that they would refer on. Constructive plans of agencies ranged from a funding application for grief counsellors, a special interest group, and pocket books for children, to increasing the time available for counselling the bereaved.

Table 46: Plan to improve suicide postvention services

Plans to change the care offered for those bereaved through suicide N=71, n=61	F	%n	%N
Yes	10	16.4	14.1
No	51	83.6	71.8
No response	10		14.1

Suggestions for improving the care of people bereaved through suicide

Suggestions for improving care fell into five categories – suggestions relating to optimal care for the bereaved, improvements to services, improvements to service provision within agencies, community issues and research.

There were various suggestions relating to optimal care for the bereaved including help at the site of the suicide:

> *"…It would be great if a trauma counsellor or grief worker could attend the scene of the incident and assist the police with the victims and families. Also some volunteer to help clean up the mess at a family home where a person has committed suicide and the body fluids etc left by the deceased cause great distress and police officers are often left to clean up the scene to avoid further trauma to the family"*. (#2)

Leaving information as immediate follow up was not considered sufficient but that there should be immediate personal support:

> *"There is a strong need for early contact to be made with survivors as soon after the suicide as possible, similar to the SIDS model of intervention"*. (#38)

This should be followed by regular follow-up and continuity of care. Peer group services by someone who had themselves been bereaved through suicide, support groups, teleconferenced support in country areas, services for bereaved children and youth, 24 hour support and home visits were all suggested. In addition appropriate "*workplace practice that allow for people bereaved through suicide to grieve appropriately and without penalty or risk to their jobs*" (#39) was also seen as important.

Improvements to services included providing more services, particularly of the types mentioned above as well as directories of services and printed information about grief.

Improvements to service provision within agencies included having protocols and best practice guidelines, collaboration between service providers:

> "*Collaboration between service providers. Consistent uniform services so that support groups/counselling etc available on a regular basis rather than ad hoc. Sufficient funding to ensure service delivery is maintained*". (#53)

Adequate training of providers and specialists in the field were also advocated:

> "*Publish list of people who have special interest and skills in the area*'" (#35)

> "*Services should have clearly defined workers who are trained and respond when clients suicide*". (#19)

Discussion

Generalisations from this data are cautioned for several reasons. The study aimed to include as many agencies as possible that might provide services for those bereaved through suicide, particularly in the area of general counselling. However the original sample of 170 agencies is limited in certain subcategories such as religious institutions and funeral directors. Should more in-depth data be required of these specific providers, further research is required. No attempt was made to survey specific legal, financial and school services.

The return rate of 41.76% is relatively high compared to other studies. A number of non-responses occurred because addresses changed and agencies were not able to be located. Some agencies returned the questionnaire uncompleted, stating that they did not deal directly with suicide bereavement.

Further, interpretation of some of the data was difficult because of the low numbers of responses to some questions. Possible reasons for this are that the respondent possessed little or no knowledge of how the issue under question applied to, or was dealt with, by the agency, because the agency did not carry out that particular function, or because the agency or the respondent gave the particular function low priority. This might have been a reflection of how the agency functioned, for example no registers of clients being kept resulting in being unable to give the numbers of clients bereaved through suicide. Alternatively this might have been because of the low profile given by the agency to bereavement through suicide. The

response rate may also have been due to the length of the questionnaire, difficulty with understanding the question, low motivation to complete, and the length of time required.

One of the difficulties in providing services in the area of suicide postvention is that suicide has a very low base rate and the need for services may therefore be perceived as minimal. However, if the ripple effect from suicide is considered (see Literature Review) the requirements for postvention services are numerous and far-reaching.

One of the effects of the questionnaire may have been to raise awareness among agencies of the needs and level of service provision for people bereaved through suicide as shown in the quote below:

> *"This questionnaire has raised the issue for me, my staff. We would welcome additional resources to improve our understanding. Other parts of the organisation that are dealing more directly with client experiencing drug and alcohol issues have developed more guidelines". (#68)*

Summary

The responses indicate considerable service provision in the area of generic grief. However, only 20 agencies provided services specific to suicide bereavement and only two are for suicide bereavement solely. Other than referral to other agencies, the types of services most frequently nominated were counselling, both face-to-face and by telephone, and the provision of printed information. Some agencies provided home visits, financial advice and medical help. There were very few support groups identified, especially specific to suicide grief. For children, suicide specific grief services are also sparse. Counselling was the most frequently nominated service but there appeared to be few agencies with child-relevant activities

Most after-hours services are those of general grief support. Only 11 agencies indicated they provided any after-hours services for suicide-specific grief support and three of these were solely related to suicide bereavement. Only a quarter of agencies provide outreach to the bereaved and this may be even lower because of the number of non-responders: contact with agencies is predominantly made by the bereaved themselves, is established within the first week after the suicide and lasts for as long as required or at least 6 months. Few of the responding agencies charge for their services. A minority of agencies undertakes shared care and coordinated care.

Few agencies have, and comply with, written suicide postvention guidelines. Furthermore, two-thirds of agencies provide suicide-specific grief education for their staff (this may be lower considering the non-response rate), and for the majority this is of 10 hours duration or less over the past five years. The majority of agencies provide support for their staff in the event of the suicide of a client or colleague. Very few agencies indicated plans for future service delivery development in the area of suicide postvention.

Clearly the overall picture is one of considerable service provision for generic grief issues but of a low level of provision for suicide bereavement. The low response rates to a number of questions, particularly to quality-of-care related issues such as postvention guidelines and improved future postvention service provision, may indicate that suicide postvention is a low priority area to many services. Written comments indicate that culture and core business, lack of knowledge of services and referral pathways, lack of expertise of the service provider and inflexibility of the agency structures are major difficulties in providing adequate services for the bereaved.

Conclusions

Agencies varied in their knowledge and flexibility to provide for the needs of people bereaved through suicide and some seem ill equipped to provide adequate services. One of the problems seemed to be low awareness of this as an issue. Lack of training and difficulty of working in the area were some of the main concerns for providers within the agencies. Several ideas for improving services were suggested, including more research into the area.

Results: Service Providers' Questionnaire

This section reports on the responses given by the 90 service providers who returned valid questionnaires. This represents 20% of the 450 service providers to which a questionnaire was sent.

Profile of clientele bereaved through suicide

Service providers were asked for the numbers of persons bereaved through suicide they had seen in 2002 and 2003. The numbers supplied were grouped as displayed in the graph below. The number of people bereaved through suicide seen by respondents in 2002 (n=74; 82.2%) and 2003 (n=76; 84.4%), were similar, as can be seen in (Figure 5). Thirteen respondents (n=13; 17.6%) reported they did not see any bereaved in 2002, and sixteen (n=16; 21.1%) in 2003. Forty-three respondents (n=43; 58.1% in 2002 and 56.6% in 2003) reported seeing up to four clients in each year. Respondents reporting seeing a large number of bereaved persons (40+), were social workers and volunteers.

Number of bereaved seen 2002 and 2003

	0	1 to 4	5 to 9	10 to 19	20 to 39	40+	Total
2003	16	43	3	6	6	2	76
2002	13	43	4	7	5	2	74
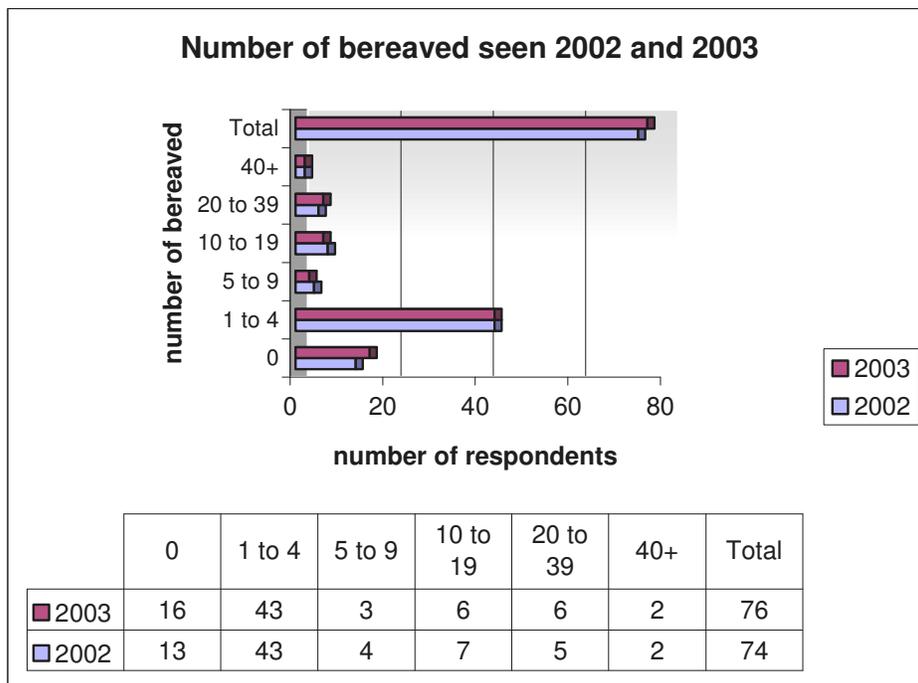
Figure 5: Number of bereaved 2002 and 2003

Service provision

Of the 90 respondents, nearly all (F=87; 96%) indicated they provided generic grief and/or suicide specific grief services but only a third (F= 28; 31%) indicated they provided any type of suicide-specific service.

Type of services offered

Respondents indicated the type of services they offered to the bereaved through suicide. The most frequently provided services were counselling (n=70; 77.8%), referral (n=54; 60.0%), medical assistance (n=40; 44.4%). Respondents offered 327 general grief services and 131 suicide specific grief services between them. In relation to the various types of service listed in Table 47 a large number provided neither general grief nor suicide specific grief services as indicated in the right hand column of the table. The other specific suicide services nominated by respondents were, contact with the GriefLink website, interpreting autopsy results and providing crisis intervention to prevent negative sequelae. Only 4 services offered only suicide specific services.

Written comments about the type of services offered included crisis intervention (3), psychiatric counselling/psychotherapy (1), interpreting autopsy results (1), spiritual counselling (4), funeral services (1) and services specific to youth aged 12-25 (2). Other comments included providing services for people affected but not bereaved by a severe suicide attempt (1) and terminating contact with the family once the client had suicided. Several comments indicated the provider was quite experienced in the area of suicide postvention such as, "*Having some training in grief and specifically suicide grief services, counselling and medical help in particular or and religious if necessary or appropriate.*" Several of the providers were familiar with appropriate support groups and web-sites to which to refer.

Table 47: Type of services offered by providers

Service (multiple responses) Respondents N=90		General Grief Services	Specific Suicide Grief Services	Both type of services	Neither service
Counselling (n=70)	F	46	3	21	20
	%	51.1	3.3	23.3	22.2
Referral (n=54)	F	35	3	16	36
	%	38.9	3.3	17.8	40.0
Medical help (n=40)	F	31	1	8	50
	%	34.4	1.1	8.9	55.6
Home visiting (n=35)	F	26	1	8	55
	%	28.9	1.1	8.9	61.1
Telephone counselling (n=34)	F	24	2	8	56
	%	26.7	2.2	8.9	62.2
Printed information (n=23)	F	14	3	6	67
	%	15.6	3.3	6.7	74.4
Services bereaved children (n=22)	F	13	2	7	68
	%	14.4	2.2	7.8	75.6
Bereavement education (n=20)	F	11	2	7	70
	%	12.2	2.2	7.8	77.8
Religious support (n=12)	F	5	0	7	78
	%	5.6	0.0	7.8	86.7
Library facilities (n=7)	F	3	2	2	83
	%	3.3	2.2	2.2	92.2
Professional led support group (n=6)	F	2	1	3	84
	%	2.2	1.1	3.3	93.3
Financial advice (n=4)	F	3	0	1	86
	%	3.3	0.0	1.1	95.6
Legal advice (n=5)	F	4	0	1	85
	%	4.4	0.0	1.1	94.4
Don't know what services (n=4)	F	3	1	0	86
	%	3.3	1.1		95.6
Other services offered (n=3)	F	0	3	0	87
	%		3.3		96.7
Non professional led support group (n=3)	F	1	1	1	87
	%	1.1	1.1	1.1	96.7
Drop in centre (n=1)	F	1	0	0	89
	%	1.1	0.0		98.9
Total		222	25	96	

Hours of service provision

Just under half the providers (f=41; 45.6%) indicated they did provide services outside the hours of 9am to 5 pm, 37 (41.1%) at weekends and 30 (33.3%) on public holidays (Table 48). Written comments indicate that providers provide after hours services as part of their private practice or as part of a salaried position such as in a hospital or Church.

Table 48: After hours services

After hours service multiple (responses) N=90		General Grief Services	Specific Suicide Grief Services	Both type of services	Neither service
Outside 9am-5pm	F	24	3	14	49
	%	26.7	3.3	15.6	54.4
Weekends	F	22	2	13	53
	%	24.4	2.2	14.4	58.9
Public Holidays	F	16	2	12	60
	%	17.8	2.2	13.3	66.7

Charges for services

Of the 86 (95.6%) service providers who responded to the question about charges for services, 39 (43.3% of the total sample (N=90) indicted that they charged for services. The majority of those who charged were general practitioners (n=27; 31.4%), who also clarified that these were Medicare and gap charges. Some others indicated the charges were means tested. One stated the fees were $100 per hour.

Contact with service providers

Contact with service providers was primarily initiated by the bereaved persons themselves (n=75; 83.3%).

Table 49: Initiation of contact with service providers

Mode of initiation (n=90)		Yes	No
Bereaved contacts provider	F	75	15
	%	83.3	16.7
Others refer the bereaved	F	47	43
	%	52.2	47.8
Provider contacts them	F	26	64
	%	28.9	71.1

Referrals

Of the 47 respondents who indicated that others referred bereaved clients to them, only 26 (55.3%) answered this question. The most frequent source of referral was general practitioners (n=9; 10%), followed by community agencies (n=4; 4.4%), police officers and family members (n=3; 3.3% each) (Table 50). Fewer referral sources were churches, school and education staff, hospitals and rehabilitation centres. Other sources of referral from the

written comments were funeral directors, psychiatrists, ACIS, CAMHS, social workers and support groups.

Table 50: Groups referring to provider

Sources of referrals n=26	F	%
General Practitioners	9	34.6
Community agencies	4	15.4
Family	3	11.5
Police Officers	3	11.5
Religious institutions	2	7.7
School/education staff	2	7.7
Anyone	2	7.7
Hospitals/rehab centres	1	3.8

Contact is usually established with the service provider soon after the suicide (Table 50). The most frequent time interval between the suicide and contact is 3 days (mode). The majority of contacts were reported to be made within a week of the death (n=39; 52.5%). Some written comments acknowledged ideally the urgency for the bereaved to receiving help after the death. However others indicated that the death-contact interval realistically depended on the readiness of the bereaved individual to seek help (e.g. the anniversary), and also on the availability of services and length of waiting lists.

Nearly fifty percent of respondents stated that the length of time intervention lasted was based on the personal needs of the bereaved (Table 51) and, as this was a self-nominated response, is likely to be an under-estimate of this option. The most frequent length of intervention depended on individual needs (mode). Responses indicated that the intervention most frequently lasted for at least one month (n=15; 19%), at least twelve months for some, but rarely longer than 12 months. Written comments indicated that for some providers short-term contact (2-6 sessions) was the duration of contact recommended by the service for which they worked. Others stated that it was negotiated with the client may be up to 2 years.

Table 51: Timings of intervention

How long after suicide contact is made (n=74)	F	Per Cent*	How long intervention lasts (n=79)	F	Per Cent*
Within 1 day	11	14.9	At least 1 month	15	19.0
Within 3 days	17	23.0	At least 2 months	2	2.5
Within 1 week	11	14.9	At least 3 months	7	8.9
Within 1 month	7	9.5	At least 6 months	8	10.1
Within 1-3 months	6	8.1	At least 12 months	4	5.1

Within 3-6 months	3	4.1	At least 2 years	1	1.3
Within 6-12 months	2	2.7	At least 5 years	1	1.3
Within 12-24 months	3	4.1	Depends on needs*	39	49.4
> than 24 months	1	1.4	Don't know	2	2.5
Depends on needs*	13	17.6			

* self-nominated response

Shared Care

Seventy seven respondents (85.6%) answered the question about shared care activities. Approximately two thirds indicted they did not provide shared care with other service providers for people bereaved through suicide (n=51; 66.2%) (Table 52). Occasional phone calls or letter exchange were the most frequently provided services (n=23; 29.9%). Written comments indicated care was shared with general practitioners, psychiatrists, psychologists, churches, hospitals, grief counsellors and community health centres. One commented on the difficulties of maintaining confidentiality when conducting shared care.

Table 52: Shared care services provided

Shared care service (multiple responses) n=77	Yes		No		Total	
	F	%	F	%	F	%
Occasional phone/letters	23	25.6	67	74.4	90	100
Shared management tasks	9	10.0	81	90.0	90	100
Specific care activities undertaken	5	5.6	85	94.4	90	100
One set of notes	3	3.3	87	96.7	90	100
Patient held record	2	2.2	88	97.8	90	100
Shared care						
Not provided	51	56.7	39	43.3	90	100

Services for bereaved children

Approximately half of the respondents offered services for bereaved children or young people under 16 years of age Table 53.

Table 53: Services offered for bereaved children or young people under 16 years of age.

