MANCHESTER 1824
The University of Manchester

Support After Suicide Partnership

FROM GRIEF TO HOPE

THE COLLECTIVE VOICE OF THOSE BEREAVED OR AFFECTED BY SUICIDE IN THE UK

REPORT 2020

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Members of the advisory group:

Professor Gillian Haddock, Professor Louis Appleby, Professor Nav Kapur (University of Manchester, UK) and Hamish Elvidge (Suppor After Suicide Partnership, UK)

Note of caution to those bereaved or affected by suicide

This report reflects the impact suicide bereavement has had on over 7,150 people in the UK. The results include statistics and direct quotations from those who participated in the survey, to add context. The aim of this report is to share the 'lived experience' of those bereaved by suicide to help inform policy and practice. Consequently, some of the content is graphic and may cause distress to readers. We therefore suggest that you be mindful of this prior to reading the report.

If reading this report causes you distress and you would like to talk to someone, you may find it helpful to get in touch with:

Survivors of Bereavement by Suicide (SOBS):
Helpline: 0300 11 5065 Monday to Friday 9am-9pm

Samaritans:
Helpline: 116 123 (24 hours)
Email: jo@samaritans.org (24 hours)

Cruse Bereavement Care:
Helpline: 0808 808 1677
Monday to Friday 9.30am-5pm
Tuesday, Wednesday & Thursday 9.30am-8pm
Weekends 10am-2pm

For a comprehensive list of support services please refer to the appendices on pages 63-65.

Contributors:

We would like to thank the advisory group for their guidance and expertise, Support After Suicide Partnership (SASP) and Sarah Bates at SASP. This report was only possible due to the contributions of over 7,150 people who were willing to share their experiences with us. We sincerely thank each person for completing the survey.

Acknowledgements:

Special thanks to all those who have helped raise awareness of the survey during the recruitment phase, including national organisations, government bodies, third sector organisations, and the media but especially: 'Team UK' on Twitter; Neville Southall, ex-professional football player and mental health campaigner; Madeleine Moon, former MP for Bridgend; and Lynne Neagle, member of the National Welsh Assembly. We would particularly like to acknowledge the staff and Trustees of Suicide Bereavement UK and If U Care Share Foundation (specifically Sam Hunter) for their dedication and support of this research. We would also like to thank Pennine Care NHS Foundation Trust for providing paper copies of the questionnaire and the Monument Trust for supporting the cost of launching the survey, design of the report, dissemination of the findings and travel expenses to attend team meetings. Thanks also to the Samaritans and Cruse Bereavement Care for supporting the launch of this report and to all those participants who allowed us to use their photos in this report.

Dedication:

This report is dedicated to all those who have been bereaved or affected by suicide, and to those who bravely completed the survey. We greatly value your courage in sharing this personal experience.

Hamish Elvidge – Founder and Chair, The Support After Suicide Partnership

The Support after Suicide Partnership (SASP) is delighted to collaborate with the University of Manchester in this pioneering research. I wanted to start with a heartfelt 'thank you' to each one of the 7,158 people, who responded to the survey and to Sharon McDonnell and her dedicated team of experts.

The Partnership represents 85 organisations, who provide suicide bereavement support across the UK. We were formed in 2013 and agreed a Vision that '*everyone bereaved or affected by suicide is offered timely and appropriate support*'. We decided that, to achieve our ambitious Vision, we needed to listen to the voices of people who have been impacted by suicide. So, we developed an initial, informal survey... but soon connected with the University of Manchester, who made this journey possible.

The results express a very poignant, personal and, often, devastating picture of the impact of suicide on the lives of families, colleagues and professionals... a picture that is very personal to me, after losing our son, Matthew, to suicide in 2009. This research will play a vital role in shaping both existing and new services... and make a huge, positive difference to the lives of so many people.

Professor Gillian Haddock – Head of Division of Psychology and Mental Health, University of Manchester

Each year 6,500 lives are lost to suicide in the UK. A large circle of people will be bereaved or affected by these individual tragedies, and the consequences can be life changing. From Grief to Hope attempts for the first time to give voice to the bereaved in the UK, to understand how suicide affects families, friends, colleagues, and professionals. The research aimed to gain an understanding of people's experiences and identify the kind of support that can make a difference. In recent years, great strides have been made in postvention support. Support after suicide can take many forms, and it is essential that a person-centred approach is taken to ensure individuals receive the right support, when they need it. The evidence presented in this report reflects the voices of over 7,150 people who have described the direction in which they would like to see services develop. Therefore, these findings can make a valuable contribution to shaping the future of postvention services.

FOREWORD

Professor Louis Appleby

Chair of the National Suicide Prevention Strategy Advisory Group

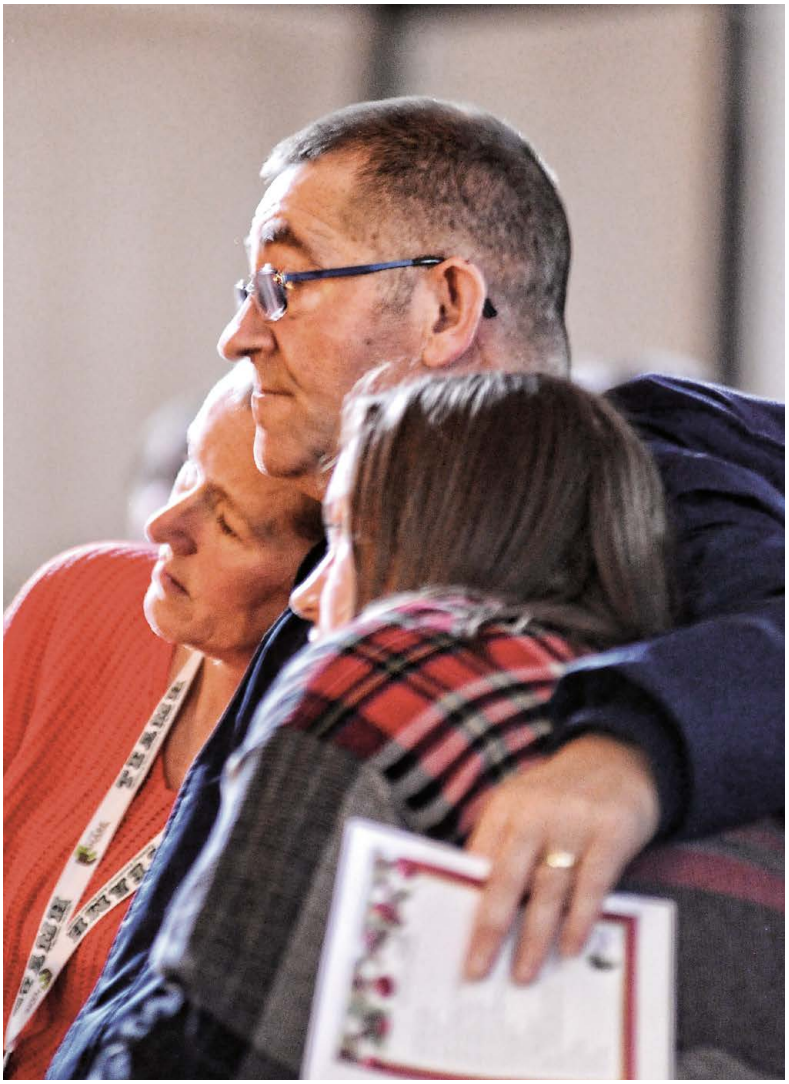
I have heard from many people bereaved by suicide and their determination to turn their tragic experience into something that helps others is inspiring. Their personal stories, their commitment, are the reasons the public and political profile of suicide is higher than it has been before. We also have to recognise how hard it has often been to find the understanding and the support they deserve. Suicide is often the culmination of a complex history of risk factors and distressing events. The impact on families, friends and communities is devastating and long-lasting. Those who are bereaved or affected by suicide are at a higher risk of dying by suicide themselves.

In 2012, the re-launched National Suicide Prevention Strategy for England listed six areas for action, including, for the first time, bereavement support. Yet, despite such calls to action, our understanding of how to help is far behind what is needed. In 2014, the University of Manchester and Support After Suicide Partnership (SASP) formed a collaboration to identify the experiences and perceived needs of those bereaved or affected by suicide.

The study has been led by Dr Sharon McDonnell, my colleague over many years, who has herself been bereaved by suicide. Dr McDonnell and her team have worked on this project for six years, in their spare time. The level of public engagement with the study has been unprecedented in this field, and as a direct result, over 7,150 people completed the survey, making it the largest suicide bereavement survey internationally.

The study is timely. The findings are powerful. They highlight the varied impact of suicide and the importance of a multi-agency approach. It offers insight, in particular, into the experiences and perspectives of previously under-researched populations, such as: children and friends of the person who has died, ethnic minorities; LGBTQ groups; men; and professionals. It identifies good practice and shows where as a society we need to improve. It will inform the work now being carried out by national and local government, with organisations across all sectors to help ensure that bereavement support is a reality. The evidence in this report is clear: those who experience suicide in their family, their social circle, their workplace require a timely, positive and co-ordinated response. Over 7,150 people have informed us of their needs on information, emotional and practical support. It is vital – literally – to listen to what they have to say.

"My experience of suicide is that it is the equivalent of a bomb going off in your living room while you're sitting watching telly. Afterwards you're astonished you're alive, but everything has changed and you have a million shards of glass embedded in your soul. Some of them are so big they fall out straight away leaving gaping wounds. But the little pieces, they can take decades to work their way up to the surface."



CONTENTS

1. EXECUTIVE SUMMARY

THE STUDY

Between September 2017 and August 2018, over 7,150 people across the UK completed an online survey about their experiences of being bereaved or affected by suicide. The study looks at the impact suicide had on these individuals, both at a personal and professional level. The study also looks at the experience of accessing support services and if it was considered helpful.

KEY FINDINGS

1. The impact of suicide

- 82% of respondents reported that the suicide had a major or moderate impact on their lives.
- A number of serious social adverse consequences were reported after experiencing a death by suicide. Examples included relationship break-up, unemployment and financial problems.
- A fifth reported poor or deteriorating physical health.
- Over a third reported mental health problems and this was particularly common for women.

2. High risk behaviours following a suicide

- Of 7,158 respondents, 543 (8%) reported self-harm. Of 5,056 respondents, 1,911 (38%) had considered taking their own life after the suicide and 382 (8%) had made an attempt (see glossary on page 59 for the definitions of self-harm and suicide attempt).
- Around a fifth engaged in other high risk behaviours following the death by suicide. The most common were substance misuse, irresponsible financial behaviours, sexual promiscuity and a lack of observance of road safety.
- These behaviours persisted long after the suicide had occurred; for example, more respondents engaged in high risk behaviours 12 months after the suicide.

3. Relationship to the deceased

- Participants experienced a range of adverse life events following the death of a spouse, child, parent, friend or colleague, and these varied depending on the relationship to the deceased.
- The most common relationship reported was the loss of a friend to suicide.
- Participants who lost friends were more likely to have experienced multiple suicides.
- Those who had lost friends often reported feelings of disenfranchised grief (also known as 'hidden grief' which is not fully acknowledged by others), isolation and being overlooked by services.

4. Accessing support

- Of 7,158 respondents, 60% did not access support following a suicide.
- Over a third did not know what types of services were available.
- Over a third had the support of family and friends and did not feel they needed additional help.
- People who accessed support did so from a wide range of sources such as GPs, NHS services, police, coroners, private sector counselling, online resources and charities.
- Of 4,621 respondents, 62% perceived provision of local suicide bereavement support to be inadequate.

5. Support requested by those bereaved or affected by suicide

- Participants bereaved or affected by suicide told us that immediate, proactive support was important. Some participants were not always ready to seek or receive this help, but they stated that information should be presented in an easily accessible format such as the 'Help is at Hand' support booklet, or an available person to contact for support when they were ready to receive it.
- After initial contact with agencies in the days and weeks following the death, participants indicated that ongoing follow-up support should be available with a specialist suicide bereavement support worker. Having access to support when they needed it was widely requested, with follow-up at 3, 6, 12 or 18 months after the suicide occurred.

RECOMMENDATIONS

Suicide prevention and, more recently, postvention support has increasingly become a government priority in the UK. The recommendations from our research build upon the current progress and set out to challenge stakeholders to ensure there is consistent quality of suicide bereavement support across all countries in the UK. We acknowledge that all nations and local governments will be at different stages of implementing postvention strategies; consequently, our recommendations offer both a universal and targeted approach to service improvement across the UK.

We recognise that implementation of the proposed recommendations requires significant commitment and collaboration from numerous organisations. Government departments, Local Authorities, key national stakeholders and third sector organisations will play a crucial role. We therefore propose that an independent advisory panel be established, connecting with existing national and local governance structures, which will include key stakeholders and experts to consider the proposed recommendations. The focus would be to agree priorities, roles and responsibilities and formulate an action plan to implement them.

1. **The implementation of national minimum standards in postvention services**

- A national set of minimum standards should be developed, building on existing guidelines, for organisations/agencies that come into contact with or are responsible for the care of those bereaved or affected by suicide.
- The approved standards should form the basis for establishing, delivering, measuring and evaluating all existing and new services across all four devolved nations.
- Those responsible for developing national postvention minimum standards across the UK should consider the empirical evidence from this study, which has identified the needs of people bereaved or affected by suicide (Appendix A).

2. **A national online resource for those bereaved or affected by suicide**

- Existing online resources should be further developed for those bereaved or affected by suicide, supported by all agencies, to provide a national comprehensive up-to-date directory of key resources with signposting to local support across the UK. Those responsible for building upon existing online resources should consider the empirical evidence from this study, which has identified the needs of those bereaved or affected by suicide (Appendix A).

3. **Campaign to raise awareness of the impact of suicide bereavement**

- A national campaign should be launched to raise awareness of the impact of suicide bereavement, the support and resources that are available and help reduce the stigma surrounding suicide.

4. **Suicide bereavement training for front line staff**

- Evidence-based suicide bereavement training should be mandatory for those who provide postvention services.
- Evidence-based suicide bereavement training is recommended for staff working in government funded services who are likely to come into contact with those bereaved or affected by suicide (e.g. health and social care, emergency services, prisons, transport/highways agencies and education); and relevant voluntary organisations.

5. **Support for people with risk taking behaviours**

- The provision of easily accessible long-term support, to help people bereaved or affected by suicide with complex needs who engage in high risk behaviours (e.g. self-harm and substance misuse), particularly young people.

6. **Workplace suicide bereavement support**

- Employers should have a suicide bereavement protocol in place to support workers who are bereaved or affected by suicide in a professional or personal capacity. This would include key government departments, who should seek to ensure that appropriate and timely support is offered to front line staff (e.g. ambulance staff, the police, prison officers and the fire service) who are exposed to suicide and those impacted.

7. **Further research on the impact of suicide**

- All UK governments and major research organisations should ring-fence funding to conduct suicide bereavement research.
- Key stakeholders, including those with lived experience, should co-produce a strategy to establish research priorities in the field of postvention.

WHAT THIS STUDY CANNOT TELL US

1. We cannot draw direct causal links between exposure to suicide and subsequent adverse social and health-related life events.
2. We cannot determine whether participants had existing premorbid conditions, e.g. self-harm, which were not attributed to the bereavement.
3. The findings are self-reported outcomes relating to suicide bereavement and do not represent all people bereaved by suicide.
4. We are unable to determine views from those aged under 18 years as they were ineligible to participate.

2. BACKGROUND

Each person lost to suicide is a personal tragedy. It is estimated that 800,000 die by suicide globally each year[1] with approximately 6,500 people taking their life in the UK in 2018.[2] Suicide occurs across all ages, genders and ethnic groups. The economic cost associated with each death by suicide in the UK has been estimated to be approximately £1.67 million per annum.[3]

Currently, our knowledge and understanding of effective postvention support is limited.[4] It is important to have a better understanding of what people find helpful in coping with their grief whilst recognising that there is no single approach that will meet the needs of each person who has lost someone to suicide.[4]

The research recommendations outlined in the NICE guidelines [5] called for the determination of the efficacy and cost effectiveness for interventions to support people bereaved or affected by a suicide. Therefore, future policy decisions on the direction of postvention services need to be evidence-informed (see Appendix B for current developments within the devolved nations).

This research aims to address this knowledge gap and inform and guide policy by making recommendations based on the collective voices of over 7,150 people bereaved or affected by suicide.

3. AIMS AND OBJECTIVES

The aims of the study were to:

- identify the impact a death by suicide has on those who are bereaved or affected by suicide
- identify the level of contact/support individuals receive from health professionals when bereaved by suicide
- explore how support for people bereaved or affected by suicide can be improved.

4. METHOD

The University of Manchester, in collaboration with Support After Suicide Partnership (SASP) have undertaken a national cross-sectional study examining the needs of people bereaved and/or affected by suicide. Data were collected between 26th Sept 2017 and 31st August 2018 via an anonymous online survey. The survey included questions on: demographic characteristics; details of the suicide, including timing and relationship of the participant to the deceased; features of the bereavement including adverse life events and high risk behaviours; and support, including views on support needs during the bereavement.

Participants were recruited by advertising and promoting the study on radio, TV, newspapers, social media, conferences, and by word of mouth. Participants were eligible for the survey if aged 18 and over, were resident in the UK, and perceived themselves as either bereaved or affected by suicide (see glossary on page 59 for definitions of being bereaved or affected by suicide).

The results are presented as frequencies and percentages. Sub-group comparisons were made using chi square tests, with statistical significance set at 0.05. We removed cases where data were not known for that item. The percentages shown, therefore, are based on the number of responders to each question. The number who provided responses will be shown for information. Open text boxes were provided in the survey to enable participants to elaborate on their answers. Content analysis was performed to identify the most frequently occurring themes. Quotations are presented verbatim from this free text information to add depth and context to these results. In line with the Samaritans reporting guidelines, we have not used the term 'committed suicide'. However, the term has occasionally been used in some of the original verbatim quotations where we respect the words of people directly impacted by suicide.

Ethical approval was received from the University of Manchester Research Governance and Ethics committee on 4th November 2016 (ref: 14432, Research Ethics Committee 3).

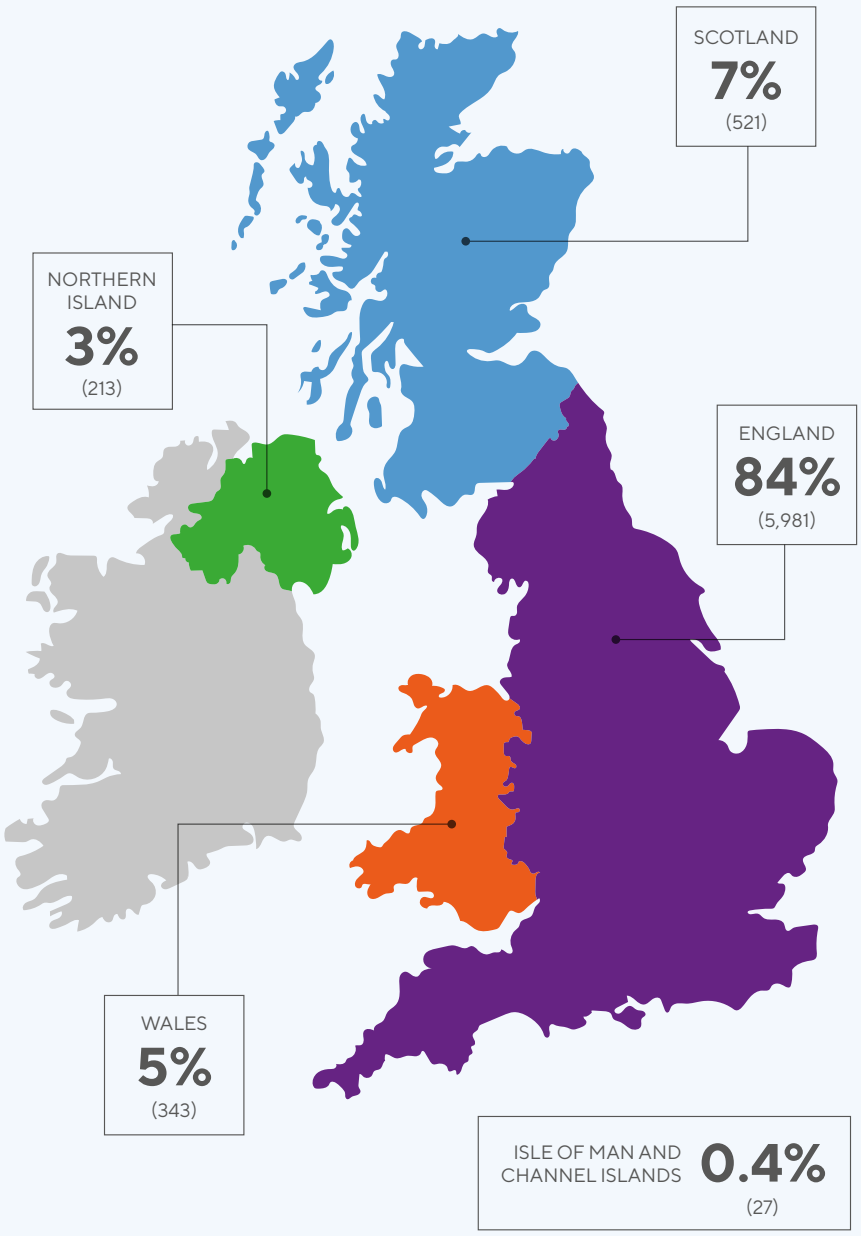
5. FINDINGS

9,744 people opened the online survey, 1,699 (17%) of whom did not continue to complete it. Of the remaining 8,045 who completed the survey, 887 (11%) were not included in the analysis due to significant missing data (n=630) or not meeting the eligibility criteria (i.e. being aged under 18 (n=64) or living outside of the UK (n=193). Our final sample comprised 7,158 people.

5.1 RESEARCH PARTICIPANTS

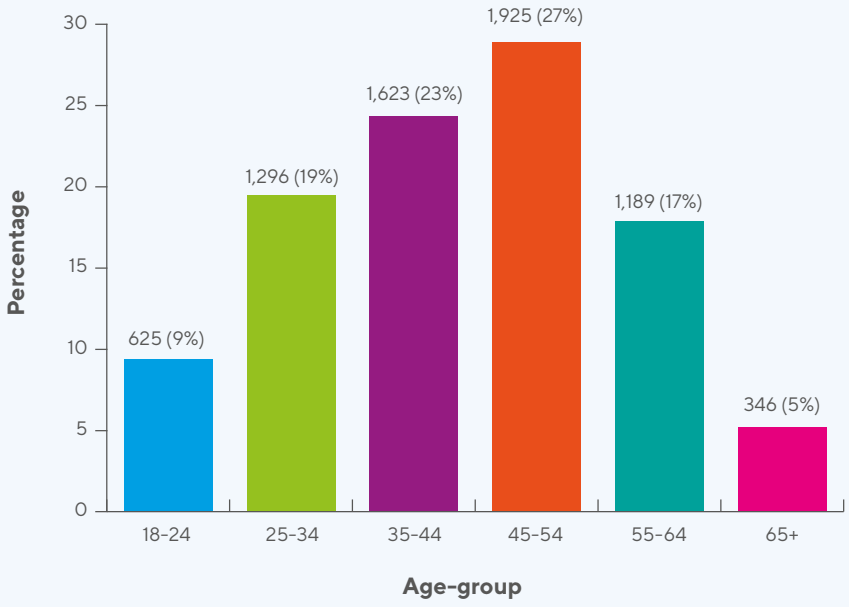
Figure 1 shows the proportion of participants by UK country. The majority (5,981, 84%) were from England. The proportions are consistent with the distribution of the UK population as reported in the 2011 census[6] suggesting none of the UK countries was overrepresented.

Figure 1: Participants by UK Country



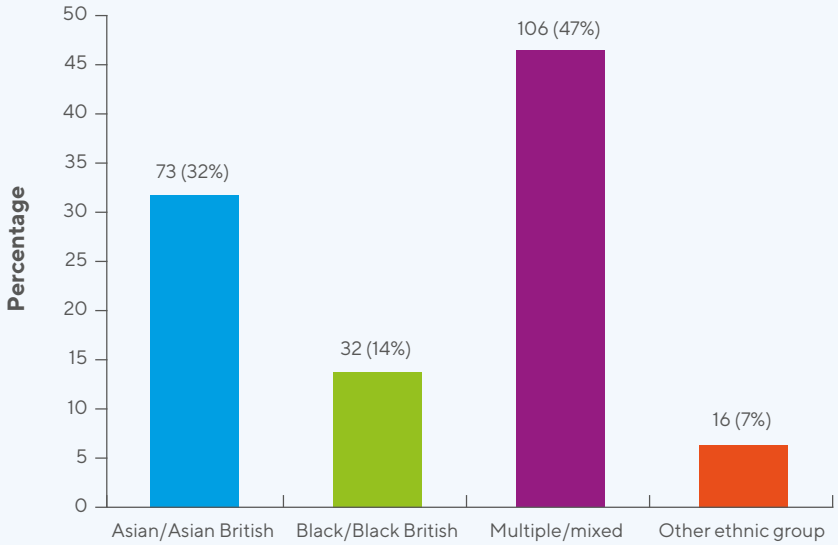
The majority were female (5,627, 79%), 1,519 (21%) were male and 11 (<1%) transgender. The median age of participants was 44 years (range 18-84); half were aged between 35 and 54 years (Figure 2).

Figure 2: Age distribution of participants



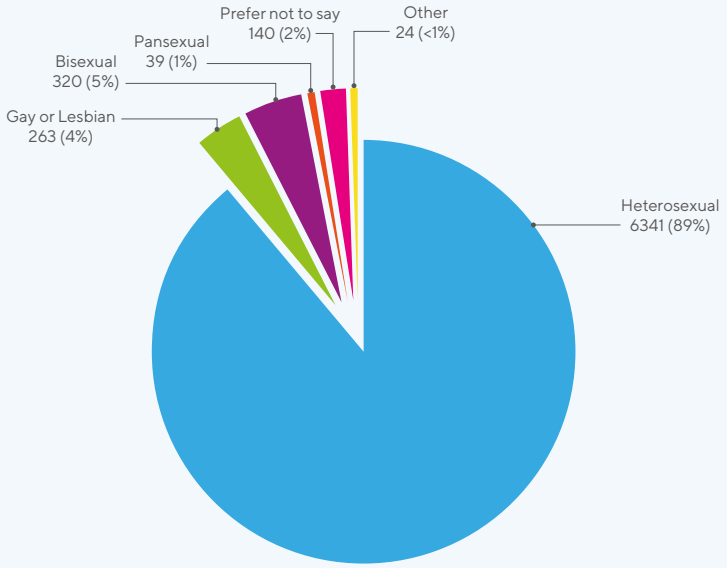
The majority (6,922, 97%) of respondents were White. There were 227 (3%) respondents from a Black, Asian and Minority Ethnic (BAME) group, nearly half of whom belonged to a multiple/mixed ethnic group and a third were Asian/Asian British (Figure 3). The proportion of participants from BAME groups was lower than the proportion of BAME groups in the UK population (3% v. 13%).[7] BAME participants were significantly younger than the White sample (median age 38 v. 44) with an age range of 18-72 years. Most were female (178, 78%).

Figure 3: Ethnicity of participants (excluding White)



The majority (89%) identified as heterosexual/straight (Figure 4). Those who identified as non-heterosexual were younger than heterosexual respondents (median age 33 v. 45). They were more likely to be male (29% v. 21%) and to live alone (23% v. 16%). Compared with other respondents, they were more likely to have experienced more than two suicides (22% v. 13%) and to have been bereaved or affected by the suicide of a friend (38% v. 17%).