Provision of care to bereaved children n=82	F	%
Yes	45	54.9
No	37	45.1

Participants were asked to indicate the type of service they provided for generic grief and for suicide-specific grief (Table 54). The most common services provided were counselling, referral, medical help, home visiting and telephone counselling. There are nearly twice as many generic grief services for children than there are for suicide specific grief provided by

this sample of service providers. Types of services described in the written comments included family therapy, child's play therapy, CBT, gestalt and narrative therapies, support for the family, communication with school staff, home visits and referral to grief agencies.

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Table 54: Type of children's services offered

Service (multiple responses N=45		General Grief Services	Specific Suicide Grief Services	Both type of services	Neither service
Counselling (n=33)	F	20	1	12	57
	%	22.2	1.1	13.3	63.3
Referral (n=25)	F	**14**	**1**	**10**	**65**
	%	**15.6**	**1.1**	**11.1**	**72.2**
Medical help (n=20)	F	17	1	2	70
	%	18.9	1.1	2.2	77.8
Home visiting (n=17)	F	14	1	2	73
	%	15.6	1.1	2.2	81.1
Telephone counselling (n=17)	F	10	1	6	73
	%	11.1	1.1	6.7	81.1
Bereavement education (n=11	F	**6**	**1**	**4**	**79**
	%	**6.7**	**1.1**	**4.4**	**87.8**
Religious support (n=7)	F	5	0	2	83
	%	5.6	0.0	2.2	92.2
Professional led support group (n=6)	F	3	0	3	84
	%	3.3	0.0	3.3	93.3
Assistance in school or childcare (n=4)	F	2	0	2	86
	%	2.2	0.0	2.2	95.6
Crisis Team (n=3)	F	1	1	1	87
	%	1.1	1.1	1.1	96.7
Non professional led support group (n=2)	F	1	0	1	88
	%	1.1	0.0	1.1	97.8
Other services offered (n=5	F	2	1	2	85
	%	2.2	1.1	2.2	94.4
Total		95	8	47	

Postvention strategies

Postvention Management Guidelines

Nearly a third (28.2%) of service providers did not know if their organisation or professional body had written guidelines for managing the aftermath of suicide of a patient or client or on supporting people bereaved through suicide. Over half of respondents (54.1%) indicated that their organisation or professional body did not. One of the 15 who ticked 'yes' to this question commented, "*Draw on bodies of knowledge contained in Department programs – Mind Matters & Education for Life. Not specific policy*", so if this is an indication of familiarity with guidelines, the proportion of providers who follow them may be even lower than a third.

Table 55: Management guidelines for the aftermath of suicide

Written management guidelines n=85	F	Per Cent*
Yes	15	17.6
No	46	54.1
Don't know	24	28.2

Postvention Support

Collegial support was the most common type of assistance indicated to be available after the suicide of a client or colleague. This was followed by immediate debriefing, counselling and case review. Ten percent of respondents indicated they would not receive any type of support after the suicide of a client or colleague (Table 56). Other self-nominated sources of support were spouses, spiritual counsellors, a study group and the 'Keep Yourself Alive' educational program.

Table 56: Type of support following suicide of colleague or client

Type of support for staff after suicide of client (multiple responses) n=90	F	Per Cent*	Type of support for staff after suicide of colleague (multiple responses) n=90	F	Per Cent*
Collegial support	63	70.0	Collegial support	61	67.8
Counselling	35	38.9	Counselling	40	44.4
Immediate debriefing	35	38.9	Immediate debriefing	35	38.9
Case review	34	37.8	Case review	10	11.1
Employee assistance program*	1	1.1	Employee Assistance program*	2	2.2
None	9	10.0	None	13	14.4

* self-nominated

Postvention training

In reporting to what extent their initial professional training familiarised them with grief after suicide, only 10 (11.6) respondents indicated it did so to a great degree. The most common response (f=31; 36%) was that it had equipped them to a small degree. A fifth (20.9%) had no familiarisation.

Table 57: Postvention education in basic professional training

Degree of postvention education n=86	F	%
To great degree	10	11.6
To some degree	26	30.2
To small degree	31	36.0
Not at all	18	20.9
Not applicable	1	1.2

Only 70 (77.8%) respondents provided information about the hours of grief training they had received as part of their continuing professional training in the past 5 years. Only two thirds had received any general grief training. The number of training hours in general and suicide-specific grief varied greatly among respondents. With regard to general grief training, the number of hours specified ranged from nil to 100 hours. Approximately two thirds of respondents indicated they had received training (n=43; 61.4%) in the last five years. The numbers of hours most commonly undertaken were 1 to 10 hours (Table 58). The three service providers who had received more than 40 hours of training were two social workers and a counsellor.

With regard to specific suicide grief training, only 59 (65.6%) respondents provided information about the hours of suicide postvention training they had received as part of their continuing professional training in the past 5 years. Less than half (n=26; 44.1%) indicated they had received any specific suicide training and the low response rate may indicate the true level to be even less. The number of hours most commonly undertaken was 1 to 10 (Table 58). The low number of hours and number of respondents with specific training is a concern if this issue is to be adequately addressed. The three service providers who had received more than 40 hours of suicide-specific training were a social worker, a volunteer and a counsellor.

Written comments about the types of training named in-service training within the organisation, peer groups and the 'Keep Yourself Alive' educational program for GPs and community health personnel (different respondent from 'Postvention Support' above).

Table 58: Number of training hours in the last 5 years

		Yes	No	Number of training hours provided (n=37)						
				0	1-10	11-20	21-30	31-40	41-50	>50
General Grief Support	F	43	27	2	21	8	3	0	1	2
n=70	%	61.4	38.6	5.4	56.8	21.6	8.1		2.7	5.4
		Yes	No	Number of training hours provided (n=24)						
				0	1-10	11-20	21-30	31-40	41-50	>50
Specific suicide Grief Support	F	26	33	3	11	6	0	1	1	2
n=59	%	44.1	55.9	12.5	45.8	25.0		4.2	4.2	8.3

Difficulties encountered

Respondents experienced a range of difficulties in assisting people bereaved through suicide. Over a third (n=34; 37.8%) of respondents found lack of specific resources to refer provided a difficulty and almost a third (n=29; 32.2%) lack of consultation time. Other difficulties that scored highly as difficulties were being able to provide long term follow up (28.9%), appropriate referral (26.7%) and inadequate training for the issue (26.7%) (Table 59).

Apart from choices that were provided, service providers also nominated other difficulties they had experienced, not shown in the table, such as lack of services for persons of non-English speaking background, a general lack of grief services, location of services, cost of services, the service focus of the organisation for which they worked, mental illness of some clients, difficulty with access to clients with specific needs (e.g. Indigenous families, children who have been in detention at Woomera/Baxter), bureaucracy (lack of support from immigration) and opposing organisational values. Other comments included the difficulty for the clinician of working in the area of suicide bereavement (dealing with guilt and shame), lack of expertise and lack of support for the clinician.

Table 59: Difficulties encountered in assisting people bereaved

Main difficulties encountered (multiple responses) n=90	F	%
Lack of specific resources to refer to	34	37.8
Lack of consultation time	29	32.2
Long term follow-up	26	28.9
Lack of specific therapist to refer to	24	26.7
Inadequate training	24	26.7
Inadequate professional support	9	10.0
Other difficulties	9	10.0
Not an issue I wish to deal with	1	1.1

Perceived difficulties

Written comments about the perceived difficulties in caring for people bereaved through suicide fell into four categories – difficulties for the service provider him or herself, problems relating to services, issues for the bereaved person and community issues. Difficulties for the service provider included the difficulty of the issue of suicide bereavement, the trauma for the clinician in dealing with this issue, fear of litigation, and lack of support for the provider. Further the lack of expertise and of training in this area was identified. Other practical issues were also nominated such as lack of knowledge of appropriate services and language barriers:

"I don't know what services exist. I mainly deal with relatives of our patients who suicide. As [named position] I have a dual role of being answerable for our service and families can be angry about our service or perceived lack of service as well as grieving. I also do a lot of counselling to staff whose patients suicide especially psychiatry registrars who are often devastated. As a psychiatrist I was distressed by the suicide of another psychiatrist and privately sought my own psychotherapy to deal with it."

A lack of services was identified, particularly of counselling facilities and support groups. A volunteer from a support group commented:

"In the group most of us work full time and there isn't enough time to devote to following people up. I sincerely believe this is a much needed area."

Another service gap was that of clean-up facilities of the suicide site. Although not the brief of this study, difficulties for rural service providers are an issue as explained by the following quotation

"In rural scene in particular, there are next to none support services that the city has. Biggest frustration is the attitude that everything revolves around the city.   No consideration for rural people, their travelling, access to transport services etc. as an example, my immediate work area covers 883,000 hectares with a population of 6000 people. I am the only minister of religion in the area."

Further problems relating to services included costs, providing the right help at the right time, and an ad –hoc network of referral instead of defined pathways. Policy issues on length of contact with the bereaved by various agencies were also seen as a problem.

Issues relating to the bereaved included the bereaved not seeking the help which they really needed because they did not perceive they needed help, that professional support could help them or for reasons of stigma, shame or pride. Community issues that created difficulties were current attitudes to mental health and suicide, stigma and lack of community education.

Service Improvement

The majority of respondents (n=73; 88.0%) considered that services for people bereaved through suicide needed to improve (Table 60).

Table 60: Service improvement

Services need to improve? (n=83)	F	Per Cent*
Yes	73	88.0
No	7	7.8
Unsure	3	3.6

Responses asking providers' views on how to improve the care for those bereaved through suicide fell into the categories of assisting the provider, improving services, improving community attitudes and research. Needs of the professional in providing improved services included providing more training at undergraduate and postgraduate levels, continued medical education for GPs and other in-service training for other professionals such as clergy. Suggestions for content of the training embraced how to deal with the various emotions experienced by the bereaved and providing structure for the counselling session.

> "*Continued education for GPs re suicide postvention, as they are more easily accessed and less threatening to see than to book into a psychiatrist. Better emphasis on suicide postvention in psychiatric training – there was none in my 3-year lecture course.*"

Support for professionals in the event of a client's suicide was also recommended:

> "*One big area is GPs – every time I do any teaching around depression or suicide with GPs they come up after the session or in the breaks and tell me about patients of theirs who have suicided – often years before; yet the wounds are still very raw. I routinely suggest to GPs that they can ring me – but no-one ever has – about suicide.*"

There were many suggestions for improving services. More professionals specialising in suicide postvention was a repeated response as well as funding for and greater availability of services. Specific improvement included making services cost-free and more culturally aware and for greater flexibility of services around tailored to the needs of the bereaved person rather than to the strategies of the host agency. Setting up guidelines and protocols was seen as important, including policy on this issue by the SA Department of Health. More services for children and youth as well as for bereaved parents were recommended. Immediate follow up after the death was seen as important and that this should include home visiting in which information about bereavement services should be offered. Continuity of care and follow up around the time of the anniversary was also seen as helpful:

> "*After a suicide a case worker needs to be assigned to a family in association with local doctor/GP interested in supporting post suicide.*"

Defined referral pathways were suggested by several respondents with additional comments of having a well advertised core of specialist professionals as well as a common reference point:

> "*Some sort of common reference point for initial advice, support, consultation would be helpful to people like myself who only occasionally encounter suicide situations.*"

Support groups were seen as important and that these need to be better resourced by volunteers and professionals:

> "*Funding at least to cover the costs of volunteers who are prepared to keep contact with clients outside of our group meetings. More volunteers/professional to share the current workload let alone expanding our services we would like to offer clients the opportunity of a professional workshop/education program that would run perhaps once every three to fours months of approx 4-5 weeks to cover all aspects of bereavement through suicide. No matter how often or for how long a client may attend our group meetings they really only receive 'bits and pieces'.*"

Increased public awareness was seen as important by several respondents so that the bereaved would not be so ashamed to seek help. Education of the public should be about mental illness, suicide and suicide bereavement.

Discussion

Any conclusions from this research should be taken in context with the nature of the sample and also of the retrospective nature of the research. The adhoc nature of the sample was diluted due to the method of sampling. The relatively low response rate (20%) may therefore indicate the sample is not wholly representative of service providers and those who did return valid questionnaires may have had particular personal agendas, but is consistent with similar studies (Andriessen, Delhaise & Forceville 2001). Reasons accounting for some of the lack of returns include attitudes of the gatekeepers (see Paper 1: **Appendix 10**). The demographics data of the providers indicates factors that are not representative of the whole, for example the high proportion working in the higher socio-economic areas. No attempt was made to survey the opinions of those whose core work was in country areas, and working with special groups such as people from non-English speaking backgrounds, with children and youth or with gays and lesbians. The numbers and percentages of responses to some questions were necessarily limited by the number and percentages of the different disciplines of respondent (refer to the sample groups in the Method). Although, as this was a suicide postvention specific survey,

the sample represented those specifically interested in and providing services in the area, and were therefore pertinent to the aim of the study.

Interpretation of some of the data was difficult because of the low numbers of responses to some questions. This might have been because of the low awareness or low profile given by the provider to the care of those bereaved through suicide. Low response rate may also have been due to the length of the questionnaire, difficulty with understanding the question, low motivation to complete, and the length of time required.

The retrospective nature of the research is an important consideration, especially as for many respondents, suicide bereavement is a rare area of provision.

The results are consistent with those of other studies examined within their contexts (Andiessen, Delhaise & Forceville 2001, Dyregrov 2003). For example the lack of expertise and personal difficulty encountered in working in this area and recommendations for improving services.

This study has identified new areas of inquiry, such as the adequacy of support for service providers, and details of service provision and training.

Summary

Providers varied greatly in the number of clients bereaved through suicide seen in a year. For some this was a rare happening whereas others, particularly social workers and volunteers saw more than 40.

Nearly all the sample of providers offered some type of grief-related service, but only one third provided any type of suicide-specific grief service. Some types of service, such as library, support group, financial advice, were offered by very few providers both for general grief as well as for suicide grief issues. Only half the providers offered any after hours services. Shared care was provided by less than a third of the sample. Charges were made by 40% providers, mainly relating to Medicare and gap charges or means tested private or agency fees.

Contact with providers was initiated predominantly by the bereaved person him or herself. General practitioners were the main source of referrals to providers with community agencies, family, police, religious institutions and schools making relatively few referrals. Most contacts were established within the first week of the death. The readiness of the bereaved individual to accept help and the availability of services and the length of waiting lists were determining factors. Providers continued contact with the bereaved person usually for as long as needed, which may be up to 12 months but rarely longer. Policy of the employer agency was a determining factor in some instances. Only half the providers practiced shared care and most commonly this was in the form of occasional letters and phone calls. Half the providers offered grief services for bereaved children but there were few who provided a limited variety of suicide-specific services.

Postvention strategies were generally lacking. Only 18% of the sample was familiar with any suicide postvention guidelines. Most indicated that they had received little input about suicide postvention in both their basic and continued professional training. However there was a small group who had undertaken considerable training, as is borne out by some written comments which indicated expertise in suicide bereavement care and familiarity with the appropriate community resources. Although most respondents indicated they had access to various types of support following the suicide of a client or colleague, 10% indicated they had no support. Moreover, the written comments indicate that lack of support may be an issue for GPs. Further inquiry is needed into how satisfactory are the current support mechanisms, particularly in view of threat of litigation and of the fact that over a third indicated that case review would be undertaken in the event of a suicide, and that this is often perceived as threatening rather than supportive (Ellis, Dickey & Jones 1998).

The main difficulties encountered by service providers included a lack of knowledge about suicide specific services, including defined referral pathways to specific counselling services and support groups. Personal and professional difficulties for the providers included lack of time and flexibility to provide the appropriate continuity of care, lack of appropriate expertise, and the trauma of working in such a difficult and personally demanding area. Costs and location (especially in country areas) and derogatory community attitudes to mental illness and the suicide bereaved were further concerns.

Nearly all respondents perceived that the care for people bereaved through suicide needed improving. This could be done by increasing the education about suicide bereavement at all levels of professional education for all provider groups and by providing more support for the individual provider. There should be greater availability of affordable and culturally aware services, and suggestions included access from a central point and defined well advertised referral pathways to specialised postvention professionals and other relevant services. Services need to be tailored to the needs of the bereaved individual and include immediate follow up, an assigned case worker and/or GP, home visiting and continuity of care. Community education to improve attitudes and support as well as more postvention research were also seen as important.

Conclusions

Experience of suicide bereavement provision varied from being a rare happening to being a specialised area of work among the current sample of providers. There appear to be few experienced providers of bereavement care for people bereaved through suicide in the current sample. Postvention awareness, education, expertise, services, policy and strategies appear to be generally low or lacking. This was a difficult area of service provision for providers both personally and professionally. Suggestions were made for improving service provision by the individual provider, the system and the community, and included research into postvention.

Results: Qualitative Data Bereaved Questionnaires

Questionnaires provided participants with the opportunity to provide expanded information in relation to their needs, difficulties experienced and their views on a variety of matters. A large amount of textual data was collected. This information has been analysed into themes and presented for additional understanding of postvention issues.

NEEDS OF THE BEREAVED

Follow-up

Immediate follow-up

Follow-up refers to the actions taken and support offered to the bereaved, directly following the suicide.

Several participants recommended that support for the bereaved must be immediate in order to cope with the veracity of the suicide and reduce the potential of negative sequelae. Some respondents commented on the lack of contact or offers of support made after the suicide and how much they could have been assisted. Respondents were of the opinion that as long as contact is made, how it is done could be by phone or post with a personal visit modified to the bereaved person's preference.