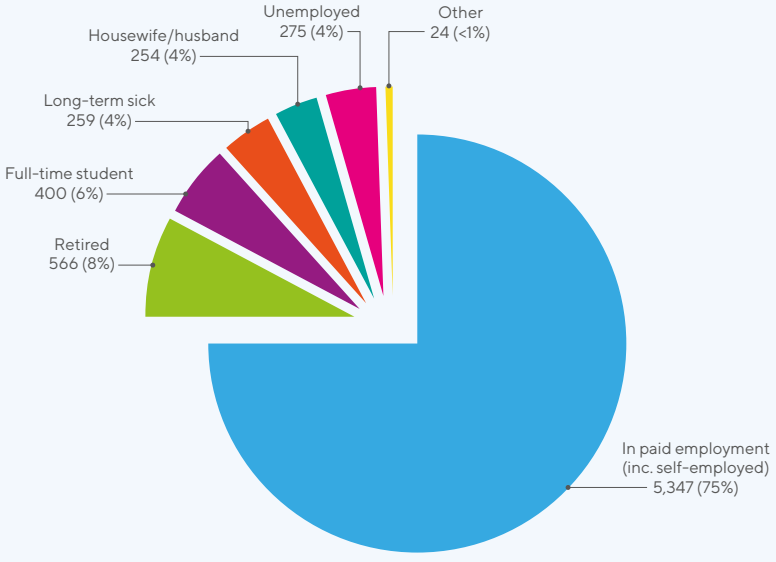
Figure 4: Sexual orientation of participants



Most (4,168, 59%) lived with a spouse/partner at the time of completing the survey; 1,204 (17%) lived alone. The majority (75%) were in full time employment or self-employed, and a similar proportion (4%) were either unemployed, on long-term sickness leave, or a housewife/husband (Figure 5). These figures reflect the UK labour market figures from ONS.[8]

Of the employed responders, 2,318 (43%) were categorised as professionals; 788 (15%) were managers, directors and senior officials; 698 (13%) were administrative and secretarial; and 691 (13%) were in caring and leisure occupations.

Figure 5: Employment status of participants



The ONS Standard Occupational Classification 2010 index[9] was used to categorise specific job titles provided by participants and these are presented in Table 1. The largest group of participants completing this survey were health professionals. This category included doctors, nurses, psychologists, pharmacists, ophthalmic opticians, dental practitioners, veterinarians, medical radiographers, podiatrists and other health professionals. This was closely followed by people working in administrative occupations such as civil servants and office workers.

Table 1: Occupational group of participants

Occupation	N	%
Health professionals	705	14
Administrative occupations	621	12
Caring personal services	535	11
Teaching and educational professionals	494	10
Corporate managers and directors	459	9
Business, media and public service professionals	444	9
Other managers and proprietors	232	5
Science, research, engineering and technology professionals	220	4
Health and social care associate professionals	209	4
Business and public service associate professionals	177	3
Protective service occupations	156	3
Sales occupations	150	3
Culture, media and sports occupations	141	3
Secretarial and related occupations	90	2
Elementary administration and service occupations	89	2
Leisure, travel and related personal service occupations	84	2
Customer service occupations	72	1
Science, engineering and technology associate professionals	42	1
Textiles, printing and other skilled trades	37	1
Skilled construction and building trades	36	1
Transport and mobile machine drivers and operatives	32	1
Skilled metal, electrical and electronic trades	25	<1
Process, plant and machine operatives	24	<1
Skilled agricultural and related trades	11	<1