> *41: I was offered no support but believe that I in fact needed support and to a degree still do, as it is an ongoing struggle to grasp the reality of it all.*
>
> *5: Depends on location, facilities available; as long as contact is made one way or another or preferably introduction by phone or post followed by personal visit.*
>
> *420: No-one made contact with me to see if I was okay, if I needed help. I had no idea where to turn. I chased rainbows seeking contact with my son. All to no avail of course.*

Police and the Coroner's Office were considered the personnel most suited to provide information to facilitate immediate contact as: *195: to contact an organization is something that takes too much effort and you reach the stage where you feel quite desperate before you do so. Friends and relatives do not always like to tell the bereaved person that they need help to deal with their grief; also what they are feeling can be a normal part of their grief.*

Suggested types of information that could be made available include contacts for support groups and support services, together with children's services, while being mindful about keeping confidentiality.

6: I recommend that support groups should be informed by coroner/police to give support to bereaved person/s because most often we are too embarrassed to reach out but if we have met someone who visited or came to say condolence and offered to listen/help 2 hours a day then it makes life easier. However confidentiality must always be maintained.

8: Although the Police were helpful, I think it would have been more helpful if they had recommended that I contact a support group and given contact details.

231: Maybe the police could have information, phone numbers and the address of support available to give to victims of suicide. These policemen (two came) had obviously been trained to be gentle, supportive, helpful and kind and I am very grateful for their help at a difficult time.

It seemed that if the deceased had already been involved with a service, then access to support was easier.

164: .... had been seeing a counsellor from [named area] CAMHS and much of our access to support came through them. I wonder whether other families, who did not already have that contact, would have received access to so much help.

Immediate follow-up is also needed to be available for second-degree relatives as pointed out by one respondent: *42: There was no support offered to me as Aunty to my nieces, the grandparents or the mother of the deceased.*

Offers of help

The need to receive offers of assistance from professionals and support services was commented on by respondents.

22: At no point has her doctor or any other outside help been offered to her support group, or any mental health groups involved. We are not professionals and yet feel we are left to try to deal with a situation that only health professionals can deal with.

310: I wish someone had simply offered help. No-one did. I was left to sink or swim on my own.

The need for a proficient person to recognise the need for professional help and take control when appropriate was also identified:

> *122: I was phoned by a ministry colleague who is a skilled counsellor and who said to me, "It is three months since this happened. Make an appointment to come and see me and we will try and get a handle on this grief". I went there fortnightly for about four months.*

Continuation of care

Continuation of care refers to help that is offered recurrently over a period of time. It was apparent from respondents comments that needs could change with different degrees and types of help required, depending on the stage of grief. There were reports of help being available soon after the suicide but not in the longer term. In addition, it seemed from comments that at times professionals do not understand the need for continuity of care and the long-term nature of suicide grief.

> *103: As this is a very important subject in my life I would like to say that although it is almost 18 years since [name supplied] suicided, my feelings of sadness and grief are as strong as ever and I know this will not change. As I said previously I take one day at a time and try to be as positive as possible.*

> *109: Initially my parish minister was wonderfully supportive, but after some weeks I had the impression he felt I should now be over things. A second minister I was most surprised offered no support at all.*

> *340: My GP has always been available and supportive to me and I am grateful for the care he has shown.*

> *49: Flurry of activity in the first month but has dropped away significantly.*

> *50: Helpful in the beginning but not in the longer term e.g. periodic visit from church school asking how daughter was going!*

> *91: I year after suicide, I spent 2 days in hospital [named] a social worker followed up after discharge. She informed me I was "going well" and that she would not return to see me. She gave me her number but I felt my complex problems were beyond her capacity to help.*

A problem was identified with regard to the follow-up of referrals for contact and support from interstate, indicating a need for the development of processes to handle referrals.

> *72: Adelaide Coroners Office who had been asked by NSW counterparts to contact us re support but did not.*

> **78:** *Social worker at Coroners Office in ACT referred to Coroners Office in Adelaide-no help!*

Summary

The bereaved require different types of support and care depending on the stage of their grief. Acknowledging this will assist in the development of appropriate service provision and education strategies for health and service professionals. The need for immediate care and offers of help soon after the suicide are beneficial for the bereaved and advantageous to the health sector. Recognising and addressing the need for on-going care that is offered recurrently for as long as required will address the shortfall in services that are available, while simultaneously addressing sequelae that may occur as a result on problems that are not dealt with.

Standards of help from professionals and service providers

Education

This section discusses some aspects about the education and training of professional service providers.

There were 30 significant comments made by the bereaved that had bearing on the educational requirements for service providers. Issues addressed covered a range of topics, which strongly indicated that suicide grief is a difficult area requiring specialised knowledge and skills. Topics included:

Lack of knowledge about what to do:

> **56:** *Counsellors contacted checked out by me who had little or no understanding of bereavement support; inappropriate responses to my grief.*
>
> **157:** *A lot of people I know did go to GP's to talk and seek help, they were only given drugs and sent on their way which I didn't find to be helpful as one person attempted suicide themselves with those drugs given.*
>
> **48:** *Some seemed fearful of my grief e.g. G.P. wanted to give me sleeping tablets and said, "don't start crying. I don't know how to help you".*
>
> **85:** *I made an appointment to see a grief counsellor and after spending an hour telling her my story her response was "I don't know what to say to you but it is a difficult time".*

Having an appropriate skill base to manage suicide grief:

> *286: Do we have a Bereavement Care Centre in Adelaide? I haven't heard of one. I know [named service] have Grief and Loss counselling. My daughter tried that. Some help but if one finds there's nothing to say after a few sessions, but still needs help, then surely it's not working.*

> *79: A counselling service I approached told me they were experienced in all areas of counselling so did not want to hear what my 'issues' were. The counsellor had no idea. He interrupted me and wanted to 'lead me' where it may have been appropriate after several sessions, not the first. I wanted to express my anger. I wasn't allowed to. He was unprofessional. He told me it (my story circumstances) was interesting. As if I wanted to be interesting. I am still angry about this 'counselling' experience.*

> *35: Went to a counsellor many times. He had never lost anyone. Finally he told me I was grieving too hard and to go to my GP and get help with medication.*

Lack of confidentiality:

> *61: At estranged husband's request (bereaved father), the Parlour distributed copies of the deceased's private suicide note written in a very distressed state, to over 300 mourners at the funeral service resulting in extreme distress to the bereaved family members and mourners. The funeral parlour should never have agreed to distribute the suicide note.*

> *343: I feel very strongly that police officers understand that their role in reporting suicide to a loved one has a most profound effect if approached without an understanding and professional attitude. In my case the attending officer passed derogatory comments against the deceased's wife, based on the nature of the suicide letter. The letter was later released into custody of an acquaintance of the family and circulated in the community for one week before being given to me.*

> *76: Since then I approached a social worker really as a result of the cumulative effect of the suicide pushing other problems to the surface and there was a breach of confidentiality and the information was leaked.*

Unintentionally creating damaging effects on the bereaved:

> *89: I found on several occasions that professionals who had not themselves lost a loved one through suicide, to be quite damaging to me (both in SA & Vic).*

> *54: I often left feeling worse than I went in because I did not have enough time to resolve my anxiety elicited by discussing sensitive issues before leaving the session.*

> *5: Contacted support professional via work who were hopeless and a total waste of time and are still a source of anger. I get upset thinking about it.*

Providing care that is appropriate for the individual client:

> ***95:*** *The push regarding medication from my psychiatrist was at times unhelpful. I had my grief and trauma medicalised and pathologised and made to feel that my natural grief was depression.*
>
> ***103:*** *Telephone crisis line dialogue was similar to conversing with an answering machine i.e. standard responses & platitudes very unsatisfactory and somewhat provocative. If they don't understand, then what?*
>
> ***73:*** *The psychologist visits arranged by my workplace were more business like than caring or supportive.*

Relevant experience in suicide grief was considered highly desirable by respondents:

> ***73:*** *Also the counsellor was clearly not accustomed to dealing with such issues.*
>
> ***284:*** *Because someone has done a course or two in grief and loss counselling it does not give them the 'know how' of grief through bereavement and/or suicide which seems to me to be the general belief.*
>
> ***285:*** *A work colleague took something off the internet that had been broadcasted on a radio show on bereavement and grief. A counsellor called [name supplied] from the Bereavement Care Centre in Sydney 'sounded' very knowledgeable and so right I thought in what he said. I thought that if only I'd had someone like that.*

Participants gave a contrasting view about the knowledge required to provide adequate care and support. One person expressed in favour of assistance from non-professional carers who may have had a similar experience, while another supported "properly trained" counsellors. Although these views are not exclusive, they each have an interesting point:

> ***8:*** *I particularly needed assistance in gaining knowledge of how to handle my husband's grief but not from someone who would rattle off textbook information.*
>
> ***14:*** *Only professional people who have been <u>properly trained</u> in counselling should be involved. Lay people who have a limited knowledge, i.e. who believe they have read a few books or have been to a basic counselling course are a menace (do-gooders).*
>
> ***163:*** *I am concerned that she may be representative of some doctors and wonder what type of training is made available to medical students during their time at university. Our own GP has been the main support for us but his understanding is underlined by his own loss 2 years ago.*

Lack of education and training to adequately equip those who provide care and support for the bereaved through suicide appears to range across disciplines as indicated by these following

quotes. Although several are about GPs, it must be balanced with the fact that they were also nominated as the most helpful professional.

> *143: The quick fix from the GP is to go on anti-depressants.*

> *151: I was disappointed with my doctor as I have depression now and when I broke down crying in his office he believed my grief and exhaustion wasn't appropriate and that I was suicidal myself. Yet I wasn't I just needed help, compassion and acceptance.*

> *331: I found the medical profession to be the most useless to me, especially my GP. He didn't seem to know what to say or do to help me. I'm hoping doctors coming into the community have much better training nowadays.*

> *25: Take a tablet to sleep that night and that was all I saw of our GP.*

> *31: They (army) had no idea how to help me. Especially the one and only counsellor I saw. She had never had children.*

> *33: I contacted my GP. Three days later he came, gave me a book on bereavement, next day I received an account for $50.*

> *58: Religious priest who visited. We did not know. Seemed impersonal, difficult for him and us.*

> *60: Church seemed uneducated about suicide and its impact. Appeared too busy to listen; appeared to be judgmental and quick to draw inaccurate conclusion; very insensitive to family needs.*

> *61: Funeral Parlour (named) was very insensitive and at times almost callous, to the very complex family situation. Appeared uneducated about the impact of suicide and very judgmental. Initially refused to provide details to funeral arrangements to the bereaved mother, including refusing the mother a viewing of her daughter.*

> *87: My own GP patted me on the back and said "well you never know what's around the corner!" He was also my husband's GP. Consequently, I went to another GP.*

> *93: Myself, her father and brother spoke to a counsellor and he was DETACHED and not on our level of thinking, intellectually or spiritually.*

One respondent provided a suggestion of what could be included in improved education:

> *226: In addition, the cultural stigma and shame and guilt factors associated with suicide need to be addressed by better education of the community as a whole, and support services e.g. Medical practitioners, religious institutions, funeral parlours and any other organizations or professionals involved with people bereaved through suicide.*

Attitudes

This section on the attitudes of professionals encompasses problems with lack of confidentiality and professionalism that have been discussed above in the professional's education section. Lack of sensitivity, rudeness and judgemental attitudes that could contribute to negative sequelae, such as suicidal ideation, mental illness or depression were a significant concern of respondents. Respondents mentioned twelve separate events where they had encountered behaviours or attitudes that caused distress.

Official Reports:

> *3: Coroner's Office on the report said the reason he suicided was because of the break up with his girlfriend. It was a number of reasons. They don't know him so who are they to say why!*
> ───
> *7: The Coroner's Office wrote in the Coroner's report that I was the reason the deceased suicided.*

Stigma associated with suicide

> *243: I also feel that the stigma still attached to mental illness including depression is a huge factor in sufferers not seeking help, and that this contributes to the high suicide rate especially for males 25-50.*
> ───
> *244: The stigma attached to suicide is a very real factor in the way surviving family and friends are viewed and treated (even by some "professionals").*
> ───
> *52: Instead of having an open view of suicide they seemed to uphold the general public concept that suicide should not be talked about.*

Professionals' approach to the bereaved:

> *6: Help from local church non-judgemental.*
> ───
> *81: I felt that doctors' attitudes to patients and their families who had attempted suicide were horrific. I feel that it is this attitude that results in poor intervention programs that simply do not work and therefore so many more individuals completing suicide.*
> ───
> *17: Later 2 police officers visited and at the front door when they realised we had been told by phone they turned to leave. I had to ask them to come in and speak to my mother who was in a state of shock. Clearly they didn't want to be there, they were officious, rude, and arrogant and made us all feel worse with their condescending manner.*

14: Even then professional people can be cold and approach their "job" in a 'just another case' manner.

17: Not the hospital social worker found them patronising and religious.

238: Police are very rude. I was told on the phone about my daughter's death. People judge you! GP try and get away from the issue.

63: She did not return my call when we contacted. Said she didn't deal with suicide. She was very unfriendly. I was sensitive at this time so it did not help.

A number of respondents described circumstances when behaviours of attending professionals such as police, counsellor, Coroner and general practitioner were aloof. This did not appear to be a particular trait of any one discipline, but more to do with personal reaction to the event they were attending. *215: walking into our home, not really acknowledging us, showing no warmth, personal contact - only to be there to do 'a job' then walk out was in itself extremely intrusive without any thought of respect for a 'family' home and the family unit going through an horrific experience. Communication was minimal.*

It was felt that there was a *150: general lack of knowledge about suicide in the community. It still carries the stigma of "sin". People do not understand the mental anguish of the person who suicided, nor seem willing to understand that there is no easy answer to "WHY?"* Also, lack of understanding in that *69: People, in general, expect you to just simply recover from losing a loved one under such devastating circumstances and "get on with life".*

Summary

The bereaved suggest that suicide be upheld as a subject that can be openly discussed and not continue to be a taboo subject. The clichés should be discouraged, i.e. "the person who suicided must have been very brave, very sick, selfish, crazy, etc". Furthermore, education about normal grief reactions so that *207: grief is reframed as a vital and transformative change process, rather than an affliction, which must be medicated or dealt with quickly and quietly.*

Education is fundamental to best practice and client focused, pertinent services. Education and training that is specifically related to suicide grief service management would provide professionals with the tools to provide appropriate care and support to people bereaved

through suicide. For example, respondents' reported they found the attitudes of police officers wanting, yet Victim of Crime Officers reported they did not receive continuing professional education on managing suicide grief.

An empathic approach from service and health professionals that acknowledges the traumas the bereaved are experiencing has the potential to facilitate the healing process. Specific suicide grief/trauma education and training may assist service providers to act with warmth and understanding, and ensure information about services has been provided. It may also provide them the confidence to openly discuss the subject of suicide with acknowledgement of its consequences. In addition, professionals need to be confident in proclaiming what they don't know and where to refer for help.

Interventions

Interventions are those postvention activities performed or provided to support, care for and assist the bereaved.