OCCUPATIONS OF THOSE WHO PARTICIPATED IN THE STUDY

Academic Account Executive Accountant Accounts Clerk Accounts Manager Acoustic Consultant Activities Coordinator Actor Actress Actuary Acupuncturist Addiction Worker Addictions Nurse Admin Assistant Administration Administration Asylum Immigration Department MOJ Administration Coordinator Administration Manager Administration Officer Administration supervisor Administration Support Administrative Secretary Admiral Nurse Admissions Officer Administrator of Local Credit Union Adult Care Services Commissioning Adult Social Care Advanced Clinical Practitioner Advanced Nurse Practitioner for Mental Health Advanced Practitioner Nurse Advertising Advertising Creative Advertising Executive Advertising Strategist Advice Worker Advocacy Administrator Advocate Advocate for Divorced Clergy Wives After Dinner Public Speaker Agency Staff Nurse Agricultural Adviser Aid Worker Air Cabin Crew Aircraft Fitter Aircraft Maintenance Aircraft Systems Consultant Airline Airport Fuel Depot Manager Alternative Therapist Ambulance Paramedic Ambulance Technician Anaesthetist Analyst Anatomical Pathology Technician Antenatal Teacher Anti Social behaviour Case Worker Antiques Dealer Apprentice Bench Joiner Apprentice electrician Apprentice Engineer Apprentice Machine Tool Maintenance Apprenticeship Assessor Approved Mental Health Practioner Approved Mental Health Professional Aquarist Architect Architect Assistant Architectural Technician Archive Assistant Archivist Area Development Area Housing Officer Area Manager Area Manager Retail Area Sales Manager Area Services Manager Armed Forces Army Dental Nurse Army Officer Army Warrant Officer Art Restoration Assistant Art teacher Art Therapist Artist Artistic Director Arts Marketing Arts Worker Assessor Assistant Accountant Assistant Accounts Manager Assistant Bank Manager Assistant Building Manager Assistant Commercial Finance Manager Assistant Co-ordinator Assistant Director of Nursing Assistant Headteacher Assistant Manager Assistant Playworker Assistant Practitioner Assistant Psychologist Assistant Retail Manager Associate Casting Director Associate Director (University) Associate Director of Communications Associate Director, Market Research Associate Professor Asssment Administrator Attendance Support Worker Audit Manager Auditor Author Autism Specialist Teacher Auxiliary Nurse Aviation Security Officer Award Co-ordinator Baker Bakery manager Bank Call Centre Employee Bank Employee Bank Manager Bank Official Bank Support Worker Bank Treasurer Banker Banking Consultant Banking Quality Assurance Tester Bar Manager Bar Staff Barber Barista Barmaid Barrister Barristers' Clerk Bathroom Fitter BBC Commissioning Editor Beautician Beauty Therapist Beer Fermentation/Maturation Operator Behaviour Change Worker Behaviour Intervention Key Worker Benefit Officer Bereavement Counsellor Bereavement Specialist Nurse Bereavement Support Worker Bid Manager Bid Writer Biomedical Scientist Book Keeper Book Publisher Book Seller Bookings 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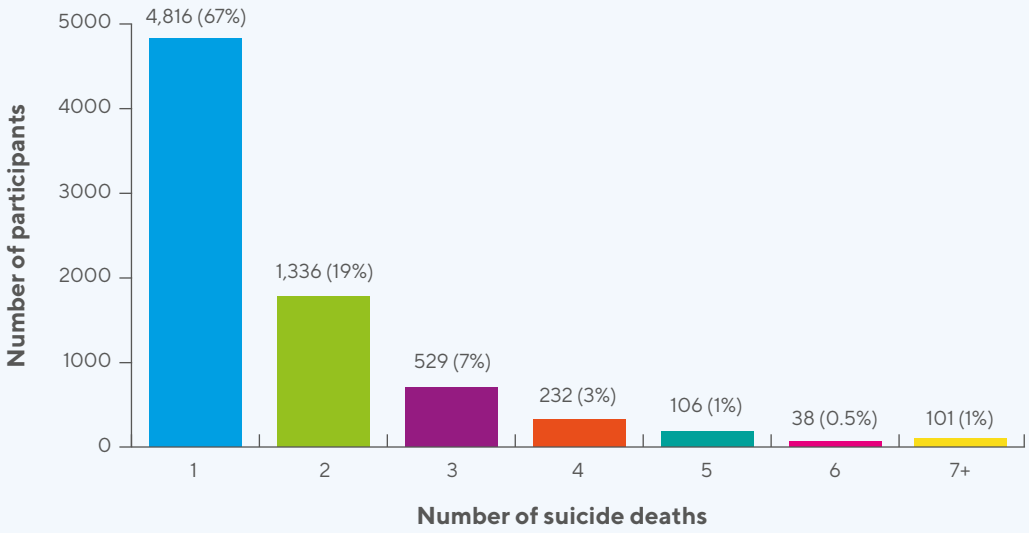
Crime Contact officer Crime Scene Examiner Crisis Intervention Counsellor Crisis Team Support Worker Critical Care Nurse Culture and Employee Engagement Execution Lead Curate Curator Curriculum Manager Customer Analyst Customer Experience Executive Customer Experience Manager Customer Operations Customer Relationship Manager Customer Service - Call Centre Customer Service Advisor Customer Service and Sales Customer Service Manager Customer Service Operative Customer Services Team Leader Customer Support Manager Cycle Trainer Cycling Ambassador Dance Teacher Data Administrator Data Analyst Data Assistant at a High School Data Centre Computer Operator Data Co-ordinator Data Manager Data Scientist Day Care Manager Debt Collector Debt Worker Decorator Degree Apprentice Site Engineer Delivery Driver Dementia Navigator Dental Nurse Dental Practice Manager Dental Receptionist Dental Surgeon Dentist Department Manager Depot Manager Deputy Administration Manager Deputy Chief Executive Deputy Chief Officer Deputy Designated Officer Deputy Director Quality Transformation Deputy Head of Patient Experience Deputy Head Teacher Deputy Manager of a Care Home Deputy Mortuary Manager Deputy Principal Operating Department Practicioner Derivatives Trader Design Company Director Design Consultant Design Management Consultant Design Manager Designer Detective Constable Development and Communications Manager Development Company Director Development Manager Development Worker DevOps Engineer Diagnostic Radiographer Diagnostics Account Manager Diagnostics Administrator Dietetic Assistant Dietitian Digital 3D Character Designer Digital Content Executive Digital Content Marketing Digital Content Writer Digital Health Consultant Digital marketing and Copy Writing Digital Marketing Apprentice Digital Marketing Manager Digital Producer Digital Product Manager Digital Trading Assistant Digital Transformation Project Officer Dinner Lady Director Director Farm Shop Director of Operations Director of a charity Director of a Community Interest Company Director of a Digital Agency Director of a Management Consultancy business and life coach Director of a School Director of Admin Director of an Arts Organisation Director of Business Management Director of Early Intervention and Prevention Director of Family Business Director of Human Resources Director of Learning and Teaching Director of Marketing Director of Online Counselling and Support Service for Children & Young People Director of Public Health Director of Training Director University Director, Veterans Healthcare Disability and Inclusive Services Co-ordinator Disability Benefit Adviser Disability Employment Advisor Discharge Facilitator NHS Discharge & Bed Flow Coordinator Dispenser at Pharmacy District Councillor District Manager of Children's Centres District Nurse District Nursing Sister Doctor Doctoral Researcher Documentary Maker [television] Dog Groomer Domestic Doula Drainage Engineer Drug and Alcohol Recovery Worker Dry Cleaning Assistant Duty Manager Duty Manager Ambulance Clinical Hub Duty Reliability Manager Early Years Practitioner Ecological Consultant Ecologist Editor Editorial Assistant Education Education Advisor Education Advocate Education Consultant Education Manager Education Officer Education Safeguarding Officer Education Support Staff Education Welfare Officer Educational Administrator Educational Provision Planning Analyst Educational Psychologist Educational Visits Co-ordinator and Information Management Educator Elected Representative, NI Govt Electrical Contractor Electrical Installer Electrical Maintenance Engineer Electrical Planner Electricians Mate Emergency Call Handler Emergency Department Nurse Emergency Healthcare Quality Improvement Emergency Medical Technician Emergency Planning Lead for Health Employability Development Officer Employee Benefits Consultant Employee Relations Senior Manager Employee Wellbeing Consultant Employment and Training Consultant Employment Specialist End Point Assessor Energy and Service Manager Energy Assessor Engagement Officer Engineer Engineering Consultant Engineering Manager Enhanced Teaching Assistant Enquiries Officer Enterprise and Funding Officer Enterprise Support and Investment Entertainer Environment Officer Environmental Consultant Environmental Educator Environmental Management System Co-ordinator Environmental Regulator Environmental Scientist Epidemiologist Equalities Employment Officer Equity Release Adviser Ergonomist Escort Estate Agent Estate Maintenance Worker Estate Manager Estate Services Estates Officer Event Manager Events Administrator Events Assistant Events Intern Events Venues and Tenancies Manager Examinations Officer Executive Assistant Executive Personal Assistant Executive Secretary Exercise and Health Trainer Fabricator Welder Facilities and Health and Safety Co-ordinator Facilities Supervisor Factory Clean Room Operative Factory Worker Family Group Conference Co-ordinator Family Liasion Support Worker Family Psychotherapist Family Resource Worker Family Support Worker Farmer Farmers Wife Fashion Designer Fashion Retail Fast Food Duty Manager Festival Director Film and TV Producer Film Editor Film Maker Finance Finance Administrator Finance Assistant Finance Broker Finance Controller Finance Director Finance Manager Financial Adviser Financial Capability Team Leader Financial Planner Financial Risk Consultant Financial Services Consultant Financial Services Steward Florist Food and Beverage Manager Football Coach Footballer Forecast Analyst Fraud Investigator Freelance Freelance Administrator Freelance Consultant Freelance Professional Freelance Risk Management Consultant Freelance Translator Freelance Writer Communications Assistant Fundraising Manager Funeral Administrator Funeral Arranger Education Tutor Futures and Options Trader Gallery Technician Garage Owner Garden Credit Manager for an Oil and Gas Company Global Head of Marketing Global Sales Manager Graduate Housing Trainee Grants Co-ordinator Grants Officer Graphic Designer Grocery Manager Gunsmith Gym Instructor Hair Stylist Haulage Contractor Head of Nursing Children's Services Local Authority Head of Clinical Governance and Clinical Risk Head of and Childcare Head of Enterprise Sales Head of Funding Policy Implementation for Apprenticeships Head of Fundraising Head of Healthcare HMP Head of Informatics Strategy Head of Internal Audit Head of Marketing Head of Mortgage Credit Risk Head of Nursing Head Of Operations Head of Patient Experience Head of Pricing Head of Procurement Head of Research Head of Safeguarding Head of School Head of Security Head of Service Children's Social Care Head of Transport Head Receptionist Health Visitor and Family Planning Nurse Health Adviser Health and Safety Manager Health and Safety Advisor Health and Safety Consultant Health and Safety Manager Health and Social Care Co-ordinator Health and Social Care Lecturer Health Benefits Consultant Health Care Aid Health Care Assistant Health Care Coordinator Health Care Support Worker Health Education Tutor Health Improvement Lead (Public Health) Health Improvement Senior Health Practitioner Health Product Specialist Health Promotion Advisor Health Psychologist Health Researcher Health Safety and Environmental Manager Health Service Clinical Lead Health Service Manager Health Trainer Lead Health Visitor Health Worker Healthcare Administrator Healthcare Assistant Healthcare Consultant Healthcare Manager Healthcare Regulation Heating Engineer Help Desk Operator Herbalist HGV Driver High School Librarian Higher Education Lecturer Higher Education Manager Higher Level Teaching Assistant Historian HM Diplomatic Service HM Prison Officer HM Prison Service Senior Leader - Governing Governor Holiday Company Worker Holocaust Education Officer Home Carer Home Tutor Homecare Worker Homeless Project Manager Homelessness Case Worker Homemaker Horse Management and Training Horse-Racing Handicapper/Analyst/Writer Horticultural Trainer Hospice Doctor Hospital Administrator Hospital Chaplain Hospital Consultant Hospital Doctor (Emergency Medicine Consultant) Hospital Junior Doctor Hospital Pharmacy Technician Hospital Porter Hospitality Hotel Assistant Hotel Manager Hotelier House Keeper House Manager House Tutor Housekeeper Housekeeping Assistant Housewife Housing Adviser Housing Assistant Housing Association Director Housing Association Worker Housing Benefit and Council Tax Assessor Housing Management Worker Housing Manager Housing Officer Housing Related Support Worker HR HR Administrator HR Adviser HR Assistant HR Business Partner HR Consultant HR Director HR Manager HR Officer HR Partner HR Professional HR Systems Manager HRT Compounder Human Resource Analyst Human Resource manager Human Resources Human Resources Advisor Human Resources Director Humanist Funeral Celebrant Hyperbaric Rescue Manager Hypnotherapist Illustrator Imaging Assistant Immunising Nurse Implementation Consultant Import Clerk Import Merchandiser Industrial Door Engineer Industrial Modelmaker Information and Library Assistant Information, Advice and Support Services Information; Communications Technology Manager Insight Director Insolvency Practitioner Insurance Assessor Insurance Broker Insurance Claims Assesor Insurance Clerk Insurance Manager Integration Lead International Officer International Tax Advisor Interpreter Interpreter and Note-Taker Investigations Manager Investigator Investment Analyst Investment Manager Investor Platform Analyst Invigilator IT Consultant Legal Sector IT Sales IT Security Manager Jewellery Maker Joiner Journalist Judge Kennel Manager Key Account Manager Kitchen Assistant Kitchen Porter Lab Technician Laboratory Analyst Laboratory Manager Labourer Landlady Laundry Assistant Lawyer Lead Business Development Officer Lead Peer Educator Leadership Coach Learner Support Adviser Learning and Development Coach Learning and Development Consultant Learning and Development Officer Learning and Professional Development Officer Learning Mentor Learning Support Assistant Learning Support Tutor Learning Technologist Lecturer Lecturer in Fine Art, Artist Legal Assistant Legal Cashier Legal Clerk Legal Consultant Legal Recruitment Consultant Legal Secretary Legal Support Manager Leisure Attendant Leisure Centre Manager LG Pensions Administrator Librarian Library Information PCV DPCV PCVOfficer Life Coach Lifeguard Lived Experience Practitioner Lobbyist Local Authority Commissioner Local Government Business Support Officer Local Government Commissioning Manager Local Government Consultation and Research Officer Local Government Ecologist Local Government Manager Local Government Property Manager Logistics and Export Administrator Logistics Co-Ordinator Logistics Manager Long-term sick Lorry Driver Lunch Time Supervisor Machine Operator Macmillan Nurse Magistrate Maintenance Engineer Maintenance Fitter Maintenance Manager Major Incident Response Team Manager Make Up Artist Management Information Analyst Marketing Marriage Registrar Martial Arts Instructor Matron Mechanic Mechanical Engineer Media Company Owner Medical Complaints Officer Medical Data Analyst Medical Laboratory Assistant Medical Receptionist Medical Records Medical Researcher Medical Sales Medical Secretary Medical Sonographer Meetings Coordinator Membership and Engagement Co-ordinator Membership Officer Mental Health Commissioner Mental Health Facilitator Mental Health Immersive Technologies Creator Mental Health Link Worker Mental Health Nurse Mentor Mentor Metal Finisher Midday Assistant Midday Supervisory Assistant Midwife Milkman Mindfulness Teacher Minister of Religion Minster of Defence Model Money and Housing Adviser Mortgage Advisor Mortgage Broker Mortgage Consultant Team Manager Mortgage Team Manager Mortuary Technician MP Multiple Sales Executive Museum Curator Museum Digital Officer Museum Learning Manager Museum Retail Music Manager Music Teacher Musician Nanny Naturopathic Practitioner Navigator Developer Navy Navy Neonatal Nurse Network Rail Operative NHS Admin NHS Allied Professional NHS Chief Executive NHS Clinicial Commissioning Night Porter Nursery Manager Nursery Nurse Nursery Practitioner Nursery Room Leader Nursery Teacher Occupational Therapist Occupational Therapy Assistant Odds Compiler Office Administrator Office Manager Ofsted Children's Social Care Inspector Ofsted Inspector Oil and Gas Manager and Special Constable Ombudsman Online Sales Online Teacher Operational Analyst Operational Area Manager Operational Manager Operational Support Grade Operations Director Operations Manager Optical Assistant Optical Lab Technician Optometrist Order Analyst Orthodontic Therapist Osteopath Osteopath Receptionist Outreach Manager Outreach Worker Overhead Line Engineer Paediatric Nurse Paint Sprayer Painter and Decorator Palliative and Bereavement Counsellor Palliative Care Clinical Nurse Specialist Panel Beater Paralegal Paramedic Paramedic Manager Paraplanner Paratrooper Parenting Practitioner Park Ranger Parkinson's Specialist Nurse Parliamentary Advisor Parliamentary Assistant Parliamentary Researcher. Passsenger Carrying Vehicle Driver Pastor Pastoral Manager Patient Care Advisor Patient Services Assistant Patternmaker Payroll Administrator Payroll and Benefits Manager Payroll Officer Peer Recovery College Trainer Pensions Actuary Pensions Advisor Performance Manager Performer Peripatetic Music Teacher Personal Assistant Personal Development Leader Personal Health Budget Advisor Personal Shopper Personal Trainer Personnel Clerk Personnel Officer Pharmaceutical Manager Pharmaceutical Sterile Specialist Pharmaceutical supervisor Pharmacist Pharmacy Assistant Pharmacy Dispenser Pharmacy Health Care Assistant Pharmacy Technician PhD student Phlebotomist Photographer Physiotherapist Physician Physician Associate Physicist Physiotherapist Piano Teacher Picture Framer Pilot Planning Administration Planning Consultant Planning Engineer Planning Policy Officer Planning Technician Plasterer Play Development Worker Play Therapist Playgroup Assistant Playworker Playwriter Plumber Podiatrist Poet Police Civilian Staff Police Community Support Officer Police Computer Systems Trainer Police Constable Police Control Room Supervisor Police Officer Police Officer Detective Inspector Police Psychologist Police Senior Coroners Officer Police Sergeant Policy Adviser Policy Analyst Policy and Public Affairs Manager Policy and Research Intern Policy Manager Policy Officer Political Consulting Agency Intern Porter Portfolio Management Post Man Post Office Clerk Post Room Supervisor Post-Doctoral Researcher Potter Powder Coat Painter Practice Manager of a Complimentary Holistic Health Practice Presbyterian Minister in the Church of Scotland Pre-school Assistant Pre-school Teacher Press Manager Press Officer Priest Print Operator Printer Printing Hand Finish Operator Prison Administrative Officer Prison Administrator Prison Governor Prison Manager Prison Nurse Prison Officer Prison Policy Advisor Prison Service Manager Prisoner Custody Officer Private Equity Investor Probation Officer Process Engineer Process Food Technologist Procurement Category Manager Procurement Specialist Producer for Digital/Radio/TV Product Manager Product Owner Technology Product Specialist Production Administrator Production Assistant Production Coordinator Production Operative Production Planner Production Team Leader Professional Driver Professional Vocalist Professor Progress Support Assistant Project Analyst Project Coordinator Project Lead Project officer Proofreader Property Developer Property Landlord Property Manager Proposition Manager Prosthetics Technician Psychiatric Liaison Nurse Psychiatrist Psychological Wellbeing Practitioner Psychologist Psychological Therapist Psychological Wellbeing Practitioner Psychotherapist Pub Assistant Manager Public Authority Chair Public Health Officer Public Servant Publican Publicist Publisher Pupil Support Assistant Purchasing Assistant Quality Analyst Quality Assurance Auditor Quality Assurance Manager Quality Assurance Technician Quality Control Quality Control Analytical Chemist Quality Engineer Quality Health Safety and Environmental Advisor Quality Improvement Lead Quantity Surveyor Rabbi Radio Presenter Radiographer Radiotherapy Dosimetrist RAF RAF Pilot Railway Director Railway Head Supervisor Railway Site Supervisor Railway Technician Railway Track Maintenance Manager Railways Manager Record Label Worker Record Shop Manager Recovery College Manager Recovery College Worker Recovery Group Worker Recovery Worker Recruiter Recruitment Advisor Recruitment Agency Manager Recruitment Manager Recruitment Operations Manager Recruitment Resourcer Reflexologist Regional Sales Manager Registered General Nurse Registered Learning Disability Nurse Registered Mental Health Nurse Registrar of Births, Deaths and Marriages Regulator Regulatory Liaison Manager Rehabilitation Worker for Vision Impaired Relationship Sexual Health and Parenting Worker Remedial Massage and Pilates Instructor Rent Services Manager Rescue Worker Research Analyst Research and Development Officer Research Associate Research Fellow Research Finance Support Officer Research Manager Researcher Resident Liaison Coordinator Residential Care Manager Respiratory Nurse Restaurant Manager Restaurant Owner Retail Retail Assistant Retail Consultant Retail Makeup Artist Retail Manager Retired Revenue and Customs Officer Revenue Controller Reward Analyst Rigger Risk Manager Road Worker Roofer Room Attendant Rope Access Technician Safeguarding Officer Safety and Security Specialist Sales and Events Director Sales and Marketing Assistant Sales Assistant Sales Director Sales Manager Sales Representative Salon Owner Scaffolder School Bursar School Business Manager School Chaplain School Clerical Assistant School Computing Technician School Cook School Crossing Patrol School Nurse School Secretary School Support Staff Scientist Scottish Court Service Screenwriter Script Supervisor for Film and Television Scuba Instructor Seafarer Senior Anatomical Pathology Technician Senior Content Designer Senior Contracts Manager Senior Data Analyst Senior Examinations Officer Senior Health Care Assistant Senior Human Resource Business Partner Senior Information and Communications Officer Senior Lecturer Senior Operations Manager Senior Strategy Advisor Senior Teaching Assistant Server in a Brewery Service Desk Coordinator Sexual Health Nurse Sexual Offences Forensic Medical Examiner Shipping Operator for a Commodity Trader Shopkeeper Signage Site Manager SM specialist Snooker and Pool Table Fitting Social Care Assessor Social Care Assistant Social Care Commissioner Social Worker Software Engineer Soldier Solicitor Sound Engineer Sound Recordist Sous chef Special Educational Needs Teacher Special Educational Needs Teaching Assistant Specialist Community Public Health Nurse Specialist Foster Carer Specialist Mentor Autistic Spectrum Disorder Speech and Language Therapist Speech and Drama Teacher Sport Development Manager Sports Massage Therapist Stage Hand Steel Works Manager Stores Person Student Student Nurse Student Veterinary Nurse Students' Union Advice Centre Manager Subeditor Substance Misuse Practitioner Substance Misuse Worker Suicide Bereavement Liaison Worker Suicide Bereavement Project Worker Suicide Bereavement Support Service Coordinator Suicide Bereavement Support Worker Suicide Prevention Advisor Suicide Prevention and Training Co Ordinator Supermarket Worker Swimming Instructor System Integrator Manager Talent Coordinator (HR and Events) Tattoo Designer Tax Adviser Taxi Dispatcher Taxi Driver Teacher Teaching Assistant Technical Machine Operator Technical Writer Technician Telecommunications Engineer Telephone Agent Telephonist Switchboard Operator Telesales Terminal Controller Textile Designer Theatre Health Care Assistant Theatre Producer Therapist Thermal Engineer Ticket Office Administrator Ticketing Manager Touch Screen Operator Tour Guide Tourism Sector Tourist Guide Town Planner Trade Analysis Trade Union Activist Trade Union Organiser Train Driver Train Guard Trainer Translator Transport Department Manager Transport Planner Trauma Nurse Specialist Travel Administrator Travel Agent Tree Surgeon Trust Administrator Trust Business Manager Tutor TV Advertising TV Cameraman TV Executive TV Producer TV Production Tyre Fitter UK Athletics Running Coach Undertaker Unemployed University Administrator University Admissions Officer University Counsellor University Director of Sport University Information Assistant User Experience Designer Vessel Traffic System Supervisor Vet Consult Assistant Veteran Veterinary Nurse Veterinary Practice Manager Veterinary Receptionist Veterinary Surgeon Vicar Video Editor Videographer Virologist Virtual Assistant Visitor Services - Art Gallery/Cinema Visitor Services at a Museum Voice Over Artist Voluntary Sector Volunteer Coordinator Volunteer Counsellor Volunteer Manager Waiter Waitress Walking Guide Ward Manager Warehouse Assistant Warehouse Assistant Manager Warehouse Manager Warehouse Operative Web Developer Wedding Planner Welder Welfare and Community Sabbatical Officer Welsh Government Window Cleaner Windscreen fitter Witness Care Officer Writer Yoga Instructor Young Carers Manager Youth Crime Prevention Practitioner Youth Justice Worker Youth Worker

5.2 FREQUENCY OF BEING BEREAVED OR AFFECTED BY SUICIDE

Two thirds (67%) of respondents reported being bereaved or affected by one single suicide (Figure 6). A third (33%) had experienced a death by suicide in their personal and/or professional life more than once; the range was between 1 and 70 deaths, with the higher number experienced by professionals. Participants from Northern Ireland were more likely than other UK participants to have experienced more than one suicide (44% v. 32%).

Of the 477 (7%) respondents who had experienced between four and 70 deaths by suicide, the most common occupations were health professionals (99, 26%), caring personal services (i.e. care workers, nursing auxiliaries and assistants; 43, 11%) and protective services (i.e. police, firefighters, prison officers; 35, 9%). The occupation with the highest exposure to suicide was crime scene examiner.

Figure 6: Number of suicide deaths experienced by participants



Multiple suicides were not only experienced by professionals; 40% of those who experienced more than four deaths worked in non-professional occupations such as caring and leisure services and administrative roles.

A male participant who had personally experienced six deaths by suicide said:

"A close friend committed suicide in [year] after we were out drinking all weekend. I carried the guilt for a long time. An ex-girlfriend did it in [year], I thought I could save her from herself. A cousin did it and I commented the last time I saw him that his eyes showed so much pain. A lad I was helping get clean sober did it in February [...]. Then we had two close family friend's sons commit suicide in the same weekend. The pain for family and friends was awful."

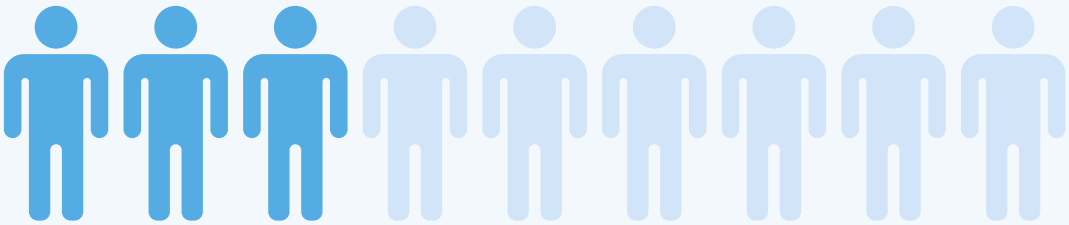
[ID: 6336]

One male participant who experienced the deaths of two family members stated:
"The death of my nephew by suicide [...] led to a deterioration in the mental health of my wife. Three weeks following his death, my wife also took her own life. Both suffered from their own quite different mental health issues [...]. I feel that perhaps had she been marked as 'at risk' and help been made available, the trigger could have been avoided."

[ID: 9622]

33%

of participants had been bereaved or affected by **more than one suicide**



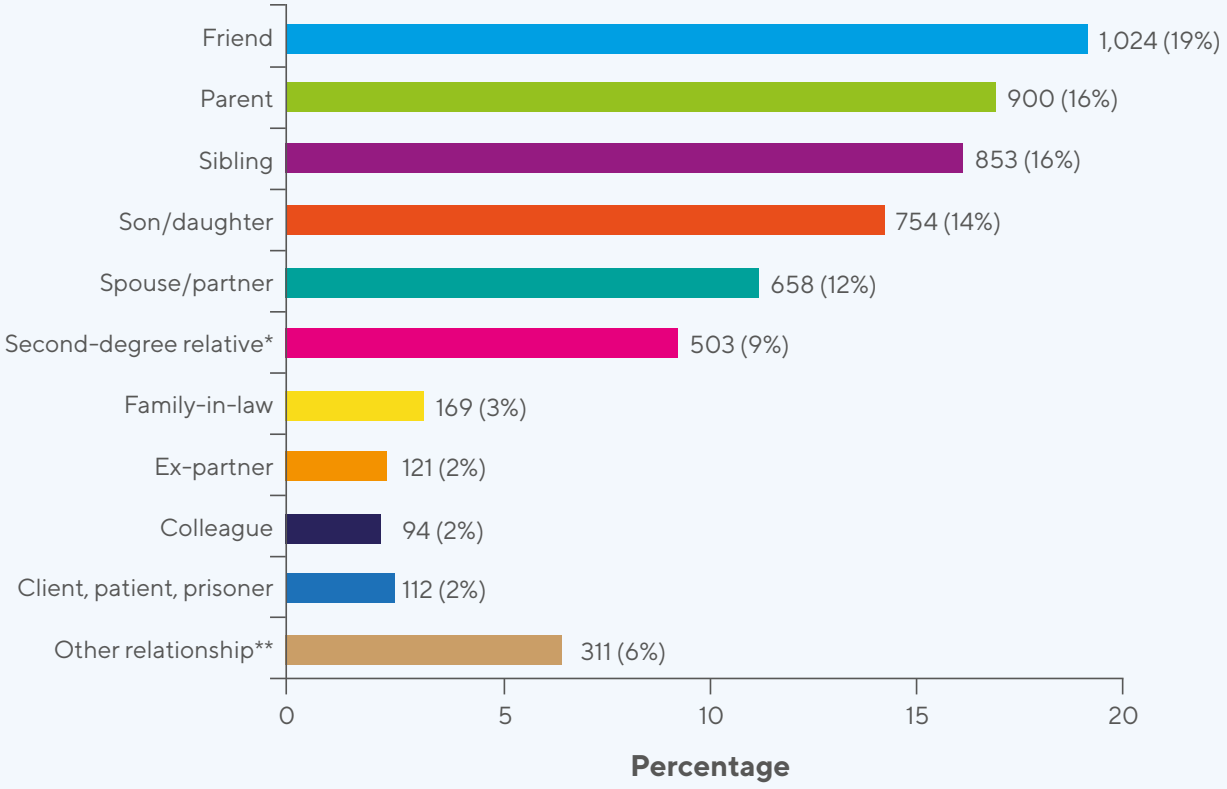
5.3 EXPERIENCES RELATING TO ONE SIGNIFICANT DEATH

Participants were asked to provide information relating to one significant suicide they had experienced. The following section refers to the death of this significant person.

5.3.1 RELATIONSHIP TO THE PERSON WHO DIED BY SUICIDE

In total, 5,499 participants provided information on their relationship to the one significant person who had died by suicide (Figure 7). The most common relationship was the death of a friend (19%), followed by a parent (16%), sibling (16%) or a son/daughter (14%). There were 206 (4%) respondents who reported the significant death to be someone known through their occupation (i.e. a colleague or client).

Figure 7: Relationship to the deceased



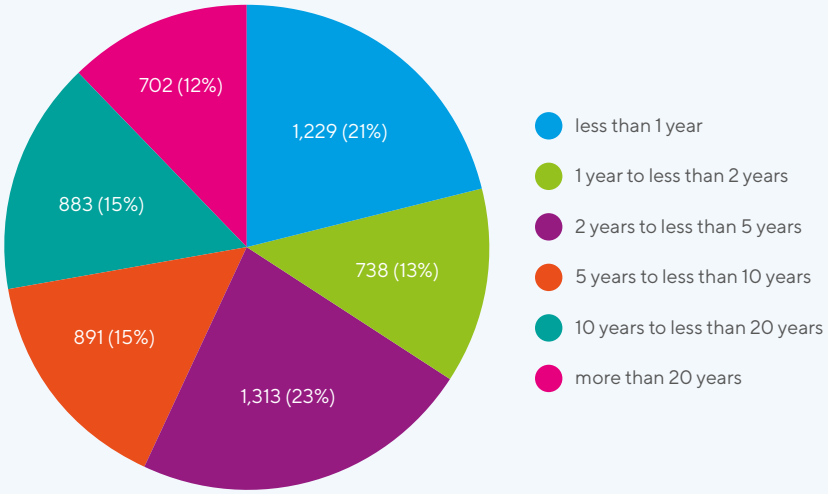
* refers to uncles, aunts, nephews, nieces, cousins, grandparents, grandchildren, or step siblings

** includes friends of friends/relatives of friends, students, neighbours, strangers

5.3.2 LENGTH OF TIME FOLLOWING THE DEATH BY SUICIDE

For a fifth (21%) of respondents the suicide had occurred less than a year ago, and for over a quarter (27%) it had occurred over ten years ago (Figure 8). For respondents who had been exposed to a death by suicide in the previous six months, the relationship was more likely to have been a friend (22% v. 18%). For 702 (12%) the death occurred more than 20 years ago; this was the death of a parent in 255 (38%) cases and a sibling in 118 (17%).

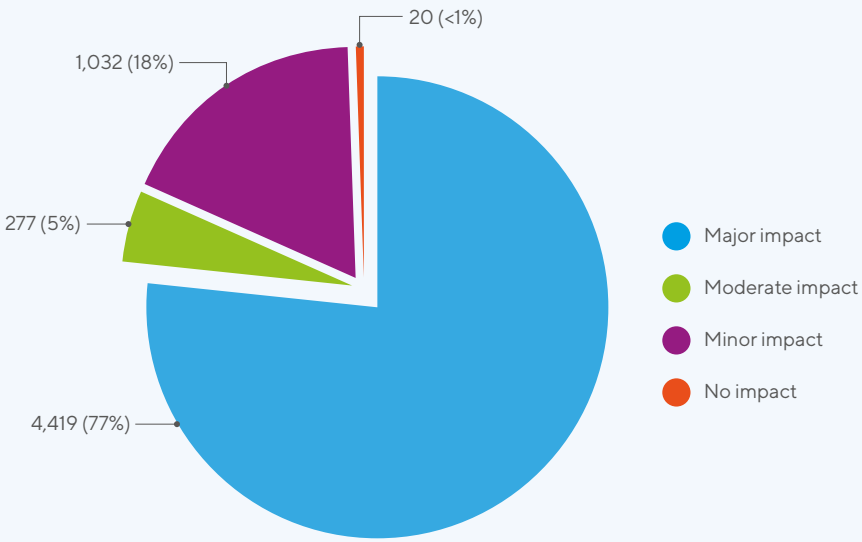
Figure 8: Length of time since the suicide was experienced by participants



5.3.3 IMPACT FOLLOWING THE DEATH BY SUICIDE

The majority (77%) of respondents reported the suicide had a major impact on their lives (Figure 9). Twenty respondents reported the suicide had no impact on their lives. Whilst the majority (95%) of those who had lost a family member reported a major impact, around a quarter (23%) of those who had experienced a suicide of a patient or client and 24% of those affected by a death of a stranger also reported the death to have a major impact on them.

Figure 9: Impact experienced following the death by suicide

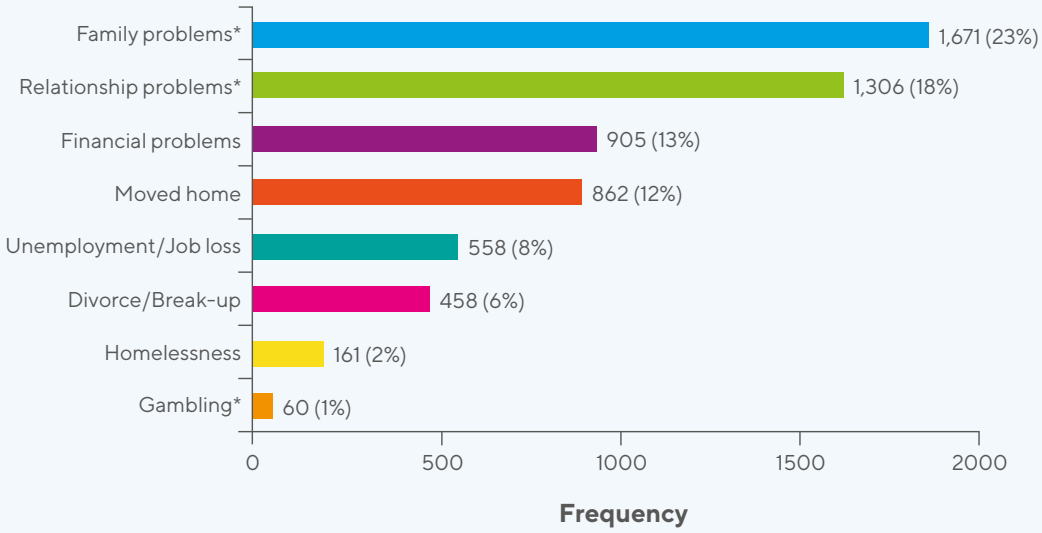


5.3.4 ADVERSE SOCIAL LIFE EVENTS FOLLOWING THE DEATH BY SUICIDE

There were 2,817 (39%) respondents who reported adverse social life events following the death by suicide. The most common were family problems, relationship breakdown and financial difficulties (Figure 10). Many experienced multiple adverse life events after the death with 1,712 (24%) reporting two or more; 855 (12%) three or more; and 424 (6%) four or more.

Women were more likely to have reported adverse events compared to men (2,328, 41% v. 480, 32%). In particular, more women reported family problems (1,395, 25% v. 271, 18%), unemployment/job loss (458, 8% v. 96, 6%) and financial problems (457, 8% v. 73, 5%). Gambling was more commonly reported by men than women (36, 2% v. 24, <1%).

Figure 10: Social adverse life events following the death by suicide



* experienced for more than 3 months

For some respondents, the adverse life events were interrelated, as one female respondent who lost her husband stated:

"The death had a vast impact on all areas of my life [...]. My guard is always up. Financial life is a struggle. I feel that I am constantly trying to juggle things our son, work, money, housework. Many times you feel like you're losing control and things are crashing down around you. I know I will be mentally scarred forever from my experiences. I will never be the same person again as I was. A part of me was shattered that day."

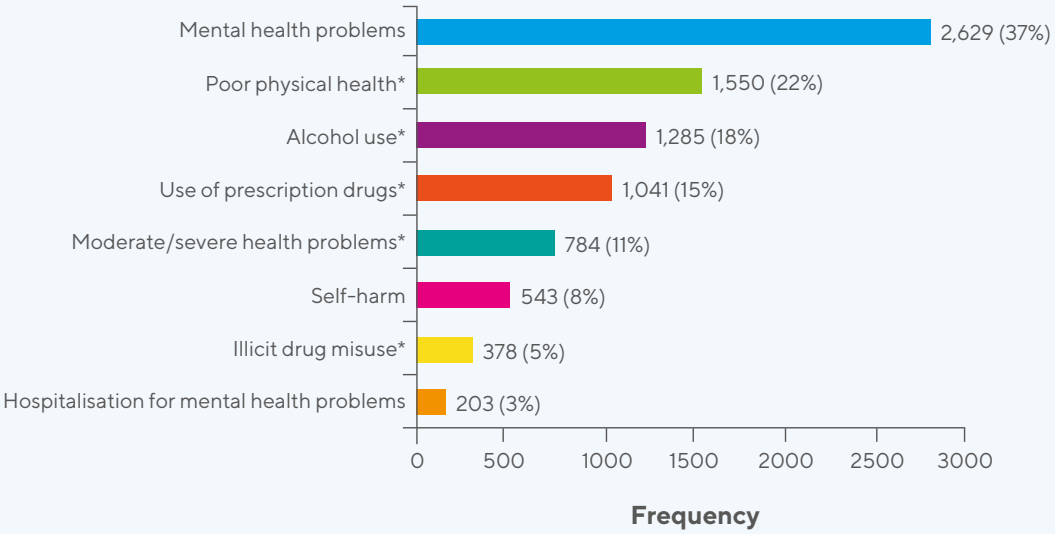
[ID: 6336]

5.3.5 HEALTH RELATED PROBLEMS FOLLOWING THE DEATH BY SUICIDE

There were 3,482 (49%) respondents who reported adverse consequences relating to their health following the death by suicide; the most common were mental health (37%) or physical health (22%) problems and alcohol use (18%; Figure 11). Multiple health-related problems were often reported: 2,233 (31%) experienced two or more health issues; 1,394 (19%) three or more; and 744 (10%) four or more.