Support for the bereaved

Respondents' comments around support appeared to focus on the need for information and knowing where to obtain support. Support was not always required face-to-face and the value of computer based support systems has a place, as stated: *159: I found great benefit in using the computer to chat to people who didn't know me. I found it very hard to communicate with people who did know me. Strangers in chat rooms can help and also recording my feelings and looking back over these writings as time passed helped me feel more positive because I could see the evidence of me healing.*

Knowing about supports or being offered support was an issue for many as is reflected in the following comments:

> *75: I feel a great need for support and help but have not known where to go for the sort of advice I believe would be helpful.*

> *128: A few support services would have helped though.*

> *177: I asked for support and found there was nothing in the support area for suicide victims.*

> *178: I have given instructions in my will that I wish that more support will be given to those who may be in this intolerable position.*

> ***225:*** *There needs to be far greater funding, education and focus on preventing suicide and on post-suicide support.*

> ***304:*** *Found it difficult to get support for her - often need to talk to someone <u>urgently</u> and phone around several places and not really get anywhere. So busy helping her didn't seek counselling myself.*

Second and third degree relatives and non-relatives had found there to be barriers to helping others and finding support for themselves. They indicated that support services needed to specifically offer assistance and advice to assist them support the bereaved family. The benefit of such a focus is empowerment of the family unit to be more self-sufficient: ***148: My family has been our biggest support but again as a unit we are now only just beginning to express suppressed thoughts/ questions about the suicide.***

> ***322****: For family (extended) and friends (and I use my circumstance and response) I don't think the counselling or assistance required related necessarily to grief. I accepted my niece's death in a fairly fatalistic manner – very sad but her death was a release from severe depression. I found great difficulty and anxiety in dealing with the grief of others and my inability to deal with it in a way which I found to be of great use to others. Therefore, I think there is value in targeting assistance / advice to this group which teaches/ coaches them in helping the immediate family.*

> ***448****: I had to make it up as I went. There seemed to be no information on "how to be a friend" – what to expect. Of our group of friends, just 2 of us stayed the distance. Given the loneliness – lack of family surrounding my friend I'm glad I was capable of hanging in there. Perhaps more could have if they had more help, on how to be a friend.*

> ***53:*** *As a former foster-carer, I was given no consideration, and neither was my family or my older foster children.*

Support must be both available and appropriate as ***96: No help is better than bad help – or draining help. People said 'be careful' about helping my friend.*** Support was well received from different areas, including internet sources, family, friends and the Coroner's Office*: **439:** One area that support would have been a great help was in the coroner's court. Immediately after …'s death a social worker from the coroner's office was magnificent. So caring and supportive.* A singular type of support that might be found in a country community was observed: ***163: We have had wonderful support from the community in general which is a product of living in a country town***, although another view was: *I believe that my mother died because of lack of information and help in the country.*

Information

How and where to find information that was required was a difficulty expressed by several respondents:

> *80: The problem, therefore, is how do you find the particular service/ person(s) who will be able to significantly help you? I would think that other bereaved people may have equally specific needs but, like me, not know where to find the particular help they need.*

Information provision was important to the bereaved for three main reasons:

1. For understanding the deceased's situation: *65: I think as far as professional help (or support services) goes, all I needed was for people to provide information on what my brother was going through to help us evaluate whether "it was always going to happen" or whether we could have done more to prevent it – a BIG issue for the bereaved of a suicide.*

2. For understanding more about mental illness: *76: I want someone to try to explain to me <u>why</u> my son took his life – I want more understanding of mental illness and, in particular, Aspergers Syndrome.*

3. For knowing how to help others with their grief: *319: Many do not know how to approach the immediate family and tend to get information through the extended family or networks – this tends to isolate them and do not feel they can regain contact (mixture of guilt/ can't deal with it). The tendency therefore, for isolation of the immediate family, grows, not only through the asymmetrical grieving patterns but the lack of understanding of how to deal with the family.*

Several respondents commented that books and other resource material had been helpful to them:

> *105: The availability of suitable reading material I think is essential. BTS has a library and COPE has helpful reading. Some one loaned me a video tape of a TV program that looked at "suicide" and how people were coping.*

Suggestions on how information about services, persons and resources might be distributed were provided by respondents, and included:

- Pamphlets/brochures
- Reliable and knowledgeable directory
- Distributed at funerals
- Given to the deceased persons' families
- Advertise suicide support groups
- Books written by knowledgeable or experienced persons

Summary

Persons bereaved through suicide require support to be available in both metropolitan and country areas, to be targeted for all, including non-relatives and friends and for it to be considerate and non-judgemental of the relationships or bonds between people. If a family unit exists, there should be facilitation to strengthen internal support structures which are complemented by external supports such as professional services.

The availability of information to guide the bereaved to expert help is a gap identified in the current health services: *414: There is a perception that immediate support (e.g. Crisis Care) type*

organizations can no longer meet this need. Similarly voluntary facilities like Lifeline. If this assumption is incorrect, much wider public education is required to advertise their services. *83: It might be helpful if there was a reliable and knowledgeable directory source that could be applied to for guidance as to the appropriate resource of support service/ person(s) to approach.*

Counselling

As an intervention, counselling provides therapy based on guidance and support. Twenty-eight passages of text were coded with comments from the bereaved in relation to counselling services.   Counselling was considered a specific intervention that should be offered immediately by personnel such as psychologists, psychiatrists, hypnotherapists and counsellors. Counselling was also recommended *230: .. ... on a regular basis in the first instance.*

The benefits of receiving counselling included gaining an understanding of the suicide act, closure for the bereaved and assisting family members to help each other.

> *26:   It has been hard supporting my mother at times and I think some help would have been good for us (such as counselling).*

> *59: The support from the counsellor in helping me understand what was happening to me. Enabling me to work through the grief process.*

> *61: Not having ever known or experienced someone who has suicided, it was beneficial for me to get a professional understanding of what the person who commits the act was possibly going through. What drives a person to make such a decision and have it explained as a state of mind situation? That those left behind are not to blame.*

308: Counselling and understanding reasons of my brother's act of suicide. Letting go of guilt.

Providers of counselling services mentioned by the bereaved were from varied disciplines and/or settings.

340: Through my GP I was referred to a hypnotherapist who helped me to disentangle the two incidents and to deal with them separately.

112: Grief counselling [name counsellor]. Really insist on grief counselling information because I felt I was going insane and [name provided] helped so much.

126: I have been receiving counselling through our work program (corpsych).

169: One on one counselling from "Bereaved Through Suicide Support Group SA Inc" (this assistance is no longer provided at home but is available at monthly meetings).

180: Individual counselling with a grief counsellor. ([named service] has a good service)

193: Counselling from medical profession. Grief counselling to some degree.

271: The most important help I received was counselling from a local mental health team. My first counselling session was commenced within 3 days of my husband's death. I had several sessions within the first month.

86: I received counselling for one visit through my local Women's Health Centre but unfortunately was never offered another visit, which I think, would have been beneficial to me.

Access to counselling services is affected by different factors, including sufficient funding for adequate services, information about services and assistance in seeking out services.

86: The unfortunate (thing) is that there is not enough funding for more visits to be possible and I think this is a great problem.

109: I was (in hindsight at least, I am) surprised no one suggested any form of professional counselling.

54: I support psychological services from my university and because it was a free service session were limited to 1 hour and in the early stages I felt this was not enough to meet my needs.

Several respondents for a number of reasons, including individual needs, gender preferences, privacy and personal preference, supported one on one counselling in favour of a support group:

> *219: Because of the stigma of suicide 'one on one' is good as many (especially males) find it difficult to bare their soul in front of people, e.g.: support group.*

> *13: I went to one meeting and found I was listening to other people's heartache and felt like a peeping tom. I would have preferred the privacy of a trained professional.*

> *23: I found the support group just wasn't for me. I only attended once. I found a one on one situation more comfortable.*

In contrast, group counselling was suggested as a viable option in some circumstances such as where non-relatives need direction or support.

> *20: The suicide impacted me only by what it has done to my friend. She is <u>so</u> wishing her own death 5 years later. A group counselling situation with her and all friends would have been beneficial.*

A few respondents mentioned the long-term nature of counselling for suicide specific grief:

> *110: Eventually, 3 months after the death, a friend suggested professional counselling for another matter, which led to ongoing counselling for the suicide.*

> *65: Years later my husband experienced severe stress at work, starting drinking more domestic altercations. I had been working part-time with a leading psychiatrist so I asked for an appointment for us to talk to him jointly. My husband attended further appointments on his own and at a later date he was able to tell me of his feelings of guilt in regard to the suicide of his brother at the age of 19 years (over 20 years earlier). Talking together about both suicides became easier for us.*

Summary

Counselling is an essential intervention that has both short and long term benefits. It needs to be tailored to individual needs and may include group or one on one therapy. Access to services can be complicated through lack of knowledge about what are available or recommended, lack of information and the number of counselling services available.

Support groups

As has been shown in the quantitative data results, support groups are a significant intervention for the bereaved. A few respondents commented that they would have liked to have attended a support group *if there is such a thing.* Others remarked *then I found the BTS group who are fantastic.* For some bereaved, finding a support group was an intervention they undertook some time after the suicide: *24: I came to hear about a support group through a*

friend who knew someone who ran one and I joined the Bereaved Through Suicide support group 11 years after the suicide.

Nearly 60 respondents passed comments about support groups. Groups were highly respected with many positive comments such as *284: Southern Fleurieu Bereavement Group. A truly wonderful group – making sure everybody is shown care and understanding – all suffering loss. Therefore you feel comfortable knowing they understand how you feel;* and *227:* The existence of the BTS support group or other similar organizations specialising in bereavement through suicide is very important because the grieving process and emotions felt by people bereaved through suicide are quite different to other types of bereavement.

One of the most appealing features of support groups was that through their very membership they offered safety, and an environment without stigma and acceptance: *154: just being with people who have been in the same position as you is a very safe place. They do not judge your emotions as "unreasonable grief" – and just being able to discuss the word 'suicide' out loud is liberating. I would recommend this service greatly.* Another advantage is a regular informative newsletter: *174: I have found the attendance at a local support group and receiving of very informative newsletter invaluable to my survival. I feel very privileged to have access to such a healing force so close to home.*

Access to support groups was identified as a difficulty for some respondents. As one person commented: *109: I was unsure how to contact them and uncertain how my sexuality would be seen - foolishly perhaps.* Distance was also identified as a barrier by a few participants: *125: All I wished was there were more support groups closer to home and during the day, as going to town is a bit too far at night.* Child care issues were also identified as a barrier to parents wishing to attend support group meetings *92: I attended BTS group but could not get child care to attend again (meeting was on Greenhill Road at night).*

Respondents commented that they would have liked to have received information about support groups so that they had the choice of attending if they wished. Two of the features some would like are *one to one counselling* and *individual support as initial contact before fronting up to a group.*

Summary

Support groups are obviously *critical in recovery* for the bereaved. A difficulty is that they are run by volunteers and the bereaved would like to see their roles broadened to include immediate follow-up, one to one counselling, home visits, phone contact, and publicity to make them more visible. In addition, support groups need to be throughout the metropolitan area so that they are more accessible. As stated by a participant: *215: This support group survives with only a small group of volunteers, it's a non-profit organization having to depend on some funding from grants. It is city based but a need for support in rural areas is strongly missed.*

Child support

Bereaved children were reported to experience depression and longer-term affects from suicide:

> *176: Unfortunately, the children were left to fend for themselves. My boys have mentioned (only recently) of being left to cope on their own. One has been affected badly and blames him self. Not that anyone has ever blamed him. He just lives with guilt.*

Achieving a balance between the needs of parents and children was difficult. *433: Because so much is focussed on the child I believe my own emotional needs were put on the "backburner" to a large degree.* Surviving parents also found *310: there is <u>very</u> little help or information regarding how or when to tell your young children that their father/ mother etc suicided, which to me is harder to deal with than the death itself.* Also, as those who were children at the time of the suicide have their own children, issues can re-emerge: *193: Although we do not often speak about him, I know we are all still affected by his death, especially as they all have children now.*

Respondents found it difficult to provide support for their children when themselves being in a state of needing support and care. Unfortunately, they found it difficult to find experienced children's grief counselors: *18: and play therapy for my daughter very worthwhile. In particular my daughter; it took 3-4 times to find a counsellor/social worker who knew how to best support my daughter at this young age and help me explain the death of her father to her.*

A specific area of knowledge deficit for addressing by health professionals was commented on:

> *432:   When there are children left by the deceased there are legal and financial ramifications which are very difficult at that time. Both adults and children are in great trauma and need help specifically targeted toward the child. There seems to be very little understanding among the health professionals around this issue.*

Summary

There is a gap for specific children's grief services that have counsellors who are knowledgeable in the treatment of grieving children. Addressing the children's grief may alleviate re-emergence of problems as they grow older, while also supporting adults with their own grief.

Need for a "Been there" other

A 'been there other' refers to a person who has experienced the suicide of a close family member or friend and who is advanced in their grief recovery. In this study respondents stated: *11:   I would like to have a 'family of suicide support group contact me',* and *36: Would have liked support from a person who has had the same experience.*

Being able to speak with someone with such experience was for several, *204:   The single most important factor in helping me to understand what was happening to me and to assure my family that I was not, indeed, going crazy was to have someone else who had been bereaved through suicide (and skilled in counselling) visit our house to reassure us of the normality of it all.* In this case, 'the been there other' could be someone from a bereaved through suicide support group.

Ideally, the 'been there other' was also a *218:'counsellor/ support worker' (especially someone who has 'been there')* who could visit within the week and connect with the bereaved would be so very helpful to allow them to tell their story, their pain someone to listen, empathise, guide them towards appropriate help and ways of dealing with the suicide.

Although those who were not professionally trained found support, it was considered preferable that **415:** *some training for these persons would be helpful.*

Summary

94: Talking to someone who has experienced the loss of someone through suicide, was a very important option for the bereaved providing safety and empathy that was not otherwise available. It was considered useful if selected people who had personally suffered the trauma of suicide were included in the immediate response team.

Recognition of the severity of bereavement through suicide

Numerous respondents were of the opinion that: *442: suicide deaths do not receive the same coverage and concern as road accidents. In my eyes a suicide is as much of a tragedy and perhaps result of society as road deaths.* Some reported not receiving acknowledgement from friends: *191: Suicide is different to 'death', when my parents died we had support, but when my sister died people I had known for years, never said a thing.*

Respondents felt that grief through suicide also needed to be recognised for its difference to other grief and the effects it can have on a family and person's wellbeing: *428: In my experience, my grief experience around my mother's suicide was vastly different to my grief around my father's death. He died (9 months) earlier from a heart failure. I was shocked but managed to grieve, "normally". Within a year, I had come to terms with the worst of the bereavement. In contrast my mother's suicide sent me on a downward spiral. It caused me further anxiety, panic attacks and deep depression. All areas of my life were affected. It caused my family to split up into haters (of me because I was seen as the "cause" of her death) and others who still chose to call me "sister".*

Summary

Respondents feel that they need recognition for the reality of their experiences. With recognition they hope there will be understanding of the loss and pain they encounter and the deceased will be acknowledged with dignity.

Sequelae of being bereaved through suicide

Numerous negative effects resulting from the trauma of experiencing a suicide were reported by the bereaved. These are not the subject of this research, but a summary of the sequelae pertinent to this study follow.

Mental sequelae

> **173:** *The combination of grief and difficult family succession issues has contributed to deep depression resulting in admission to [named hospital] because of fears of self destruction, possibly made more probable by the manner and impact of my son's death. This is where I am at time of writing this, and working on my mental state.*

> **317:** *The brother has effectively delayed his grieving until he felt that his father was emerging from his despair/grief. After 18 months he committed himself to a clinic with thoughts of suicide.*

> **4:** *Since the death of my mother, my daughter (who was 13 at the time of her grandmother's death) developed suicidal tendencies and has attempted to take her life on numerous occasions.*

Major disruptions in the family:
> *16: Her suicide seems at times not as significant as the waves left behind. I watch her children (25 & 27) lead lives of on the 'run' looking for something/ someone to love them, yet unable to accept support.*

Feelings of shame **59:** *The stigma of suicide is still with us.*

Cognitive difficulty
> **114:** *In the beginning, everything that had to be done, was looked after. I was incapable of thinking or functioning, I just wanted to die.*

> **247:** *I have had someone help me fill this form out, as my nerves are very bad and you'd never understand my writing.*

Meaning Reconstruction

Many respondents found renewed meaning in their lives by restoring their faith in themselves by their ability to assist others.

> **63:** *I would like to think that I can assist in helping other families avoid similar.*

> **309:** *When I feel stronger, I would like to be able to provide support for those who experience suicide.*

Undertaking community activities
> **131:** *The people at the church are very friendly. I first took over doing the floral roster, which opened more doors for me and people used to comment to me how nice the flowers look. Little did they know how much this built my confidence. After about 2 years I became a lay assistant. Serving on the altar is a great experience.*

> **144:** *I am participating in this questionnaire as part of my own healing.*

Writing about their experiences

> *160: Our son left a lot of pages describing his experiences and emotional turmoil. Together with my experiences and recordings I am writing a book. This has been extremely difficult but it is almost finished.*

Supporting others

> *206: It has been both difficult and easier to deal with my own grief in doing this work (support group). Difficult because at times in the first year or so of my work as group leader, I needed to take great care to separate my own grief from the grief of others. Difficult because I haven't always had support in debriefing, though now with more strict monitoring of my own boundaries this is better. "Easier" in that I was able to feel a part of a group of people sharing the same journey; that I can deal with my grief "actively" in helping others. It means that my son's death has not been for nothing.*

Re-evaluating life

> *349: I am currently working as a [provided] "doing my bit" as I see it. I bring my experience of being bereaved through suicide to relate to others who have experienced loss. This loss is the single most significant event of my whole life and it illuminated the world as it truly is. Now I focus on how to be respectful and caring of all individuals who cross my path.*

> *394: This may seem an extraordinary claim but this experience did assist in shaping my life. Firstly, it emphasized to me the value of family as a unit. It also showed me that there must be a degree of overt affection for members of one's family. Because of my own experience with my father, I have always been conscious of the need to encourage and let my family know they are important and valued.*

Summary

The experience of losing someone to suicide has immense effect on the lives of the bereaved to the extent that they often feel a need to share some of their learning with others who experience similar. It is the flip of those who are newly experienced wishing to talk with someone of older experience. Meaning reconstruction takes place in several ways, including re-evaluating directions in life, helping others either directly or in writings or in taking on voluntary activities.

Accommodation to loss

Coming to terms with the loss of a person from suicide involves adjustment and adaptation to changed circumstances and accepting the reasons for a person's decision to die. *51: It's about becoming more informed and developing the courage and strength to find the hidden reality and truth and to find a way to bring that truth to attention wherever there is a need.*

Knowing why the person suicided, especially when the reasons were related to illness became a matter of reassurance:

> *12: I understood his illness…. I think seeing him more than other family members helped me accept his reasons for no longer wanting to live … than my brother and 2 sisters … who are still coming to terms with his death.*

> *123: Supportive friends have been my most valuable asset. It took 13 months before my late husband's GP informed me that "my husband couldn't accept that diabetes was rapidly taking his eyesight from him'.*

Summary

Respondents who were able to understand reasons for the suicide adjusted to their loss more easily. Measures that could provide some closure or reassurance included supportive friends, being able to talk about the deceased, visiting their workplace and applying to view Coroner's documents.

Successful postvention services

Counselling was recommended as a successful postvention strategy to help put matters into perspective.