Two hundred and three (3%) respondents reported they had been hospitalised for mental illness following the death by suicide. Examples of the mental health problems reported included anxiety and panic disorders, post traumatic stress disorder (PTSD), depression, eating disorders, and psychosis.

Figure 11: Health-related adverse events following the death by suicide



* experienced for more than 3 months

More women reported a health-related problem compared to men (2,835, 50% v. 636, 42%), especially symptoms of mental illness (2,135, 38% v. 484, 32%).

One female participant described the impact the death of her mother had on her mental health and wellbeing:

"To others it might have looked as though I carried on pretty much as normal but life was exhausting, trying to keep going for my other family members, trying to ensure that they felt loved when really all I wanted was to die, not to have to cope with life anymore."

[ID: 2639]

Women were also more likely to report deterioration in their physical health (1,309, 23% v. 237, 16%) and to have used prescription drugs (892, 16% v. 144, 9%). In contrast, illicit drug use (138, 9% v. 239, 4%) and alcohol use (316, 21% v. 964, 17%) were more commonly reported by men.

A mother described how the death of her son affected her health:

"I tried to be strong but after nine months, I had an episode which doctors thought may have been a TIA [Transient Ischemic Attack]. During investigations, the doctor found that my immune system was impacted in a serious way, as if it had shut down. I researched myself and found that some parents, of children who took their lives, had suffered a similar problem."

[ID: 2047]

5.3.6 SUICIDAL BEHAVIOUR FOLLOWING THE DEATH BY SUICIDE

5.3.6.1 Suicidal ideation

Of 5,056 respondents, 1,911 (38%) reported they had considered taking their own life following the suicide; this proportion was similar for men (34%) and women (37%). However, we were unable to determine if these participants had a history of suicidal ideation prior to this incident.

A male participant who experienced the death of a friend said:

"I was hospitalised as a voluntary patient 3 months afterward suffering from extreme suicidal ideation. While I was only hospitalised for a short time, I was actively suicidal for 18 months afterwards and suffered with reactive depression for 8 years during which I was unable to work. Coming back from that took everything I had."

[ID: 7021]

A female participant who lost her father told us she had:

"A continued fantasy to do the same thing. I even wrote a suicide letter, to try and see/understand how he could do it."

[ID: 5091]

After the loss of her daughter, one participant stated:

"My whole life feels totally worthless and empty. I don't really want to be here but have to carry on for my son. Just waiting for life to finish - it can't come soon enough."

[ID: 3563]

5.3.6.2 Self-harm

Of all 7,158 participants, self-harm was reported by 543 (8%) and was more common in those aged under 25 (145, 23% v. 390, 6%) and in women (455, 8% v. 81, 5%). Those who had self-harmed were more likely than other respondents to have experienced the loss of a friend (164, 32% v. 860, 17%) or a parent (109, 21% v. 791, 16%).

One man who had lost his brother to suicide stated:

"I engaged in self-harming as the pain of cutting myself, took my mind off the awful circumstances of his death."

[ID: 1864]

5.3.6.3 Suicide attempts

Of 4,818 respondents, 382 (8%) reported making a suicide attempt following the person's death; the proportion was similar for women (294, 8%) and men (82, 9%). The most common relationships to the deceased in these participants were: parent (83, 23%); friend (80, 22%); spouse/partner (66, 19%); sibling (47, 13%); or child (40, 11%).

A male participant who lost his friend to suicide shared his experience:

"I attempted suicide and ended up with severe physical injuries as a result of this 3 months after her death. I dropped out of university when [I] found out."

[ID: 1999]

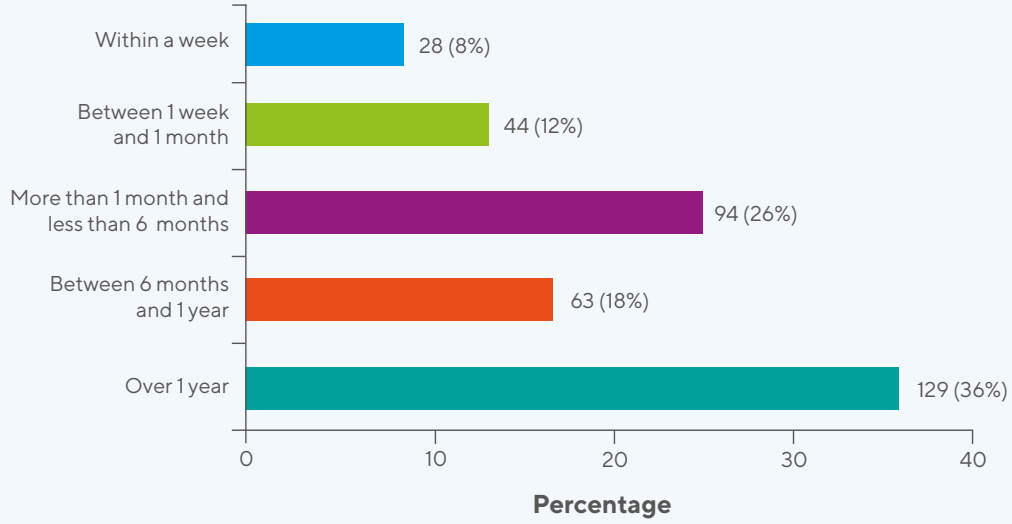
A female participant who lost her husband to suicide said:

"The life I knew before he [died] ceased to exist. I had two failed attempts to end my own life in the first 6 months following his death."

[ID: 2108]

Figure 12 shows the time between the person's death and the attempted suicide. The majority (64%) of those who attempted suicide did so within a year; the remaining 36% a year or longer after the death. Of the 229 people who attempted suicide within a year, 166 (72%) did so in the first six months.

Figure 12: Time between the person's death and attempted suicide



Suicidal behaviour reported by respondents

38%

Suicidal ideation

8%

Self-harm

8%

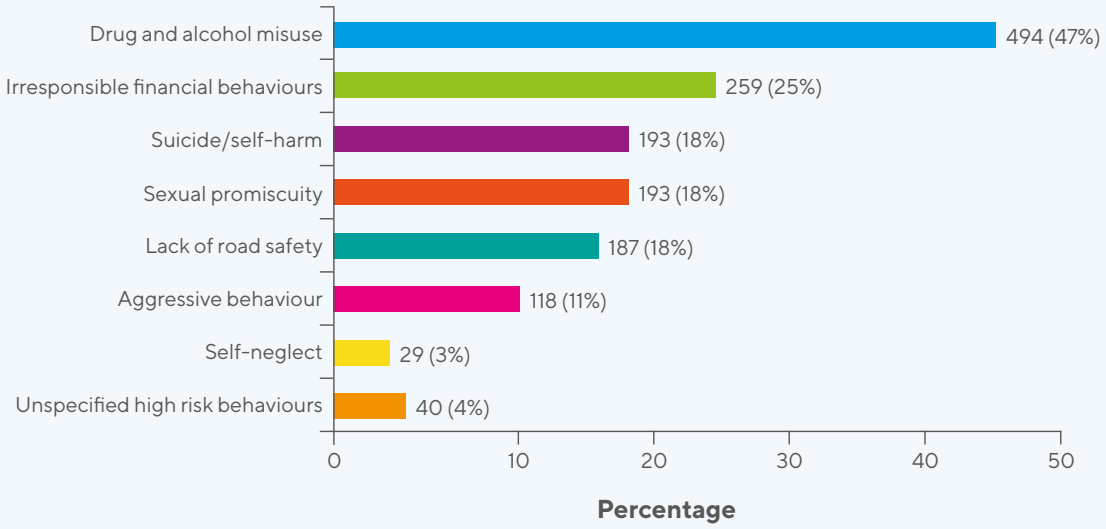
Suicide attempt

5.3.7 HIGH RISK BEHAVIOURS FOLLOWING THE DEATH BY SUICIDE

Of 5,470 respondents, 1,641 (30%) reported they had engaged in high risk behaviours following the suicide. These participants were more often aged under 25 (199, 12% v. 228, 6%) compared to those who had not reported high risk behaviours, and they were more likely to be male (363, 33% v. 1,271, 29%). More had been bereaved by a parent (300, 21% v. 517, 14%) or a spouse/partner (240, 17% v. 382, 11%) and they were more likely to have experienced multiple (>3) suicide deaths in their lifetime (130, 8% v. 232, 6%). Those who had been bereaved over a year ago were significantly more likely than other participants to have engaged in high risk behaviours (1,240, 82% v. 2,933, 77%).

There were 1,055 respondents who provided further information on the high risk behaviours they had engaged in. The most frequent were drug and alcohol misuse and those relating to finance, such as excessive spending and gambling (Figure 13).

Figure 13: High risk behaviours engaged in following the suicide



Note: All proportions are calculated based on 1,055 respondents to the question on high risk behaviours

5.3.7.1 Drug and alcohol misuse

Almost half (494, 47%) of the 1,055 respondents reported misusing substances following the death by suicide, including alcohol, prescription drugs and illicit drugs. These participants were more often aged under 25 compared to other respondents (15% v. 7%).

One female participant whose brother-in-law and friend took their own lives said:

"Drinking as a coping strategy - to self-medicate and forget all that had gone on [...] I would want to get so drunk to forget."

[ID: 2523]

In a small number of cases, participants used medication prescribed for others (including medication used by the deceased to end their life).

The following extract is by a son whose mother died of an overdose:

"I abused the prescribed medication my mother used to take her life as some of it was still in my home at the time and for a long while afterwards."

[ID: 7259]

5.3.7.2 Recklessness with finances

A quarter (259, 25%) of the 1,055 respondents reported problem behaviours relating to finance. This included excessive spending, gambling (especially online) and giving considerable amounts of money to charities. There were no gender or age differences. Around a quarter (24%) had been bereaved by their spouse, significantly more than other participants (12%).

A female participant whose husband died described a change in her behaviour after the death:

"Drinking more and spending carelessly including gambling which I had never done before."

[ID: 4435]

A male participant who lost a colleague said:

"It contributed to a mental health problem which in turn contributed to overspending and debt."

[ID: 2598]

5.3.7.3 Sexual promiscuity

One hundred and ninety-three (18%) of the 1,055 respondents reported that they had changed their behaviour and put themselves at risk sexually after the death. Behaviours included promiscuity, having unprotected sex, placing themselves in dangerous sexual situations, and becoming involved in abusive sexual relationships. There were no gender differences, but these behaviours were significantly more prevalent in those aged between 25 and 44 (53%) compared to other age groups (39%).

A female participant who lost her father described her behaviours as:
"Unprotected sexual activity, excessive partying, aggressive attitude, one night stands with strangers."
[ID: 7182]

5.3.7.4 Road safety

One hundred and eighty-seven (18%) of the 1,055 respondents reported high risk behaviours relating to road safety including driving vehicles recklessly, driving over the speed limit, and having severe road rage. There were no gender or age differences, but these behaviours were more common in those who had lost a child compared to other relationships (43, 25% v. 615, 14%). Some participants described walking in front of vehicles, and a general lack of care for their own safety or wellbeing.

One mother whose son took his own life described her behaviours as:
"Driving at speed, drink driving, crossing roads and not looking just stepping out, wandering off to bridges, train lines, self-harm, not eating."
[ID: 360]

One father who lost his son stated:
"High risk taking, not afraid to die, speeding, working at heights unattached."
[ID: 654]

5.3.7.5 Aggressive behaviour

Of the 1,055 respondents, 118 (11%) described experiencing intense anger and aggression. There were no gender differences but those who reported aggressive behaviour were more likely to be aged under 25 compared to other respondents (16, 18% v. 347, 7%). This behaviour involved arguments with partners, family, friends, and colleagues. For some, physical aggression was directed toward themselves and others.

A male who lost his best friend reported:

"I became aggressive, I was told I had an affliction called pure rage, they put me on [beta] blockers to calm me."

[ID: 6331]

A woman who lost her father reported feeling:

"Very aggressive, drinking every night, wanting to fight everyone."

[ID: 2917]

5.3.7.6 Self-neglect

Self-neglect was mentioned by 29 (3%) of the 1,055 respondents. Neglect manifested itself in a number of ways, and included stopping prescribed medication for serious medical conditions, refusing to receive life-saving treatment, over exercising, eating too much or too little, and a general lack of self-care, including poor hygiene.

A mother whose daughter died by suicide told us:

"I don't care about myself so I don't look after my diabetes or other health problems. I've put on lots of weight and taken up smoking again... [...] I actually don't care about anything as I've got nothing more to lose and would happily be dead."

[ID: 3563]

A male participant whose wife died by suicide stated:

"I have become very lonely and reluctant to go out, unless someone asks me to. Low self-esteem, personal hygiene was low but that's improved now, over eating and under eating put on weight three stone. Don't want to accept that my wife won't come back to me."

[ID: 3393]

5.3.8 IMPACT BASED ON THE RELATIONSHIP TO THE DECEASED

In this section we show the impact experienced by participants based on the relationship to the deceased. The majority of people will experience adverse life events as part of everyday life. Although the participants linked these events to the suicide, we are unable to determine if these incidents occurred more frequently compared to individuals who have not experienced a death by suicide.

5.3.8.1 Loss of a friend

The death of a friend was the relationship most frequently reported (1,024, 19%). These participants were younger than other respondents (median age 36 v. 46), more often male (29% v. 16%), and more likely to have experienced more than two suicides (18% v. 13%). Self-harm (16% v. 8%) and illicit drug use (10% v. 6%) were more common compared to other respondents.

A male participant whose friend took his own life said:

"My circle of friends and I were young (in our twenties/early thirties) and were not well equipped to deal with our friend's suicide. We all, to a greater or lesser extent, self-medicated, partly because it was a cultural norm. While we felt supported by each other, we didn't seek help or advice, and were all in a state of shock for several months. There were some positive aspects, for example a sense of putting things in perspective, but the effects were largely negative, and quite traumatising."

[ID: 7895]

5.3.8.2 Loss of a parent

There were 900 (16%) respondents who had experienced the suicide of a parent, including 560 (10%) the death of their father and 340 (6%) the death of their mother. In over half (564, 63%), the death had occurred more than 5 years ago; 255 (28%) more than 20 years ago. The majority (72%) of these respondents reported health-related problems and adverse social life events (64%) which they linked to the suicide, including relationship problems (28%), unemployment (12%) and divorce (11%). Over a quarter (28%) reported engaging in high risk behaviours following the suicide.

Having lost her father to suicide, one female participant commented:

"Having the medical knowledge about mental health, alcoholism and suicide didn't really help. I can try to rationalise it all, using my psychiatry placements, but none of that is useful when you're absolutely crying your eyes out because your daddy won't see you graduate, won't walk you down the aisle, won't meet his grandkids. He would've been the BEST grandad, because he was the BEST dad. Despite all of his demons and struggles he was a fucking fantastic dad and fucking fantastic person."

[ID: 3449]

5.3.8.3 Loss of a son or daughter

There were 754 (14%) respondents who reported being bereaved by the death of their son or daughter. Adverse life events were reported in over half (55%), including relationship difficulties (28%), moving house (18%) and financial problems which lasted longer than 3 months (12%). Deterioration in physical health (40%), alcohol use (26%) and prescription drug misuse (26%) were also commonly reported.

A mother whose son took his own life stated:

"I never in a million years thought I would be this person, it was always happening to other people. But here I am that woman whose son killed himself. People whisper and look at me with pity in their eyes, people who talked to me then, later avoid and give me that knowing smile. Yeah, someone told them and now they avoid me, and that's okay because that used to be me! But my beautiful caring unique son taught me how to be a better human being in the most heart breaking painful way."

[ID: 1120]

A female participant who lost her daughter to suicide explained:

"We needed to know the truth about her death. It completely ruled our lives. As the death was by her own hand some people found it impossible to understand and we found who our friends were. We had to be strong through the inquest. Our son was affected as he had to watch us suffering as well as endure his own grief."

[ID: 4519]

5.3.8.4 Loss of a sibling

The death of a sibling was reported by 853 (16%) respondents. Adverse social life events were reported in 59% and were most often related to family problems (41%) and relationship difficulties (28%). Half (50%) reported mental health problems.

A female participant whose brother died described the impact losing her brother had on her:

"I became quite isolated, refusing to participate in any kind of social activity for around 9 months (I was also on maternity leave at this time) as I felt I was being disloyal to my brother in some way. I couldn't see any enjoyment in going out and would feel guilty at the thought of it. I also became very angry, angry at myself and at others but not with my brother. I felt I should have known."

[ID: 5322]

5.3.8.5 Loss of a spouse or partner

There were 658 (12%) respondents who had been bereaved by the death of their spouse or partner. Social adverse life events were reported in 69% and included family problems (36%), financial difficulties (22%), unemployment (21%), and homelessness (8%). Both mental (51%) and physical (42%) problems were common, as was the use of alcohol (31%) and prescription drugs (28%).

A male participant who lost his partner told us:

"After my wife's death by suicide, I seriously considered ending my own life - including researching methods of suicide. Every day, for a long time (some years?) I wanted also to die early by natural means e.g. cancer."

[ID: 2808]

5.3.8.6 Suicide of a work colleague

There were 94 (2%) respondents who told us about the death of a work colleague. These were most often colleagues in healthcare services (26, 30%) or protective services (14, 16%). Adverse health-related events were reported in 26% whilst adverse social life events were reported in 12%.

A male participant whose colleague took their own life told us:

"The shock/anger of their death. It felt totally unexpected. Never saw it coming and wish they had spoken about things more. Such a waste of life, cut down in their prime. As a vet I have experienced friends attempting suicide multiple times. And have heard of other vets in different social circles committing suicide. It sadly seems to be an expected part of our profession. I don't understand how we can't look after our mental health better."

[ID: 8215]

A female police officer described the loss of a colleague:

"Made me feel angry as she was the third person in the organisation that has died by suicide and the organisation has never really acknowledged it or thought there was any fault in the workplace."

[ID: 1309]

5.3.8.7 Suicide of a client, patient or prisoner

There were 112 (2%) respondents who completed the survey in relation to a significant suicide experienced through their occupation, including the death of a client, patient or prisoner. Whilst adverse health-related and social life events were less commonly reported compared to other respondents, they still occurred in 32% and 16% respectively.

A male mental health professional who lost a patient reported experiencing:

"Chronic anxiety and low mood in the following year and a half at least. Frequent problems sleeping and going over the event in my mind to see if I could have done something different. It has only been recently I have been able to discuss it without becoming upset. Grief and guilt about the family and my role."

[ID: 4912]

5.3.8.8 Suicide of a stranger

There were 34 (1%) respondents who reported a death of a stranger, including those experienced by police, frontline staff, or members of the public. Adverse health-related (24%) and social (12%) life events were less often reported in these participants compared to others. However, over half (56%) reported the suicide had a major or moderate impact on them.

One female participant described the impact after discovering the death of a stranger:

"I found a man [...] in the woods when I was running early one Sunday morning. I didn't know him, but I think about him all the time. Every time I'm walking in the park or woods with my family, I feel completely terrified. I am suffering from panic attacks when I run near wooded areas."

[ID: 6907]

Table 3: Summary of adverse health-related and social life events following the suicide by relationship to the deceased

	Friend n=1,024	Parent n=900	Son/ Daughter n=754	Sibling n=853	Spouse/ Partner n=658	Work Colleague n=94	Client/ Patient/ Prisoner n=112	Stranger n=34
Adverse health events	570 (56%)	648 (72%)	533 (71%)	563 (66%)	477 (72%)	24 (26%)	36 (32%)	8 (24%)
Adverse social life events	310 (30%)	572 (64%)	438 (58%)	502 (59%)	453 (69%)	11 (12%)	18 (16%)	4 (12%)

5.3.9 IMPACT OF SUICIDE ON CHILDREN

Only those aged 18 and above were eligible to participate in this study, therefore we have not sought information directly from children. However, we asked participants if they were aware of any children affected by the suicide and, if so, to provide further details.

5.3.9.1 Impact on children

Almost a third (1,027, 31%) of 3,302 respondents were aware of children directly affected by the suicide death. Anger, mental health or substance misuse problems, suicidal behaviour and self-harm were commonly reported. Parents often described children being angry and confused at the situation and being unable to understand what had happened and why. In some cases children went on to develop mental health problems such as depression and anxiety, and sought support through counselling.

One participant whose husband took his own life described the impact this had on her son:

"What can I say, the effects have been beyond belief, or rather I knew straight away how serious an impact this would have on my youngest son. Example of the impact: started to self-harm, smoking dope, illegal highs and prescribed anti-depressants. There is no real professional support out there for anyone, regardless of their age, other than counselling - but this doesn't exist for people recently bereaved, kicks in 6 months later at earliest and only for 6 week period which equates to 6 hours support! All the professionals in the world with their expertise and so said knowledge, must recognise that this is not nearly enough for most people bereaved by suicide, especially for children!"

[ID: 7292]

A female paramedic commented:

"I know of children affected by [a] sibling's death having to be on a long waiting list for CAMHS support and repeatedly falling through [the] net until they too attempted suicide."

[ID: 6696]

5.3.9.2 Childhood experiences of suicide

Participants reflected on their own childhood experience of bereavement by suicide.

One female participant who had lost her father stated:

"It took me 20 years to get over the death of my father. I was a very angry teenager and got into trouble at school and beyond. I had difficulty trusting people and forming relationships. Eventually I began to forgive him and understand that when you are desperate normal logic doesn't apply. As soon as the penny dropped with this I understood it wasn't that he didn't love us he just couldn't live anymore in his head. In the 80s when my dad killed himself people blamed us and crossed the road to avoid talking to us. Mental health awareness has come on leaps and bounds since then. More needs to be done as with everything but there's a much healthier attitude today."

[ID: 7213]

A male participant who lost his father described his own suicidal behaviour:

"I was 13 when my dad committed suicide. From this, as a child, the lesson I took from that experience was when life gets too hard, you can always take the easy way out, which led to a number of attempts of suicide that would all inevitably fail."

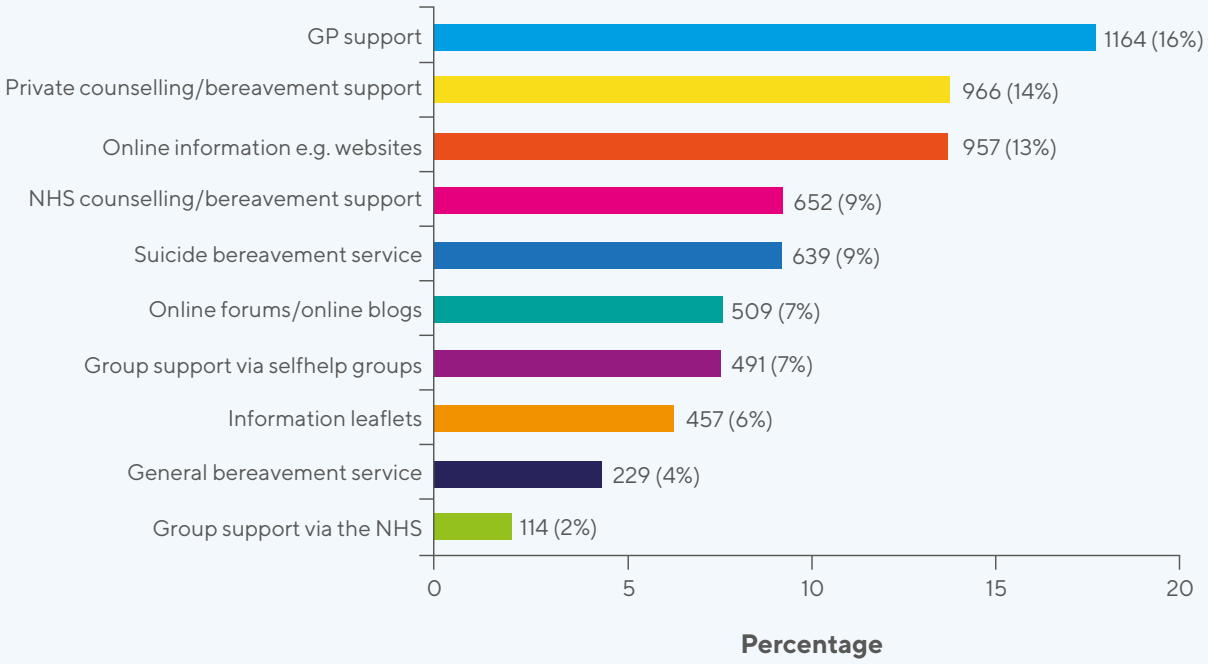
[ID: 4809]

5.4 SUPPORT FOLLOWING A SUICIDE

5.4.1 NUMBER OF PEOPLE WHO ACCESSED SUPPORT

Of all 7,158 participants, 2,864 (40%) accessed support from one or more services. Support was most commonly accessed from GP services (16%), private counselling/bereavement support (14%) and from the internet (13%) (Figure 14). The organisations that offered information and support within the first week after the bereavement were most often the police (85%), emergency services (80%), faith leaders (66%) and funeral directors (64%).

Figure 14: Support services used by participants



5.4.2 REASONS WHY SUPPORT SERVICES WERE NOT USED

Of the 4,294 (60%) respondents who reported they did not access support, 1,575 provided information on why this was. The commonest reasons support was not accessed included having supportive families and friends, feeling able to cope alone, and being unaware of available services (Table 4). Nearly 200 (12%) respondents reported there were no local support services available to them.

Table 4: Reasons for not accessing support

Reason	N	%
I had the support of family and friends and I felt I did not need any additional help	624	40%
I felt I could cope with it on my own	576	37%
I did not know what services were available to me	557	35%
I felt I needed to be 'strong' and look after others	533	34%
I did not feel able to talk about my loss	408	26%
I was not offered support	378	24%
I did not think the available services would be able to help	246	16%
There was no local support available	192	12%
The support I was offered was not appropriate	40	3%
The support I was offered/found was too far away/too difficult to get to	35	2%

A common theme identified was from those who had lost a friend or extended family member and did not feel services were accessible to them as they were not immediate family.

One participant who lost her aunt explained:

"There were other family members who were more closely related to the person that had died by suicide than I was, so I thought I did not have a right to seek help and that I should stay strong for others."

[ID: 4545]

A female whose friend died by suicide stated:

"Support is only really provided first-hand to immediate family but the effects are felt much [more] widely."

[ID: 858]

A male who lost his close friend suggested:

"Maybe at the crematoriums a pamphlet could be left with advice on who to contact, or just to let you know that those services are there for friends not just for the immediate family."

[ID: 4426]

One female participant whose brother took his own life felt her grief came secondary to that of her parents:

"The pervasive bullshit cultural belief that my parents' loss was more important than mine. That I was somehow expected now to look after them, and make them proud, rescue my family, when I myself was desperately trying to survive. That was the hardest."

[ID: 5726]

For some participants, there were difficulties in accessing support services due to personal circumstances, including not being able to drive to out-of-area services, being illiterate, not having access to a computer or the internet, etc.

As one participant mentioned after losing her friend:

"As I am deaf, unfortunately there were many issues with accessing any services as they were so reliant on telephone as a method of contact and communication."

[ID: 7589]

5.4.3. SUPPORT PROVIDED IN THE WORKPLACE OR BY AN EMPLOYER

There were 808 respondents who provided information on support provided by their employer. Over half (458, 53%) reported being offered support. Participants reported examples of support they found to be helpful and included the opportunity to talk openly with colleagues and identify coping strategies. A number of barriers to accessing support were mentioned by some respondents, including time being made available by employers.

A female nurse described how making the time to access support offered by employeers was difficult:

"Offered counselling with occupational health but must be done in own time and with managers approval. Not confidential and not making it easy to access. I didn't access it. No time around 12-14 hour shifts."

[ID: 4894]

It was also noted that while some employers offered time off, it was often unpaid.

A mother whose son died by suicide said:

"I can only say that my boss and work colleagues (friends) were brilliant, nothing was too much trouble, my only downfall was that I did not get grief pay, so only had a short time off."