> *4: counselling (ten years late!) she is now in recovery and all is fantastic*

> *63: We went to our closest funeral parlour (named) who have always been great. We have always dealt with them for all our family funerals. They gave me the name of a grief counsellor who operated out of their Woodville business.*

Information about suicide and suicide grief was frequently found valuable to help the bereaved understand their grief and also *77: to understand what my brother was going through at the time and to fully understand exactly how he died, ie. the physiological process. (the doctor helped there).* Main sources of information were books and information networks.

> *4: Reading books also very important this came about by hearing a book launch on ABC Radio. After Suicide Help for the Bereaved and asking professionals for recommendations.*

> *215: Information obtained from COPE.*

> *325: Women's Information Network Library on Pennington Tce was helpful.*

Non-professional assistance was a significant source of support for the bereaved. Many commented on the support received from family and friends as well as church communities and work colleagues.

> *20:   Family and friends have been there and we have helped each other. Talking to family and friends about my daughter.*
> ───
> *30:   Support from friends, church and workplace. Friends were very experienced some social workers, psychologists etc.*
> ───
> *44:   Also I had a part-time job and my employers and work mates were totally caring. I was a mess.*

Someone to talk to was an asset.

> *16:   Talk to your friends and family. Don't presume that they will get tired of listening or will feel uncomfortable. If they are true friends they will be supportive.*

Non-professionals and professionals are able to offer different types of support. This was highlighted by respondents who clarified the difference as in the questions that need answering:

> *158:   I received almost no help, however the support I had from some friends was really appreciated, although I never felt they could really understand as they had had no personal experience of suicide.*
> ───
> *161:   I needed to know how long I would hurt for, when I would start feeling better and what type of things I could do to ease the pain.*

Respondents reported they found constructive interactions with professionals from different disciplines:

Counsellors

> *94:   and also talking to a counsellor who can reassure you that what you are feeling is normal.*
> ───

Psychiatrists

> *178:   I have received great benefit both practical and emotional from regular visits to a psychiatrist. My husband and [name supplied] father and my son, [name supplied] brother have both been hospitalised with depression since her death. My husband 7 times, my son 2 times.*
> ───

Coroner's Office

> ***197:*** *[named professional] and other social workers at the coroner's office. [Named facilitator] who is a convener of a 'Death by Suicide' support group.*

Funeral Directors

> ***252:*** *The support from the funeral directors was fantastic. Luckily we had a very supportive GP who helped in the first few weeks while I was trying to support my friend and her family.*

Churches

> ***275:*** *The Pastoral care and prayer support by church and members' visits and encouragement, (Would not recommend mental health), probably close friends as well.*

Doctors

> ***325:*** *The help my doctors had given me in dealing with depression, helped me with this tragedy, and helped me help into the future.*

Social Workers

> ***318:*** *I saw a social worker once a week during the first year and I found that very beneficial. I would suggest to anyone experiencing grief to see one, if even only once.*

Outreach services

> ***104:*** *Talking to the psychologist once a month for six months was the best help I received. I lived in a small country town in SA and she flew down from Adelaide. She gave me an insight into his behaviour and helped me realize that I didn't need to feel guilty or that it was my fault.*

The value of qualified people to offer help was emphasized:

> ***28:*** *A Minister of Religion TRAINED in helping people who are Christians who have lost their son through suicide. We were just plain lucky we stumbled (guided by God) to find [named Pastor] at [named church] [named town] who is a Police Chaplain (brilliant).*

The importance of being able to choose the most suitable person for assistance is necessary but can be quite a difficult task:

> ***331:*** *One visit each with a psychologist and counselling support with someone who has personally had the same relationship loss. Though one visit only was certainly not enough psychologist was far too expensive and the meeting with other had a religious overtone with I felt uncomfortable and suspicious of motives.*

Summary

Person's bereaved through suicide need to be able to choose interventions and professionals to work with them who suit their needs and meet their values. Non-professional help provides a great deal of support and is essential to maintaining family cohesiveness. Ideally, support services would work to maintain or enhance this feature within networks of friends and family members. Resources for postvention are varied and include videos, books and information networks.

Postvention Strategies

Respondents found a variety of strategies, which assisted them in their grief. Most frequently mentioned was talking about the event:

> *67: Being able to talk to someone who understands your feelings at that time and was un-judgmental.*
> ──

Faith in God and spirituality:

> *108: Belief in God. Friends. Pets. Nature the simple things in life are quite delightful.*
> ──

Joining support groups, reading books and maintaining close relationships:

> *102: Attending the "Bereaved through Suicide" support group was good. Reading "After Suicide" by [named author] was probably the most useful experience (after my wife's love, support and understanding).*
> ──

Playing sport:

> *136: Encouragement to return to playing in a sporting team, by a good friend, another friend helped me plan a holiday, which we then took together.*
> ──

Maintaining friends and contacts:

> *120: I recommend: Counselling (4 fortnightly visits). Having close friends around you. Reading about suicide to understand more. Attending the suicide support group. Speakers talking about suicide. Family members nearby especially children.*
> ──

Keeping busy:
> *142: Very busy at work and karate instruction/ participation. To do events where there is no time to think about suicide.*
> ──

Remember the deceased:

> *220: To gather your <u>real</u> friends around you as well as family and talk about how you feel. Remember the person with love, dwell on the good times, the other's don't matter. As long as you loved the person as much as you could while they were alive. I*

hope I did?

As a helper keep in contact

> *232: For others in a similar situation I think it is important to not "swamp" the person with contacts immediately but to keep in contact, particularly remembering important anniversaries and birthdays of the deceased.*

Trust in those who try to help:

> *241: The right medication (largely Lithium) but now through side effects over making too much calcium so I have had to give up Lithium 30-40 yrs on it which was wonderful for me. Still struggling with the right medication at the moment. Being freely able to converse with my GP and psychiatrist and my faith in God has helped considerably.*

Self Help:

> *312: Self Help. Be strong to yourself. Those close to the one lost have to support each other. Be positive.*

Summary

The depth and breadth of strategies suggested by the bereaved participants was overwhelming and demonstrated a wealth of knowledge and strength that had been gained from their traumatic experiences. It showed that there are many ways to assist someone with suicide grief bereavement, but most of all that the person's inner strength must be enhanced and encouraged for postvention services to be successful.

Ideal support

Directory of services

Much support was given for the provision of information about grief and suicide grief services to be available via a directory or information pack. The pack would contain:

> *217: Support group / services brochures and/or phone contact made to bereaved persons as a matter of procedure by Coroner's Office, to ensure that people are aware of the support systems they can access.*

> *103: Leaflet(s) with information about services, support groups and counsellors (who deal specifically with suicide) and how to access these supports. (Suburb) location of these supports could also be useful.*

> *91: Information regarding groups of people who are/ have been in similar*

circumstances to me so that I could openly express my feelings/ thoughts.

Availability of the pack would be from:

> ***233:*** *An information kit made available immediately after the suicide by the Coroner's Office and/ or funeral parlour including support contact details, information on coping with grief, and the emotions and various stages of grief that can be expected.*

Types of grief information

- Respondents thought that the type of grief information available to the bereaved should include books about suicide or issues relating to suicide,
- Films that deal with the topic,
- People that can provide medical information and legal advice, and
- Access to police reports and autopsy reports.

One of the most frequent suggestions has been extensive advertising of community information on all media. ***212:*** *MORE media coverage to bring suicide out into the "real world". I was shocked to discover how many people suicide each year.*

Immediate follow-up

There were frequent references to the need for immediate care (follow-up) for the bereaved following a suicide. Part of this was for professionals to make the contact so that the bereaved felt cared for and supported. Respondents were of different opinions as to whether contact should be make by telephone, post or in person but often suggested a combination of all three methods. They also suggested that:

> ***170:*** *Police and Ambulance staff to have knowledge / information about the services available and to offer it immediately. Counselling services should be offered; they approach you, rather than you having to seek them out you can always refuse or defer until later.*

Immediate contact is necessary to:

- Humanely explain and make people aware about the autopsy and any other legal procedures that will occur.
- The bereaved should be informed of any options available to them (the autopsy of our

son is causing me enormous suffering).

- Subsequent visits (after funeral etc) to make assessments of the family's circumstances, dynamics and individual needs. Some needs may require immediate attention others may need to be addressed during subsequent visits.

- Re-assess further, the circumstances and how the bereaved are coping.

- If they are ready, introduce to them information about the support services available, and the legal procedures that will follow.

- If necessary encourage participation, make referrals for them and follow through with support.

- Listen to people, try to understand them and allow them to move at their own pace in their own way while still providing backup support. *:56*

Home visits

Support through the provision of home visits has been supported by the bereaved in this study -67.3% indicated they would have liked home visits. The ideal situation is reflected in the following quote: *249: In an ideal world, with unlimited resources, the offer of a home visit (or maybe 2 or 3) by a trained counsellor after maybe 2 months or so might be useful to help assist people get the help they need, ie. what are you doing? Is it helping? Is there anything else you would like organised? Have you thought of trying this? <u>Is there anyone else affected by losing this person who might need some more help?</u> - this has been an issue in our family and it is difficult to approach family members easier by far for a neutral person.*

24 hour: 7 day assistance

Several respondents confirmed that they had found it difficult to find ideal support, which, in their opinion would be available 24 hours a day over seven days:

> *8: Rang compassionate friends a couple of times and just got an answering machine so gave up trying.*

> *210: A 24-hour phone number specifically for people affected by grief through suicide.*

"Been there" other

Many respondents expressed a wish to have had a "buddy" who had been in the same situation. It was felt that a person who had experienced this type of trauma understood like no-on else could and offer "tools" for coping.

> *109: I really believe that you have stages that you have to go through. You have to have someone that has been through the same as you to talk to. Even after 5 years I'm still going through stages as my 2 grandchildren have been born. After 5 years a lot of people think I should be over my mum's death.*

> *131: Talking and listening with people who have also been affected by suicide. Myself and my mother found that after the funeral was the hardest time. You are surrounded by people which ends as abruptly as it started. People tend to think you should get over it and move on quickly, but it is not always possible.*

> *255: Opportunity to speak with someone who has experienced the devastation of a loved one's suicide as soon as possible. No-one else understands. (they just think they do).*

Country services

With regard to services for those living in country areas, respondents felt that there must be more to offer people who are *8: unable to go to Adelaide for support group meetings*. Ideally there would also be additional support to be able to stay overnight in Adelaide for those who work in the city.

The suggestion of establishing a network to improve service provision for the bereaved was made:

> *135: As a country person, I would recommend a network be established involving the local police, GP, perhaps hospital, then one from that group could contact such a group as Solace, to make contact with the victim within 3-4 days for counselling. If not Solace, a group such as the Lower North Community Health Care, to make contact with the victim within the above time span, even if it was to make initial contact to arrange a meeting for personal contact.*

Summary

Ideal support encompasses the provision of a wide range of different types of information, and immediate follow-up after the death, including home visits. Visits or contact from another who has also experienced suicide bereavement was widely supported. Both information and

assistance should be available twenty-four hours a day, seven days a week in both metropolitan and country areas.

Strategies for suicide bereavement

Strategies nominated as ideal support included, talking with friends and family, keeping busy and in routine, keeping positive thoughts, maintaining work, and attending a grief course.

> *16: Speak to friends and try to maintain your normal everyday routine as much as possible.*

> *204: Just having someone force you to stop retiring from the world by just helping you to garden anything to keep your hands busy and your mind off your own tragedy.*

> *259: True friendship and understanding from friends and family avoiding some people who you know would not understand.*

> *266: Keep life as normal as possible keep working and <u>always</u> think positive. Do <u>not</u> blame yourself, beating yourself up is so negative, trust me, been there, done that. After 5+ years have to always remind myself even now.*

> *286: I found going back to work was the best thing, at least eight hours of the day I was busy.*

> *324: I believe funeral parlours could run a grief course for their clients. {Named funeral parlour] did in 1990 on but I believe that is no longer the case. But I have always found [named funeral parlour] staff very caring and helpful when I have approached them.*

Postvention as prevention

> *37: Regular professional counselling, weekly at first or more often if needed, reducing even to yearly. Maybe my depression would not have developed if I'd been counselled correctly at first opportunity.*

> *18: Counselling for my children and myself has been very valuable and I have found over the last 2 months talking to people who have experienced suicide very beneficial.*

> *35: For our situation her death was a relief but the waves left behind could have been relieved by family counselling and encouragement to participate.*

> *241: A stranger to take the load of your feeling of guilt and just listen to your "sadness". Family are feeling devastated and don't need your extra grief. To off load on to someone not related to my father who died, would have been a huge support.*

Several suggestions for ideal counselling services were provided, including:

> *85: I think if it were possible to have someone coordinate a <u>group</u> counselling session with <u>everyone</u> that wanted it, who was related or close to the <u>one</u> person. I felt that all I wanted to do was be among those people and discuss my brother a good kind of therapy. You don't feel alone and don't feel that people don't understand about your brother (and that he's not just another "statistic")*

> *229: Local community support centres, or volunteers, for people who have lost someone, to be contacted by Police / Coroner and arrange contact with a volunteer to help them cope and let them know they are not alone.*

> *305: Ideal support would extend to those linked to those most immediately affected by the suicide. In this case, the mother, father, brother and sister will grieve for a lot longer after relatives and friends have finished grieving. They need to make conscious decisions to recognise and continue to support the immediate family and understand that they will continue to suffer.*

Counselling offers to talk with someone who understands and offers support which friends or family may find difficult. Respondents considered that counselling should be immediate, one on one and group (family) counselling, short-term and long-term, and immediate. The advantages were seen as:

Support group

Support groups provide an ongoing support network comprised of people who have a personal experience of suicide. Bereaved respondents who reported attending support groups spoke of them highly. A suggestion about the environment was made: *20: The venue should be easily accessible, not sterile but welcoming. There should be counselors who have had special training in this area. There should also be tissue boxes easily on hand.*

Advantages of support groups include:

> *123: Speakers talking about suicide.*

> *184: As my family lives interstate (and my mother's death was interstate) I needed to find plenty of local support. After reading an article advertising the formation of a local bereavement group specifically for people who have lost a loved one to suicide, I phoned the facilitator [named, and attended the group's first meeting. My family has gained fantastic support via newsletter, books, articles, guest speakers, workshops, videos, social contact all of which has helped us enormously to deal with a subsequent loss and also to offer assistance to others in their healing.*

> *235: Ongoing support network, eg: BTS support group.*

Suggestions about the roles support groups could play were:

315: If at all possible a BTS parent to come to my home as soon as possible after finding out about my son's death.

316: Telephone contact with BTS parent.

206: Contact to be made by support groups to bereaved instead of just passing on information (pamphlets).

Financial help

The need for financial assistance was identified for funeral expenses and practical for day-to-day financial management. If a bereaved person worked, Centrelink did not provide support for this even though this regardless of income. As was noted in the quantitative results section, 42% of respondents held health care cards. Other financial support required was *151: Advise on navigating things like super/ tax the practical things that have to be done when you are still in shock.* And *336: Access to finance (i.e.) like special benefits / sickness benefit to allow time for recovery.*

Offered help

To be offered help without having to seek it was highly desirable and is commented on in other areas of the report (Offers of help): *39: The real effects of suicide for me increased with the passage of time so I would have found it helpful to have been contacted to discuss my feelings etc 6-12 months after the suicide.* This passage emphasizes that to be offered help is still desirable some months after the suicide.

Quality care

Respondents suggested that ideal qualities in the care offered to persons bereaved through suicide should encompass more compassion, support and kindness: *53: The bereaved families and individuals should receive personal more humane visits by sensitive, compassionate and professional carers. The manner in which the letters from the State Coroner's Office are written should be re-vamped. Attention should be given to the particular circumstances of the next of kin, and the wording of the necessary information.*

Better skill in those providing care:

125: People bereaved by suicide just need understanding and caring people who

gently and sensitively make contact and gradually develop an on going relationship. We have no idea that this is going to be such an on going affair!!

73: At first, give people time and space especially if the suicide was totally unexpected or coupled with other trauma. Be very mindful of the age of persons bereaved. The persons offering assistance should be made aware (as fully as possible) of the full circumstances but keep the knowledge to themselves let the bereaved tell the details if and when they are ready. A GP or religious person should only be involved if they are well-known by the family. Every one is different in the way they handle trauma etc.

Regular contact and follow-up

75: Regular contact whether by personal contact, phone or letter, (and all three together).

Assistance in understanding

95: I was approached by a friend and he confided in me about the problems he was having with his son. We were able to discuss many aspects he and I had in common. He gave me an insight into depression which he and his son suffered from. I came to realise that my son was suffering from depression, although this went undiagnosed all his life. I have had similar discussions with BTS counsellors.

Appropriate training and education for professional carers

269: 'People' need to follow through with info/ help. The help should be offered by someone really experienced in death and/ or suicide, and that's more, I believe, than a person saying they do loss and grief counselling which can cover many other losses. I should not have had to do the chasing up of help.

Gender balance in carers available

180: A female and male police officer in attendance when informing family of the death.

Availability of information

155: Availability of information, but people need to decide to seek help. Perhaps some periodic contact from professionals/ support? When everyone goes home after the first few weeks, it's easy to feel alone and forgotten about.

Appropriate language use

225: Challenging the language used by professionals and service providers such as "committed suicide", "completed suicide" reframing to "died through suicide",

avoiding language which perpetuates the stigma of sin or crime surrounding deaths through suicide.

Co-ordinated care between service providers

> *227: Combination of support from family doctor, funeral service, support group (BTSSG) in conjunction with Bereavement counsellor (refer to 'Further Comments').*

Care at the site of the suicide

> *309: Number one the Police need to be trained in how to deal with these situations as they are the first on scene. In my situation I called an ambulance and the Police came with it, they took my husband away and left me alone with a four year old child, not even asking if they could contact someone for me!*

Continuity of care to help prevent negative sequelae developing

> *337: Monitoring of any suicidal ideation, to help prevent further suicide.*
> _____

> *345: Ongoing contact from anybody who cares that the person is affected. I realise I need to just think about where I am at in terms with my grief and progression in life from that point. I need and find it therapeutic to acknowledge that the event has affected my life and to discuss the issue with others.*

Legal help

Although *212: I think the ideal support for people bereaved by suicide is a close and supportive family*, there are some other needs that family and friends cannot support such as legal issues:

> *149: Legal advice/ information re: wills, next of kin rights to information, etc.*
> _____

> *190: We were extremely fortunate to have family and friends to deal with the practical details. Our daughter died in the UK so the plans were further complicated. If we had been without this support it would have been helpful to have someone to guide us with some of the legal issues, options as far as bringing our daughter's body home.*
> _____

Practical help

Respondents indicated that ideally, practical assistance should be available for a range of needs including care of children, home help and information:

> *249: Practical help is also very useful in all shapes and form. Food, child care,*

shopping, cleaning etc for as long as people need it which is sometimes a long time.

269: Practical help would be good so the grieved can curl up in bed for days if they want, without having to cook and clean etc.

39: Some practical information on how best to support the parent of the deceased.

Child support

Respondents felt that where children are involved, *148:   parents need extensive counselling for themselves but also to help the children. Not just initial short term assistance but provisions in years to come as kids grow up they have different questions and needs.* In the situation where the bereaved are a young family, the provision of *237: a carer for support as well as their family member. On going support such as visit from governmentt member.*

Other suggestions were *286 a Child Health Team for children*, and *326: Referrals to Child Health Services as mandatory practice.*

Summary

Ideal support encompasses many factors, which within themselves have many options, as is dependent upon individual choice and circumstance. Ideal support for those bereaved through suicide is led by the need for adequate and appropriate care from carers who are adequately and appropriately trained. Adequate and appropriate services need to support the carers. The bereaved respondents have explained how they need particular information, specific financial help, access to bereaved support groups and home visits, and care over an extended period of time as grief moves through different stages. Adults with children require assistance with caring for the children in both a practical and grieving sense. Services need to be available in both country and metropolitan areas twenty-four hours a day, seven days a week. Counselling services and support groups have received a great deal of support. Respondents suggested many strategies for ideal care and support and these have been detailed under the appropriate headings above.

Difficulties experienced by the bereaved

Practical Difficulties

Respondents reported problems such as practical difficulties, difficulties with support systems and difficulties accessing help

Practical difficulties are such as what to do after the event or how to do some things. Examples of practical difficulties are:

Financial:

> **38:** *Psychologist gave financial help by discounting fees so son and respondent could attend consultations.*

> **42:** *Reduction in childcare fees.*

> **344:** *As in case of spousal suicide financial counselling is a priority, in my case there was a need to stop working as a RN to attend to children 5 and 8. There was a need to notify Centrelink and fill out necessary forms etc. I was very confused. My outstanding debt exceeded $100,000.*

> **46:** *My lawyer still hasn't settled my spouse's estate. Therefore all bills left by him haven't been paid and creditors have constantly harassed me.*

> **346:** *I particularly recall feeling need for an advocate in dealing with creditors, bank managers and other business matters.*

Informing people of the suicide:

> **8:** *I didn't realise that one of the more difficult aspects would be calling people to tell what happened, and then getting various questions asked of you and also "hearing" various aspects of "why couldn't/didn't" when you obviously are distressed yourself. The feelings of guilt afterward are overwhelming.*

Clean up of the site of the suicide:

> **71:** *Comments made by my mother were that SAAS left used gloves and other rubbish lying around. Also the rope dad used to hang himself was still affixed to the wooden beam this caused a lot of distress for mum. Perhaps SAPOL and SAAS members could be aware of the debris left scattered at the scene.*

> **121:** *I have nothing but praise for the local policeman because I found my husband's body in his truck at 5.15 am. He came to the farm immediately, with my help in finding his way. I had no contact with the CIB men who came from [name place]. It distressed me to find my husband's bloodstained clothes left on the back of his truck for me to dispose.*

162: Our son [named], shot himself in his room at home. Once the coroner had taken him and the police had left, we were left alone. The main area, in the immediate aftermath of the suicide, where we received no help or offers of help, was in the cleanup. We had to clean up his room ourselves, including blood and brain matter on the walls, cupboards and bed. Ten months later, we still have a large blood stain on the carpet which I covered with a rug. We have just organised for new carpet to be laid, but my husband, who found Sam, will have to help the installers to remove the blood stained old carpet. I know that in the USA they have private contractors who will come in after a suicide or crime and do a cleanup. I would like to see, at the very least, the police, coroner or ambulance personnel, have information that is available to people about who/ which services are available for this task.

Caring for children:

347: I would have given an arm for the opportunity to have time away from my children. I had the hours between taking them to and collecting them from school, I would sometimes weep all day. But I had no relief from my responsibilities.

Coping with returning to everyday life and responsibilities:

348: When I was finally able to (1998) I returned to nursing. I completed RN re-entry course at UNI SA. The workload nearly killed me (I still had no-one to relieve me of my child care responsibilities) consequently, following a number of bouts of flu, I became "sick". For 8 months I struggled with a "reactive depression" that rendered me physically weak and constantly crying. I could not work. The ACIS team assessed my situation and told me it was time to grieve. Seven years after husband's suicide I gave myself permission to collapse. I was as weak and fragile as a small child. It was necessary and I took the opportunity to review everything.
This respondent reported severely grieving at 7 years – another participant also reported likewise but for 15 years.

Difficulties with the system

Difficulties with different parts of the social, health and legal systems were reported by respondents and often involved issues of communication and sensitivity for the bereaved. Examples included the Coroner's Court:

33: The State Coroner has rejected our submission for an inquest. In a standard form, his letter to us simply states that he is satisfied and accepts the opinion of the 2 (eminent) psychiatrists who have looked at all of our son's medical records and the information that we submitted. However, we raised a number of issues in our submission to the Coroner that were not addressed. Nor did the Coroner address the flaws and contradictions that we had found in the Psychiatrist reports and had responded to in writing. There was no personal or written contact with us, at any time, by any one reading and reporting on our documentation.

Status in the community:

> **67:** *I also have found it hard that I'm not considered a widow, but a single parent and that gives us all the stigmas relating to that.*

Interstate Deaths:

> **233:** *My partner died in Perth, Western Australia. I was pretty much given no support thru' the Police or Coroner's Office. I also lost everything I owned that dreadful day as my partner burnt our home down. The only support I received was thru' the Fire Chaplain and that was financial support. I had one meeting with a counsellor at the coroner's office and it did not go well as I was very angry and in shock still at this stage. The police treated me as if I did not exist and I had to read the probable cause of death in the paper, the police didn't even have the courtesy to tell me face to face. Although I was next of kin, WA's laws are different, his family took my partner's body to a different state for cremation and all the Coroner's Office could say is 'oh well, you should have been quicker in organizing a funeral.' So I cannot really comment on South Australia's coroner's office and police, but WA's, well what can I say I lost my partner twice, once to suicide, and once to his family!*
> ──
> **277:** *My son died in the ACT (drove his car into trees). We were informed by police here the following day. They were as helpful as they could be. When we tried following it up ourselves by contacting police in the ACT we had difficulty. But for the fact that another son was very assertive and demanding we would have had to wait until the next day to get more info.*

Inappropriate communications

> **294:** *I found the contact from the Coroner's Office shocking. It took them 4 months to complete their report. The interviews taken during the investigation arrived in the mail one day without any warning. These included the police interviews describing how my husband was found and removed and included information that I had not been told of before that was extremely upsetting.*
> ──
> **439:** *The inquest was quite upsetting. They (the doctor from [named hospital]) spoke about [named] as if he was a commodity. One that they were unable to afford. My feelings on reading the coroner's report caused me great distress. I was so angry. He died because of mistreatment.*
> ──
> **29:** *Rang a suicide support group in Adelaide very distressed a man answered phone and said counsellors had gone home!! Call back!! Great when you feel the bottom has fallen out of your world so don't bother again.*

Unhelpful experiences

> **73:** *When I endeavoured to change an appointment 23 hours prior to appointment time I was told that payment for initial appointment would be required as it was not 24 hours notice i.e. No flexibility or understanding.*
> ──

99: Funeral parlour. Car went to wrong address to pick us up. The driver did not know where the cemetery was.

Accessing help

31: I am still on a waiting list for counselling through North East Mental Health Services it has been 2 years.

44: Tried to communicate with the psychiatric nurse but she didn't return my calls.

65: My 8 year old was placed on priority but I was told it would be 6-12 months before any help would be given.

68: I asked my GP for a referral to a psychologist who visits once a month a guy who had been recommended to me. I was told there was a 3-6 month wait to see him but it is over 6 months since I initiated the referral.

72: Being a working single parent I find it difficult to be able to get to meetings in the evening. And if there are any day meetings I'm usually at work.

Summary

Difficulties encountered by the bereaved encompassed a wide range of factors and included the health, legal and social support systems. They encountered long waiting lists, requests for assistance not being acknowledged, lack of flexibility and understanding, tactless, insensitive communications, obstructive help, and complicated systems to work through. Addressing these difficulties in light of many of the recommendations provided by respondents would assist in designing more user-friendly systems.

Support for this research study

Many respondents stated that they participated in the research study as part of personal development: ***144****: I am participating in this questionnaire as part of my own healing.* We also received several commendations for the project:

10: Thank you for this opportunity, to try and help.

55: I would like to be kept involved and informed of what your research identified. Should you wish to talk to me about my experience please do not hesitate to contact me. Thank you.

84: I commend the acknowledgment of this project that grief after a suicide may be rather different from that experienced in other bereavement situations.

133: I hope this bit extra information will all help your research and if you require any more research information please contact me.

179:   Great to hear someone is interested in doing research on those bereaved through suicide.

312:   Please carry on with as many studies as possible to help prevent people taking their lives.

329:   I have many comments about the way my husband was treated and myself. If I can help, please call.

338:   Thank you for doing the survey.

351:   I am particularly pleased this problem is being addressed in this way. I have commented on my own experience at some length, in the hope it might be of some use.

382:   I have never in a voluntary sense confided in anyone outside my family, about the matter, and would be reluctant to do so, this study excepted.

417:   Hope this research helps people understand suicide and go some way to preventing it.

440:   Thank you for allowing me to take part in this survey.

444:   I am grateful for the learning and growing of the experience and thinking of it in this way has been a great help. Thank you for offering the opportunity to be involved in something like this.

Summary

For some participants, taking part in the survey became part of their personal meaning reconstruction), whereby persons find renewed meaning in their lives through restoring their faith in themselves by assisting others or writing about their own experiences.

Conclusion

Immediate follow-up with support and offers of service provision is vital to the on-going good health of the bereaved. This can be offered in a variety or combination of ways but offers of help should be made in the first week. Offers of assistance and support are required for some time following the death and respondents spoke of requiring assistance for up to fifteen years.

Highly recommended was the wider advertising of support services that are available so that the bereaved are already informed when the suicide occurs. In addition the advent of an information directory that is widely available and provided by those services first on the scene is desired. As respondents reported using the Internet to seek support, this pack should be

available by that medium too. Also, an arrangement of co-ordinated care with a "buddy" to guide the bereaved through the systems and identify potential problems early.

Support groups are highly favoured but given their voluntary nature the community has unrealistic expectations of them in what they would like them to provide, especially as the study unveiled only two specific suicide support agencies and few who offered after hours care. One of the major advantages of support groups is that they provide the much requested 'been there other' who has personal experience of a suicide. There is an opportunity for the health system to support the support groups and expand their role.

Many of the troubles respondents experienced with the social, health and legal systems seemed unnecessarily complicated. Police Officers were reported to exhibit inappropriate and insensitive attitudes towards the bereaved and yet themselves report no training in managing the terrible situations they encounter. The impenetrable nature of problems arising from interactions with the Coroner's Court cause considerable distress that heightens the overall distress experienced at a traumatic time. Considering how to address this in a more positive frame while meeting legal requirements would build a more constructive interface between the community and the Coroner's Office.

Many recommendations are provided by respondents to guide the training and education of support professionals for working in the area of suicide bereavement. It has been made clear that this field is different to other bereavement fields and requires dissimilar knowledge and skills. This affects support professionals from across the board, emergency services, health, education, social services, community groups, the legal system and others.

Extended family members, work colleagues, neighbours and friends have requirements with suicide bereavement that may be as acute as the next of kin's and this needs to be taken into account when planning and providing services. They have needs of their own to cope with the loss of the person and the closeness of the relationship is not an indicator of whether they deserve a service. In addition they have important support roles that if nurtured would assist professional services in their delivery.

Counselling services were valued but considered difficult to access and sometimes unaffordable or limited. Specific grief counselling services by professional personnel trained

in the area were considered desirable as they could offer information that non-professional supports could not. There is also a gap in the way that referrals are managed, especially from interstate, indicating a need for a process to manage referrals.

On the whole participants enjoyed taking part in the research study and valued it as an opportunity to express much about their experiences that had remained contained for some time. In itself this is an indicator for greater awareness about the health requirements and implications for those bereaved through suicide. It also shows how little research has been conducted in this area.

Discussion Forum

The preliminary findings of the study were presented in the draft research report to the Reference Group, which also represented the main stakeholders in suicide bereavement and providers of postvention services. The draft report was circulated ten days prior to a forum held for discussion of the findings. The forum acted as a validation process that allowed the researchers to examine multiple levels of data and explore phenomena with specific reference to the three sample groups. At the meeting, attendees were asked to address each sample group in turn and discuss what the report revealed under the following three headings – *what is already there, what is missing, what is needed.* This information was collated to form the recommendations that now follow.

For the Bereaved (Table 61)

What is already there

The discussion forum confirmed that:

- Limited crisis response services are available to administer emergency support such as ambulance, fire and police response teams.

- In 2003 a national *Information & Support Pack for those bereaved by suicide or other sudden death* was prepared with information relevant to South Australia by the Commonwealth Department of Health & Aging. Two thousand packs were prepared and provided to the Coroner's Office for distribution.

- Well established are resources and services that are dependent on those individuals who offer them from a personal perspective rather than from a planned, co-ordinated approach to service delivery. A range of individual expert resources was identified such as counsellors and funeral directors.

- Print and some web based resources for example, some people find chat rooms very helpful.

- 4 Support groups for those bereaved through suicide were facilitated, generally, by bereaved volunteers.

- People bereaved through suicide ("been there" others) who are associated with support groups are an untapped pool of volunteers who are not currently connected with a helping agency.

- A broad range of health and mental health services and social support services are offered by government and non-government providers.

- Overstretched services for children and youth.

- Limited non-metropolitan bereavement services.

- Few cultural specific services.
- Limited national and international postvention research.
- Stigma about mental health, suicide and suicide bereavement.

What is missing

Both the respondents in the research study and members of the forum identified:

- That an identified role of others who had experienced suicide bereavement in the role of a "been-there" other or "buddy" was missing from the immediate response team, and who could give continuing care following the initial event.
- Appropriate approaches to bereaved persons by crisis team personnel.
- Clean up services to the site of the suicide to save family members the distress of doing this themselves.
- Follow-up with planned, co-ordinated and comprehensive care individualised to suit the values and needs of each family.
- Sufficient information packs for distribution to individual family members, including second-degree relatives and non-relatives. The packs need to be comprehensive and include a wide range of services.
- An adequate pool of expert counsellors who can engage in low-cost interventions and give on-going support. There is no register of such experts nor established networks or referral pathways for them.
- Volunteer operated support groups were acknowledged as being under-resourced to meet all the activities required of them, such as more frequent meetings, home visiting, individual counselling in addition to group meetings and telephone support and were unable to broaden their service provision to meet demand. They lacked professional co-ordination, funding to support their services and pathways to formal health and mental health networks. Groups were overwhelmed by the requirements on their services. Based on volunteers who are self-directed they often struggle to meet everyone's expectations.
- A co-ordinated pool of volunteers who had personally experienced suicide bereavement and are available 24/7 to provide: emergency response outreach and continuity of care through a "buddy" system.
- Recognition of suicide postvention as an important prevention strategy.
- Adequate age specific children's and youth resources. Age appropriate activities, both 1:1 and group; Links to existing suicide postvention groups or activities such as with Mind Matters and Seasons for Growth. Child and youth counselling; Child care services.
- Country as well as metropolitan counselling services.
- Culturally appropriate services.
- Evidence base on which to form interventions and service provision.

- Appropriate community attitudes and knowledge about mental illness, suicide and bereavement.

What is needed

The discussion forum discussed the findings and identified features and structures required to construct a reasonable and beneficial service structure for the bereaved. The components are:

- Appropriate, immediate, crisis response – appropriate trained providers (similar to SIDS Model and international models).

  o A "been-there" other person who can be part of the emergency response team to the site of a suicide, and as one who has experienced similar trauma, would be able to assist the bereaved through the legal and practical processes entailed.

  o Clean-up services

  o A co-ordinator of response and follow-up who would monitor the crisis response and ensure home visits to follow from the initial emergency outreach.

  o Follow-up home support

- Clearly defined pathways to care

- Promotion, identification and recognition of suicide postvention with a specific pathway that promotes postvention as a suicide prevention strategy that should provide telephone support and counselling 24 hours a day, 7 days a week.

- Bereavement information packs.

  o Information on other services not currently detailed such as cleaning up services for the suicide site and other support groups.

  o Packs to be more widely disseminated from emergency services, community agencies, hospitals, general practitioners, support groups, funeral parlours, cemeteries, educational institutions and service providers.

  o Packs to be more widely available for individuals within families and to 2nd degree relatives and non-relatives.

  o Recognising that this requires considerable funding, it was suggested that intra-organisational funding of packs be considered.

- Coordination of suicide bereavement experts to facilitate access by the bereaved:

  o a register of experts,

  o networking,

  o pathways,

  o training and support the experts

  It would seem more economical to fund a coordinator who can facilitate the pathway to care for individuals rather than the vast number of unproductive cries for help that are currently evident and the wasted providers' time when bereaved individuals seek help from untrained and inexperienced providers.

- Support groups require greater resourcing e.g. professional co-facilitation support groups. Training of facilitators and support volunteers in specific issues of suicide

grief, group management skills, crisis intervention, pathways etc. Core funding to support above services.

▪ Co-ordination of volunteers by a facilitator who has experience and or knowledge of suicide bereavement. This person could facilitate recruitment, training, emergency response outreach and follow-up by volunteers. With core funding, support groups could offer an expanded range of services covering 24 hours, 7 days a week

▪ Promotion and establishment of suicide postvention as a suicide prevention strategy within the state health system with relevant pathways into human service networks.

▪ More and age appropriate children and youth services, such as play-centred groups for children and activity groups for youth.

▪ Central agency to provide:

    o Initial emergency response

    o Initial follow up & coordination of care

    o Provision of an 1800 statewide telephone support service staff by experts and bereaved volunteers.

    o Co-ordination of volunteers

    o Information, support to providers & bereaved

    o Outreach to country areas as appropriate and to co-ordinate care with local services. Use of technologies to provide rural outreach e.g. telephone group support similar to that of the Organ Donation Foundation.

▪ Culturally appropriate services for NESB and indigenous peoples as well as for gay and lesbian groups and others.

▪ Research into suicide postvention with specifically nominated funds so this does not become consumed by prevention research. Research to be grounded in clinical and service provision and identify acceptable models of care and services. Further research on how to supply the needs of the rural and remote population, children and young people, including those of a non-English speaking background. Investigate examples of best postvention practice nationally and internationally.

▪ Informed and appropriate multimedia approach to reduce the community stigma about mental illness, suicide and suicide bereavement. Annual theme day to raise awareness about suicide grief in the community and to destigmatise suicide.

For agencies (Table 62)

What is already there

Identified by the discussion forum as already existing within the community are:

▪ Existing agencies with a brief for crisis response, mental health and primary health care service delivery.

What is missing

Participants of the forum agreed that missing within the current service delivery structure were:

- Rural and metropolitan services which have suicide bereavement as part of their core business and are adequately funded to deliver targeted services. As has been mentioned, a co-ordinated referral and service management system is lacking.

- No single agency with a mandate to make immediate contact with the bereaved.

- Skilled and knowledgeable service providers who are sensitive and empathic.

- Few specific statistics on clients bereaved through suicide, so agencies are not aware of whom they are seeing – possibly entered under categories of depression or mental illness.

- Policies and guidelines on how to care for and support staff when working with the bereaved including support systems for staff dealing with reactions, such as debriefing, and counselling support. No best practice procedures and guidelines or, if present, lack of adherence to them.

- Lack of training on suicide and suicide bereavement for staff.

What is needed

The forum agreed that agencies are in need of structures to support them in their delivery of suicide postvention services. Recommended structures are:

- A central agency that:

    o Is a centre of expertise

    o Contactable by police and emergency response teams in the case of a suicide.

    o Has a broad role of co-ordination of care of the bereaved individual from the time of the crisis and providing long term continuation of care within the health and social networks. It may include the care of families where sudden and unexpected death could not be proved to be suicide.

    o Has secure funding for the agency and possibly from collaborative sources.

- Provision of immediate follow-up and support early after the suicide for those bereaved such as counselling, referral, information and access to co-ordinated services. Facilitation would occur through the central agency with a specific service co-ordination role.

- Skilled response teams educated on how to manage traumatic situations including suicide bereavement, and with the facility to contact a person who has experienced suicide bereavement to act as a "been-there other".

- Education on suicide bereavement for personnel to increase awareness and understanding of inherent issues. A central agency could facilitate education programs for all associated organisations, such as for Victim Support Officers.

- Flexible approach to service delivery that acknowledges what the bereaved are suffering.

- Accurate statistical data of the suicide bereaved population to best identify the need for particular services, as it is thought that data on these clients is lost when categorised under depression or mental illness.

- The development of suicide postvention policy to guide best practice procedures and guidelines that address issues for service delivery, support of staff, education for professionals and accreditation of counsellors. This could be led by South Australian Mental Health Services.

For service providers (Table 63)

What is already there

From the data collected and discussed in the forum is was agreed that for service providers there exists:

- Duplication of resources and adhoc information on available referral sources and about managing suicide bereavement

- Adhoc knowledge of qualified service providers and support services.

- Individual service providers such as general practitioners and counsellors who provide services. The skills of some providers are skilled in the area but there are no pathways directing bereaved clients to them.

What is missing

To facilitate effective and purposeful services, providers require:

- Easy access to up to date, planned and prepared information sources that include a directory of appropriate resources, including professionals and referral pathways.

- Longer consultations to more adequately address needs and issues of the bereaved and provide effective counselling.

- Consistent identification and record keeping of bereaved through suicide clients seen each year

- Provision of suicide bereavement in undergraduate & postgraduate training programs.

- Continuing education that includes grief, loss & suicide (trauma) and support.

- Identified referral pathways in order to know who to refer to for specific issues.

- Identified networks.

- Support for country service professionals.

- Supportive environment for professionals working in this area e.g. how to deal with own grief in the death of a client through suicide, own emotions, and support for helping the family.

What is needed

To address those issues identified as missing, service providers require:

- A comprehensive central resource with accurate and appropriate information sources, consisting of
  - Information pack detailing where to access help with wide dissemination via printed copies, CD and from a suicide bereavement website – Emergency Services, Coroner's Office, Community Agencies, Hospitals, GPs, Support Groups, Funeral Parlours, Cemeteries, Education institutions, service providers.
  - How to respond to a suicide death
  - Information about their own personal grief in the event of a suicide of a client.
  - CD of information pack to be available (not to replace printed copy)
  - Directory of skilled service providers in both metropolitan and rural areas.
  - Suicide Bereavement website
- Easy access to practitioners trained in suicide bereavement such as general practitioners and counsellors.
- Adequate and comprehensive education in grief, suicide postvention, trauma, support and self-care. Inclusion of suicide bereavement education in under and post-graduate training programs and continuing professional education in grief, suicide and loss.
- Recognition through accreditation of skilled professionals. It is important recognition is based on experience as well as training.
- Telephone conferencing to improve access to resources e.g. for country based service providers.
- Special consultative service for establishing supports in country areas.
- Establishment of support structures for professionals working in suicide bereavement that include best practice guidelines which are current, adhered to and updated regularly to aid and guide professionals in the conduct of their work.
- Networks and forums to share expertise and seek advice through an identified set of contacts with whom to associate for collaboration and support.
- Policies and procedures for addressing stress in professionals, for example, immediate de-briefing provision.

Summary

This section has summarised the outcomes of the discussion forum and presented the information according to the three main sections of the report. Issues around the needs of people bereaved through suicide and the support and educational structures available for services providers of postvention services were the focus of this Project. These issues have been drawn together to form an *Ideal Model of Suicide Postvention Services (p.159),* which is presented in the following chapter.

Table 61: Issues for the Bereaved

WHAT'S ALREADY THERE?	WHAT'S MISSING?	WHAT'S NEEDED?
Limited crisis response E.g. ambulance, police, fire	"Been there" other Appropriate approaches to bereaved persons by crisis team Clean-up services Follow up with planned, coordinated & comprehensive care	Appropriate emergency response mechanism similar to the SIDS model Appropriate team including a "been there" other & clean up facilities Appropriate training of response team Coordinator of response and follow-up Network of referral pathways
	Initial home outreach	Home visits to follow from the initial emergency outreach
Bereavement Information Packs	Sufficient packs for distribution to individual family members including second degree relatives Listing of some services identified by this study	Information on other services not currently listed, Eg other support groups, cleaning up services. Wide dissemination. Intra-organisation funding of packs
A range of individual expert resources Eg counsellors, funeral directors,	A adequate pool of expert counsellors who can engage in low-cost interventions and give on-going support Register of experts Networking of experts Pathways of referral to experts	Co-ordination of suicide bereavement experts to facilitate access by the bereaved, a register of experts, networking, pathways, training and outreach of the experts, and to support the experts
Support Groups (4 in SA).	Meeting more than monthly as is current 1 to 1 counselling in addition to group meetings. Co-coordination by professional and bereaved "been there" other Funding to support services Pathways to formal health & mental health networks	More local support groups A professional to co facilitate support groups Training of facilitators and support volunteers in specific issues of suicide grief, group management skills, crisis intervention, pathways etc. Core funding to support above services
Existing bereaved volunteers ("been there" others) associated with support groups An untapped pool of bereaved people who are not currently connected with a helping agency	Co-ordinated pool of volunteers (experienced in suicide bereavement) who are available 24/7 to provide: emergency response outreach Continuity of care - "buddy" system	A system of recruitment and training of bereaved volunteers. Coordinator of volunteers to facilitate recruitment, training, emergency response outreach and follow-up ("Buddy" system) by volunteers
Broad range of health and mental health care services and social support agencies.	Promotion, identification and recognition of suicide postvention as a suicide prevention strategy	Create appropriate pathways & networks. Postvention needs to be promoted as a preventative strategy and its place defined among existing health and human service sectors.
Print and some web based resources for example, some people find chat rooms very helpful.		
	Telephone support / counselling 24/7	1800 state-wide telephone link

		staffed by experts/ bereaved volunteers.
Overstretched services for children and youth	Adequate age specific resources; Age appropriate activities 1:1 and group Links to existing with suicide postvention groups /activities such as with Mind Matters and Seasons for Growth Child and youth counselling Child care;	More and age appropriate children and youth services
Limited non-metropolitan bereavement services	Country as well as metropolitan counselling services	Central agency to provide information, support and outreach to country areas as appropriate and to coordinate care with local services Use of technologies to provide rural outreach eg telephone group support as per the Organ Donation Foundation
Few culture specific services	Culturally appropriate services	Culturally appropriate services for NESB and indigenous peoples as well as for gay and lesbian groups etc
Limited national and international postvention research	Evidence base on which to form interventions and service provision	Research into suicide postvention with specifically nominated funds so this does not become consumed by prevention research. Research to be grounded in clinical and service provision and to identify acceptable models of care and services. Further consultation re how to supply needs of children and young people including those of rural and non-English speaking backgrounds. Investigate examples of best postvention practice nationally and internationally.
		Central Administrative base
Stigma	Appropriate community attitudes to respond supportingly to individuals bereaved through suicide.	Informed and appropriate multimedia approach to reduce the community stigma about mental illness, suicide and suicide bereavement. Annual theme day

Table 62: Issues for agencies

WHAT'S ALREADY THERE?	WHAT'S MISSING?	WHAT'S NEEDED?
Existing agencies with a brief for crisis response, mental health and primary health care service delivery.	Services with suicide bereavement as core business. Appropriate funding levels for agencies to provide suicide bereavement services. Co-ordinated referral and service management.	A central agency with clear, defined pathways and a broad role for co-ordination. Broad co-ordination role – suicide and sudden unexpected death. Funding that is collaborative and secure.
	No single agency with a mandate to make immediate contact with the bereaved. Immediate follow-up and support early after the suicide.	Immediate follow-up and support from an agency with a specific service co-ordination role. Skilled and knowledgeable police and emergency response teams.
	Skilled and knowledgeable service providers who are sensitive and empathic.	Education on suicide bereavement for personnel to increase awareness and understanding of inherent issues. Provision of education by the agency for all associated organisations e.g. SAPOL (Victim Support Officers). Flexible approach to service delivery that acknowledges what the bereaved are suffering.
	Few specific stats kept on clients bereaved through suicide so agencies not aware of whom they are seeing - probably often put under depression or mental illness.	Specific data collection of bereaved through suicide clients seen by agency.
	Policies on how to care for and support staff when working with the bereaved. Support systems for staff; dealing with reactions. No best practice procedures and guidelines or, if present, lack of adherence to the above Postvention training for staff	Suicide postvention policy that addresses staff needs, services, education, procedures and accreditation for counsellors.

Table 63: Issues for Service Providers

WHAT'S ALREADY THERE?	WHAT'S MISSING?	WHAT'S NEEDED?
Adhoc information sources of suicide bereavement services Adhoc knowledge of qualified service providers and support services. Some web based resources – some people find chat rooms very helpful.	Easy access to up to date, planned and prepared information sources Directory of appropriate resources and referral pathways.	Comprehensive resource database with accurate and appropriate information sources • Information pack (printed, CD and web based) detailing where to access help with wide dissemination via printed copies, CD and from a suicide bereavement website – Emergency Services, Coroner's Office, Community Agencies, Hospitals, GPs, Support Groups, Funeral Parlours, Cemeteries, Education institutions, service providers. • How to respond to a suicide death • Information about their own personal grief in the event of a suicide of a client. • Directory of skilled service providers in both metropolitan and rural areas. • Suicide Bereavement website
Individual Service Providers e.g. General Practitioners Counsellors	Longer consultations to more adequately address needs and issues. Adequate undergraduate & postgraduate training Referral pathways – knowing who to go to. Identified networks Continuing education that includes grief, loss & suicide (trauma) and support. Support for country service professionals	Easy access to service providers trained in suicide bereavement. Adequate and comprehensive education in grief, suicide bereavement, trauma and self-care. Accreditation of professionals. Inclusion of suicide bereavement education in under and post-graduate training. Continuing education in grief, suicide and loss. A core group of experts as there appears to be few and important this is based on experience as well as training. Telephone conferencing e.g. for country based service providers. Special consultative service for establishing services in country areas.
Stressful environment for professionals working in this area.	Awareness of how to deal with work trauma. Trauma support for professionals	Immediate de-briefing. Agency policies for managing stress in professionals. Best Practice guidelines for guidance and support Networks and forums to share expertise.

Ideal Model of Suicide Postvention Services

The discussion forum identified the instigation of a facility offering centralised co-ordination of service provision for those bereaved through suicide. Such an agency should operate on a model similar to the renowned SIDS Model. It would have clear, defined pathways and a broad role for co-ordination with the mandate to liaise and negotiate with generic grief agencies. It would encompass a broad co-ordination role for suicide and sudden unexpected death. Located in a meaningful place to enhance visibility, the facility's structure would include a number of features targeted toward addressing the negative consequences of suicide grief and loss. The foremost undertaking of the agency is to provide co-ordination of services for persons bereaved through suicide from a central administration base. To do this the agency would be connected to established structures within the health care system. A graphic representation of the Ideal Model of Suicide Postvention Services is on page 162. The agency would comprise the following features.

Service structure

Specific activities offered by the agency include:

- Response to an initial trigger from crisis services for support at the site of a suicide. Provision of co-ordination of response and follow-up.
- Co-ordinate home visits from "been-there other" trained volunteers who are themselves experienced in suicide bereavement and have been trained in basic listening and befriending skills with the potential to become "buddies" to the bereaved and assist them through post-suicide processes
- A 24 hour, 7 day a week state-wide free call telephone help-line
- Deployment of a suicide site clean-up team
- Co-ordination of and support for bereavement support groups.
- Facilitate co-ordination of specific services for bereaved persons
- Facilitate and identify means of non-metropolitan support
- Co-ordination of suicide bereavement experts to facilitate access by the bereaved, a register of experts, pathways, training and outreach of the experts, and to support the experts

Education

- Establish and conduct an annual theme day to promote understanding of suicide and suicide bereavement in the community with the aim to destigmatise suicide.

- Conduct training of the initial response team and volunteers

- Co-ordination of training for the experts and other personnel to increase awareness and understanding of inherent issues.

- Provision of education by the agency for all associated organisations e.g. SAPOL (Victim Support Officers).

- Education and training for staff in suicide bereavement.

Communications / Networks /Information

- Publish newsletters with information on suicide grief and bereavement

- Identify and make available a network of referral pathways

- Develop information about suicide bereavement

- Maintenance and dissemination of suicide bereavement information directories

- Maintenance of suicide bereavement web site

- Co-ordination of networking, pathways and outreach of the experts, and to support the experts

- Provide information, support and outreach to country areas as appropriate and to coordinate care with local services

- Provide rural outreach e.g. telephone group support

- Lobby for the inclusion of suicide bereavement education in under and post-graduate training. Continuing education in grief, suicide and loss.

- Develop a core group of experts based on their experience as well as training.

- Provide telephone conferencing facilities e.g. for country based service providers.

- Facilitate a special consultative service for establishing services in country areas.

- Co-ordinate networks and forums to share expertise.

Staff

- Co-ordination of professional and volunteer staff. Recognition of the expertise of volunteers as those experienced in suicide bereavement.

- Co-facilitation of professional and volunteer personnel for support groups

- Coordinate volunteers to facilitate recruitment, training, emergency response outreach and follow-up ("Buddy" system) by volunteers

Policy

- Lobby for suicide bereavement policy to promote and protect all areas of suicide bereavement, in particular suicide postvention policy that addresses staff needs, services, education, procedures and accreditation for counsellors.

- Encourage further consultation on how to supply needs of children and young people and those of non-English speaking background

- Encourage culturally appropriate services for NESB and indigenous peoples as well as for gay and lesbian groups and others.

- Assist agencies develop policies for managing issues around suicide bereavement service provision.

- Encourage and assist in the development of Best Practice Guidelines for guidance and support of agencies and professionals.

- Promote suicide postvention as a preventative strategy and seek its placement among existing health and human service sectors.

Funding

- To seek funding that is collaborative and secure.
- Encourage intra-organisation funding of information directories.

Summary

The *Ideal Model of Suicide Postvention Services* is characterised and underpinned by flexibility and adaptability, allowing for services to be tailored to an individual person's needs. The affects of suicide on individuals is not static and services need to be moulded by a range of factors, including professional services available, geographical location of the bereaved individual and service, community resources available and structural arrangements for care and support.

In its entirety, this study has identified new areas of inquiry, such as the adequacy of support for the bereaved and service providers, and details of service provision and training for those experiencing the area of suicide postvention.

Figure 6: Model of ideal suicide postvention service delivery

MODEL OF BEST PRACTICE

Central informational resource
Best practice guidelines
Models of best practice
Directory of services
Bereavement pack
Pathways to care

PATHWAYS TO CARE

Support Provision
Follow-up
Home visiting
Coordination of care
Immediate response
Country outreach
Age & culture appropriate services
Coordination of volunteers
1800 24 hour telephone service

Coordinating Agency

Policy and liaison
State, national and international postvention networks
Child and youth services
Mental health networks
Bereavement networks
Postvention research
Funded agencies
Advocacy

POLICY & RESEARCH

Training
Communities
Support groups
Service providers
Quality assurance monitoring

INFORMATION & RESOURCES

References

Alexander DA, Klein S, Gray NM, Dewar IG, Eagles JM. (2000). Suicide by patients: questionnaire of its effects on consultant psychiatrists. *British Medical Journal,* 320:1571-1574.

American Association of Suicidology (1992). Survivors of Suicide Support Group Guidelines. Washington, American Association of Suicidology.

Andrews G, Tennant C, Hewson D & Schonell M. (1978). The relation of social factors to physical and psychological illness. Amreican Jouranl of Epidemiology, 108, 27-35.

Andriessen K. (2004). Suicide survivor activities, an international perspective. Suicidologi; 9(2) 26-31.

Andriessen K, Clara A & Beucks K. (2002). The suicide prevention policy of a mental health centre. International Journal of Mental Health Promotion. 4(1), 20-23.

Andriessen K, Delhaise T & Forceville G. (2001). De quelle(s) aides/assistance(s) les proches des personnes suicidée ont-ils besoin? Une recherche exploratoire. Etude réalisée pour le compte du Ministère des Affaires Sociales. [The needs of suicide survivors. An explorative study. Requested by the ministry of Social Affairs]. Brussels: Cetrum ter Preventie van Zelfmoord.

Australian Bureau of Statistics (2002). Causes of Death. http://www.ausstats.abs.gov.au/ausstats/subscriber.nsf/Lookup/632327CB179DB59BCA256 DEF0075E998/$File/33030_2002.pdf Accessed 29/11/04

Australian Bureau of Statistics (2003). Socio-Economic Indexes for Areas 2001. ABS Catalogue 2039. .Canberra: Commonwealth of Australia.

Australian Health Ministers (2003). National Mental Health Plan 2003-2008. Department of Health & Ageing. Canberra, Australian Government.

Barrett, T.W. and Scott, T.B (1990) Suicide bereavement and recovery patterns compared with nonsuicide bereavement patterns. *Suicide and Life Threatening Behavior*. 20, 1, 1-15.

Beautrais AL. (2004). Suicide Postvention. Support for Families, Whanau and Significant Others after a Suicide. http://www.myd.govt.nz/media/pdf/postvention-lit.pdf Accessed 24/11/2004.

Begley M. (2003). Suicide Prevention Strategy Coordinator, Tipperary, Ireland. (personal communication).

Brent, D.A., Bridge, J., Johnson, B.A. and Connolly, J. (1996). Suicidal behavior runs in families. A controlled family study of adolescent suicide victims. *Archives of General Psychiatry* 53, 1146-1152.

Brent, D.A., Perper, J.A., Moritz, G., Liotus, L., Schweers, J., and Canobbio, R. (1994) Major depression or uncomplicated bereavement? A follow up of youth exposed to suicide. *Journal of the American Academy of Child and Adolescent Psychiatry.* 33, 231-239.

Campbell FR. (1997). Changing the legacy of suicide. Suicide and Life Threatening Behavior. 27, 329-338.

Campbell FR, Cataldie L, McIntosh J & Millet K. (2004). An active postvention program. Crisis 25 (1): 30-32.

Clark S. (2001). Bereavement after Suicide: How far have we come, and where do we go from here? Crisis: 22 (3):102-108.

Clark (2001). Bereavement after Suicide: Mountains, milestones and the New Millenium. Where to now? Report of the Forum at the 7th national Conference of Suicide prevention Australia. 2000. Sydney; Suicide Prevention Australia.

Clark, S.E. and Goldney, R.D. (1995). Grief reactions and recovery in a support group for people bereaved by suicide. *Crisis.* 16, 1, 27-33.

Clark SE, Goldney R. (2000). The Impact Of Suicide On Relatives And Friends.. International Handbook of Suicide and Attempted Suicide, Chapter 26 in: Hawton K, Heeringen K Eds), John Wiley, UK.

Clark S, Martin G & Beckinsale P. (1998). Keep Yourself Alive. Evaluation report: Analysis of Qualitative Data from Workshop Participants. Report to Commonwealth.

Clark SJ, Hillman SD & Ministerial Council for Suicide Prevention. (2001). Information and Support pack for those bereaved by suicide and other sudden death. Perth, Australia, Ministerial Council for Suicide Prevention.

Cleiren, M.P.H.D. (1993). *Bereavement and adaption. A comparative study of the aftermath of death.* Washington, DC, Hemisphere Publishing Corporation.

Cleiren, M.P.H.D., Diekstra, R.F.W., Kerkhof, A.J.F.M. and Van der Wal, J.(1994). Mode of death and kinship in bereavement: focusing on the "who" rather than "how". *Crisis.* 15, 22-36.

Cleiren MPHD, Grad O, Zavasnik A & Diekstra RFW. (1996). Psychosocial impact of bereavement after suicide and fatal traffic accident: a comparative two-coutry study. Acta Psychiatrica Scandinavica 94:37-44.

Corr CA, 1999. Enhancing the concept of disenfranchised grief. Omega 38 (1): 1-20

De Fauw N & Andriessen K. (2003). Networking to support suicide survivors
Crisis 24 (1), 29-31.

Demi A. (1984). Social adjustment of widows after a suicide death: suicide and non-suicide survivors compared. Death education 8:91-111.

Department of Health. (2002). National Suicide prevention Strategy for England. London: Department of Health.

Department of Health and Aged Care and the National Key Centre fro SocialApplications of Geogrphical Information Systems (GISCA). (2001). Accessibility/Remoteness Index for Australia 2001. Occasional Paper new Series: Number 14. Canberra: Commonwealth of Australia 2001.

Dunn, R.G. and Morrish-Vidners, D. (1987). The psychological and social experiences of suicide survivors. *Omega.* 18, 3, 175-215.

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

Dyregrov K. (2004). Strategies of professional assistance after traumatic deaths. Empowerment or disempowerment? Scandinavian Journal of Psychology 45:181-189.

Dyregrov K & Hauge NP. (unpublished). From research to reality. The establishment of an organisation for suicide survivors: LEVE.

Dyregrov K, Nordanger D & Dyregrov A. (2003). Predictors of psychosocial distress after suicide, SIDS and accidents. Death Studies. 27(2): 143-165.

Ellis TE, Dickey TO & Jones EC. (1998). Patient suicide in psychiatry residency programs. A national survey of training & postvention practices. Academic Psychiatry. 22 (3):181-189.

Farberow, N. (1998). Suicide survivor programs in IASP member countries: A survey. In Kosky, R.J., Eshkevari, H.S., Goldney, R.D., Hassan, R. (Eds) *Suicide prevention: The global context.* New York, Plenum Press.

Farberow, N., Gallagher, D.E., Gilewski, M. and Thompson, L. 1987). An examination of the early impact of psychological distress in survivors of suicide. *The Gerontologist.* 27, 5, 592-589.

Farberow N, Gallagher-Thompson DE, Gilewski M & Thomson L. (1992a). Changes in grief and mental health of bereaved spouses of older suicides. Journal of Gerontology, 47 (6): 357-366.

Farberow N, Gallagher-Thompson DE, Gilewski M & Thomson L. (1992b). The role social supports in the bereavement process of surviving spouses of suicide and natural death. Suicide and Life Threatening Behavior 22(1): 107-124.

Fisher J. (2003). The story of the Standby Suicide Bereavement Response Service. Conference paper, 10th National Conference of Suicide Prevention Australia.

Grad, O.T. 1996) Suicide: how to survive as a survivor?. *Crisis.* 17, 3, 136-142.

Grad O, Clark S, Dyregrov K, and Andriessen K. (2004). What Helps and What Hinders the Process of Surviving the Suicide of Somebody Close*? Crisis* 25 (3), 134-139.

Grad OT and Zavasnik A. (1996). Similarities and differences in the process of bereavement after suicide and after traffic fatalities in Slovenia. Omega 33 (3): 245-251.

Grad, O.T. and Zavasnik, A., 1998). The caregivers reactions after suicide of a patient. In Kosky, R.J., Eshkevari, H.S., Goldney, R.D. and Hassan, R. Eds) *Suicide prevention: the global context*. New York, Plenum Press.
Harwood D, Hawton K, Hope T & Jacoby R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: a descriptive and case-control study. Journal of Affective Disorders, 72, 185-194.

Hazell P, Hazell T, Waring T, Sly K. (1999). A survey of suicide prevention curricula taught in Australian universities.

Health Innovations Management Services. (2004). Report on Research Findings. Support for Families, Whanau and Significant Others Bereaved by Suicide http://www.myd.govt.nz/media/pdf/postvention-lit.pdf accessed 24/11/04.

Hendin H, Lipschitz A, Maltsberger JT, Pollinger Haas A & Wynecoop S. (2000). Therapists' reactions to patients' suicides. American Journal of Psychiatry 157(12): 2022-2027.

Hill K, Hawton K, Malmberg A & Simkin S. (1997). Bereavement information pack: for those bereaved by suicide and other sudden death. London, The Royal College of Psychiatrists.

Hodgkinson, P. (1987). Responding to in-patient suicide. *British Journal of Medical Psychology*. 60, 387-392.

International Association for Suicide Prevention. (2002). European Directory of suicide Survivor Services. Gondrin, France, International Association for Suicide Prevention

International Association for Suicide Prevention. (2004). World Suicide Prevention Day. Information Flier. Gondrin, France, International Association for Suicide Prevention.

Kalischuk R.G. & Hayes V. E. (2004). Grieving, mourning and healing following youth suicide: a focus on health and well being in families. Omega 48 (1), 45-67; 2003-2004.

Knieper AJ. (1999). The suicide survivor's grief and recovery. Suicide and Life Threatening Behavior 29(4), 353-364.

Leenars A & Wenckstern S. (1998). Principles of postvention: application to suicide and trauma in schools. Death Studies: 22; 357-391.

Living Links. (Undated). Constitution of Living Links, Ireland.

Maenpaa E. (2004). Finnish Representative at the 2003 Postvention Taskforce meeting of the International Association for Suicide Prevention. (Personal communication)

McIntosh, J.L. (1987). Survivor family relationships: Literature review. In Dunne, E.J., McIntosh J.L.and Dunne-Maxim, K Eds). *Suicide and its aftermath. Understanding and counselling the survivors*. New York, WW Norton and Co.

McIntosh, J.L. (1993). Control group studies of suicide survivors: a review and critique. *Suicide and Life Threatening Behavior*. 23, 146-161.

McNeil, D.E., Hatcher, C. and Reubin, R. (1988). Family survivors of suicide and accidental death: consequences for widows. *Suicide and Life Threatening Behavior.* 18, 2, 137-148.

McLennan, W (1999). An Introduction to Sample Surveys: A User's Guide. Australian Bureau of Statistics: Canberra.

Michel, K., Armson, S., Fleming, G., Rosenbauer, C. and Takahashi, Y. (1997). After suicide: who counsels the therapist?. Report from the workshop of the 29th Congress of the IASP. *Crisis*. 18, 3, 128-139.

Middleton, W. Burnett, P. Raphael, B. Martinek, N. (1996). The Bereavement response: a cluster analysis. *Brit J Psychiatry*.169, 167-171.

Mitchell AM, Kim Y, Prigerson HG & Mortimer-Stevens M. (2004). Complicated grief in survivors of suicide. Crisis 25(1): 12-18.

Murphy, S.A., Johnson, C., Cain, K., Gupta, A.D., Dimond, M., and Lohan, J. (1998). Broad spectrum group treatment for parents bereaved by violent deaths of their 12- to 28-year old children: A randomized controlled trial. *Death Studies*. 22, 209-235.

National Advisory Council on Youth Suicide Prevention. (2000.) Living is for Everyone. A Framework for the Prevention of suicide and self-harm in Australia. Canberra: Commonwealth Department of Health and Aged Care.

Ness, D.E. and Pfeffer, C.R. (1990) Sequelae of bereavement resulting from suicide. *American Journal of Psychiatry*. 143, 3, 279-285.

New South Wales Health Department. (2001). Postvention Guidelines Surrounding a Suicide Death. Sydney, New South Wales Health Department.

Parkes, C.M. (1998). Bereavement in adult life. *British Medical Journal* 316, 856-859.

Pfeffer C, Jiang H, Kakuma T, Hwang J and Metsch M. (2002). Group intervention for children bereaved by the suicide of a relative. *Journal of the American Academy of Child and Adolescent Psychiatry*, 41 (5): 505-513.

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

QSR International Pty Ltd (2002). NVivo qualitative data analysis program; Melbourne, Australia; QSR International Pty Ltd. Version2.

Range LM, Kovac SH & Marion MS. (2000). Does writing about the bereavement lessen grief following sudden, unintentional loss? Death Studies 24 (2): 115-134.

Roy A, Nielsen D, Rylander G, Sarchiapone M. (2000). The genetics of suicidal behaviour. In Hawton K, Heeringen K Eds) *Suicide and Attempted Suicide* UK, Wiley,.

Sanders, C. Risk factors in bereavement outcome. (1995). In Stroebe, M. Stroebe, W. and Hannson, R. *Handbook of Bereavement: Theory, Research and Intervention*. Pp 255-270.

Séguin, M., Lesage, A. and Kiely, M.C. (1995a). Parental bereavement after suicide and accident: a comparative study. *Suicide and Life-Threatening Behavior*. 25, 4, 489-498.

Séguin, M., Lesage, A. and Kiely, M.C. (1995b). History of early loss among a group of suicide survivors. *Crisis.* 16, 3, 121-125.

Shneidman E.S. (1972). Foreword. In A. Cain (Ed) Survivors of Suicide. Springfield, Illinios, Charles C. Thomas.

SPSS Inc. Version 11.0 for Windows. SPSS Inc. Headquarters, Chicago, Illinois.

Streufert B.(2004). Death on Campuses: common postvention strategies in higher education. Death Studies 28, 151-172.

Valente, S.M. and Saunders, J.M. (1993) Adolescent grief after suicide. *Crisis.* 14, 1, 16-46.

Van Dongen, C.J. (1991). Experiences of family members after a suicide. *Journal of Family Practice*. 33; 4, 375-380.

Van Dongen C. (1993). Social context of postsuicide bereavement. Death Studies, 17, 125-141.

Van der Wal, J. (1989). The aftermath of suicide: a review of empirical evidence. *Omega.* 20, 2, 149-171.

Wilson A., Clark, S. (2004). Desperate to tell: towards improving the care of people bereaved through suicide- a report of work in progress. Published in *RED Snapshots, March 2004, Issue 2: PHCRED-SA State Conference 2003 Proceedings.* www.phcred-sa.org.au/REDSnapshots.htm

Wilson A., Clark, S. (2004). Hidden or missing? Suicide postvention services: bereaved persons' perceptions of need. General Practice and Primary Health Care Conference. Sheraton Hotel, Brisbane, 2-4th June 2004.

Woof, W.R. and Carter, Y.H. (1997). The grieving adult and the general practitioner: a literature review in two parts part 2. *British Journal of General Practice*. 47, 509-514.

World Health Organisation (2000). Preventing Suicide: how to start a survivors group. Geneva, Department of Mental Health, World Health Organisation.