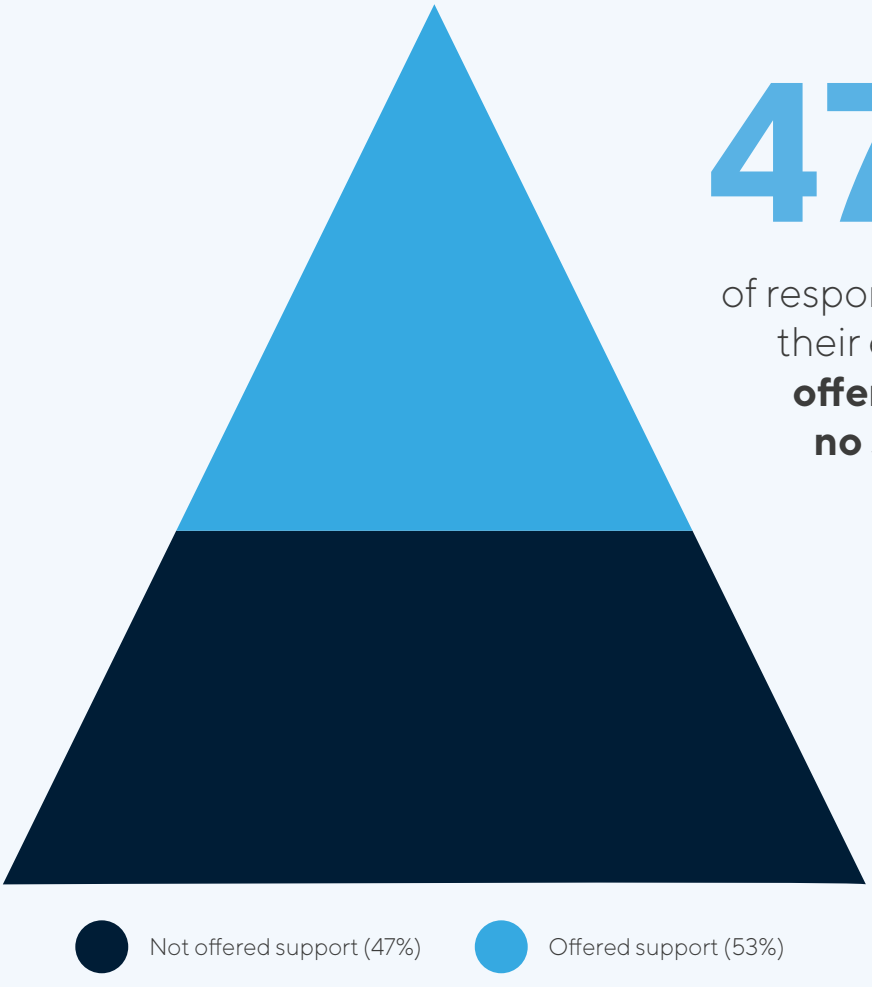
[ID: 1760]

Two-fifths (349, 41%) stated that they would prefer to access support externally rather than to obtain it from their employer. Respondents found the support provided by employers to be less helpful or non-existent.

One female participant who experienced the death of a prisoner stated:

"I was offered no support [...] I was told I needed to 'pull myself together'. After doing the debrief with the staff involved I went home to an empty house, it was horrible. I didn't know who to talk to or what to do. I was never spoken to again by anyone to ask how I was doing after it - I think maybe because I was just managing the incident rather than on the scene it wasn't considered relevant. But I'd worked with the man who died quite a bit and I held myself responsible for what happened. I wish I'd had someone to talk to about it - I carried it around with me for years afterwards...I still do a bit I think."

[ID: 168]



47%

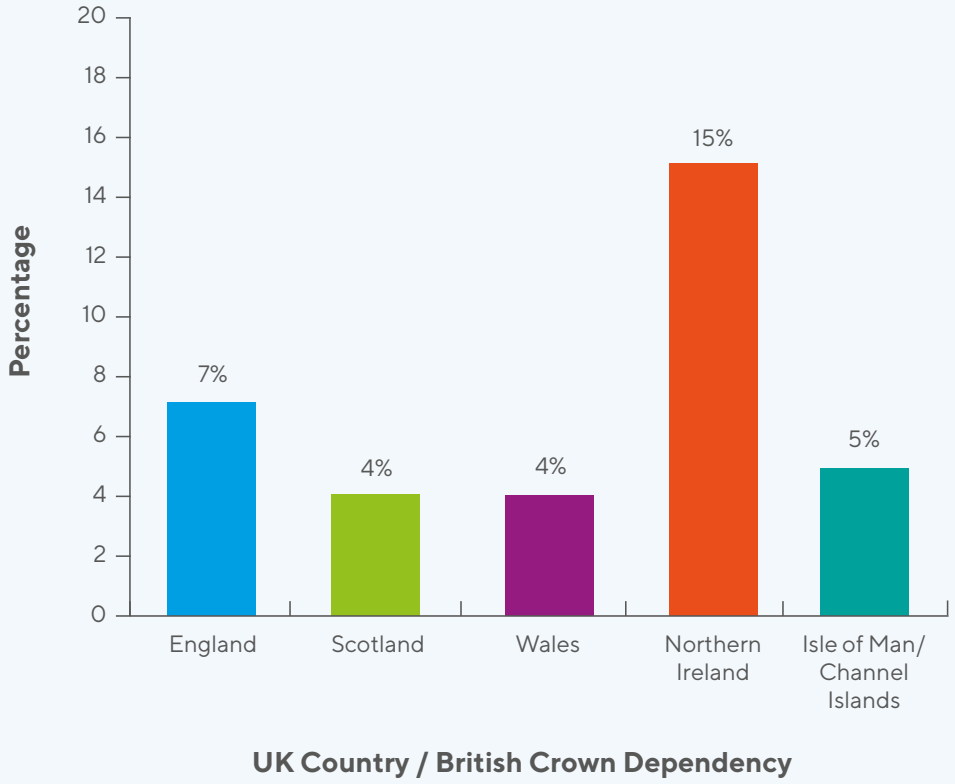
of respondents stated their employers **offered them no support**

5.4.4 USE OF LOCAL SUPPORT SERVICES

Few respondents (779, 11%) were aware of suicide bereavement services available in their local area. Of those that did have knowledge, 453 (58%) knew of adult services, 46 (6%) child services, and 280 (36%) both child and adult suicide bereavement services.

Of 4,621 who answered the question on whether the provision of support for people bereaved by suicide was adequate in their local area, 2,876 (62%) reported the level of support to be inadequate, 326 (7%) adequate and 1,419 (31%) did not know. When examined by UK country and Isle of Man/Channel Islands, significantly more respondents from Northern Ireland thought local provision of suicide bereavement support was adequate, compared to other UK countries (Figure 15).

Figure 15: Percentage who viewed the provision of local suicide bereavement support to be adequate, by UK country



We asked participants to provide further information on the support services they found to be most helpful and would recommend to others. The most common services recommended were charitable organisations (62 charities were named) with SOBS, Cruse Bereavement Care, The Compassionate Friends, and If U care Share Foundation being the most frequently cited. Participants also found the police to be helpful immediately following the death. Many also used online resources such as Facebook.

A female participant who lost her brother described positive aspects to accessing support but also highlighted how some services were not fit for purpose:

"I found SOBS and Cruse both very helpful. The SOBS helpline gave me my first chance to talk to someone who understood what I was going through, and that was a great relief. Cruse provided me with a counsellor who I saw at home for some months, and that was helpful too. I did attend one meeting of their local suicide bereavement group, but found myself the only survivor present in a room full of (perfectly kind!) volunteer workers, so did not go back. My GP listened, but as I was already on psychiatric medication and already seeing a therapist[...], felt unable to do anything but recommended the book, 'A Special Scar'. I would have appreciated it if she had offered me a follow-up appointment, as I would have felt someone was looking out for me."

[ID: 1560]

A female assistant head teacher whose student took their own life commented:

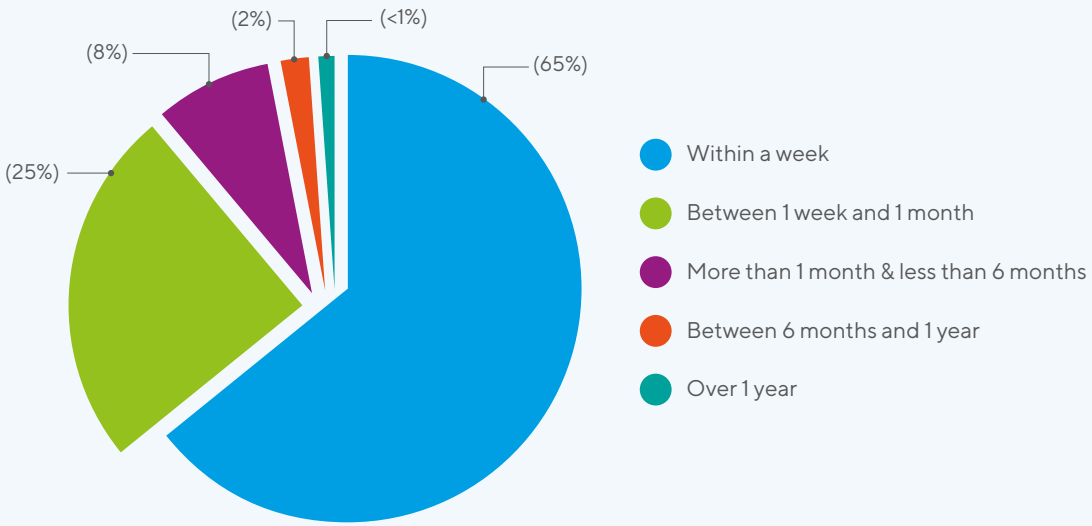
"Bereavement support was good as a space to allow emotions out. Students benefited heavily from this too - both in small groups and individually as time progressed. Use of online research was good - could access in my own time, in my own space."

[ID: 168]

5.4.5 VIEWS ON THE APPROPRIATE TIME TO OFFER SUPPORT

Participants were asked when they would prefer to be approached and offered support. Of the 1,732 respondents, 1,116 (65%) suggested help was most needed within a week of the death (Figure 16), with comments such as 'immediately' or 'straight away'. A quarter preferred to be approached between 1 week and 1 month, with many suggesting after the funeral to be an appropriate time.

Figure 16: When people bereaved by suicide would like support to be offered



There appeared to be no overall agreement on the most appropriate time to receive this support. This was dependent on the individual and their own personal circumstances. Despite many suggesting they wanted help and support straight away, this often constituted being given an information booklet with details of organisations they could contact at a later date when they felt ready.

One mother who lost her daughter to suicide stated:

"I think ASAP as just knowing what support is available locally would have been really helpful. I would suggest GP/Support services contacting the family within a couple of days and then again after 3 weeks/soon after the funeral to offer again. I spent hour's googling for advice and support but found nothing really even though there is some support out there. In the event you may not be thinking straight so a human help would have been really helpful. I think you need practical advice on 'what happens next' i.e. death certificate/interim, funeral, inquest. The coroner did explain the inquest process very well and it took 11 months to happen. The NHS services interviewed us after 2 months for their internal serious investigation report. They were very defensive and didn't offer us any support that I can remember."

[ID: 5477]

The request for ongoing support was a common theme. It was suggested that organisations could approach people bereaved at regular intervals. Having a dedicated suicide bereavement support specialist was recommended not only to offer direct support and advice, but also to signpost people to other appropriate services.

One female participant who lost her son commented:

"I would like a victim support type system so everyone has a visit with information on services, procedures, inquests, support groups. GP's need training in how to deal with families; my GP could not cope with the situation after a few months."

[ID: 1744]

5.4.6 VIEWS ON HOW SERVICES COULD BE IMPROVED

We asked participants to share their views on how services could be improved and what support they would like services to provide. The following themes are the most commonly reported.

5.4.6.1 A proactive response

Participants requested that services should provide a co-ordinated, proactive response, with regular follow up to reduce feelings of isolation.

A female participant who lost her brother to suicide said:

"There needs to be a more joined up response between the various services – e.g. police/ emergency services/ GP/ coroner so that once the immediate priority of informing the family and dealing with the body are taken care of, someone reaches out to the family to provide mental/ emotional support/ counselling if needed – or even just sends details of local groups/ resources. If you didn't have family/ friends support, you could feel very alone following a bereavement by suicide which could be dangerous for vulnerable people."

[ID: 2128]

Another female participant whose mother died said:

"Initially often people are lost and need someone to contact them and guide them along the path".

[ID: 3260]

5.4.6.2 Signposting to resources and services

Many respondents identified signposting to resources and services as a priority area where improvements could be made.

One male participant who lost his child commented:

"The key factors are awareness amongst first responders, such as police, coroner, ambulance, NHS, GPs, clergy etc. It then needs them to have the awareness of support organisations in order to signpost survivors to the appropriate service. If the first responders don't know about support organisations, they can't signpost. Raising awareness amongst the professionals is key to all this support."

[ID: 5407]

5.4.6.3 Tailored help and personalised support

Our findings have shown that participants require various forms of support during their personal stages of grief, and there is no 'one size fits all' solution to supporting those bereaved by suicide. A range of personalised support tailored to an individual's needs was considered to be an area in which current service provision could be improved. The suggestions of the type of services that would be most helpful included:

- Timely access to a free NHS or affordable counselling service.
- Face-to-face (practical and emotional) support.
- Support groups for adults, young people and children.
- Support for schools and workplaces.

A participant whose father took his own life said:

"There is absolutely no support for children bereaved by suicide in my area. The bereavement charities for children were general. I believe suicide and the aftermath is far too complex to not have specific support for."

[ID: 1894]

5.4.6.4 Training and education

Clinical teams and service providers across all agencies require specialist skills. Services need confident, compassionate and skilled workers to understand the complexities of suicide bereavement in order to effectively support those bereaved or affected.

After the death of her brother, one participant gave her views on how services could be improved:

"A better understanding within GP practices of the impact both physically and mentally that suicide can have on those left behind. [...] The bereavement counsellor didn't specialise in suicide and again seemed overwhelmed by my situation - it would have been helpful to speak with someone who knew more about the impact of suicide on siblings. I felt I needed more than a friendly chat with someone objective - I needed support in processing what happened to me and how it would affect my identity, my relationship with myself and others; self-destructive behaviour and long term frame of mind - irrational fears of dying or suffering loss and becoming a pessimist and fatalist."

[ID: 2128]

5.4.6.5 Raising public awareness

A high profile awareness campaign was suggested by many participants to highlight the impact suicide has on families, friends, colleagues and anyone who knew the deceased.

A female respondent who lost her friend suggested:

"Public Campaign [...] to raise awareness of the scale of the impact and that people left behind have had a bomb go off in their lives. Ripples go far and wide."

[ID: 7322]

Increasing awareness can also help to create hope as one participant mentioned following the loss of her brother:

"Positive, helpful, constructive discussions and public examples of people leading good, happy lives after suicide bereavement. It must surely be possible. Also, more open discussion of suicide, everywhere. Something so dark and sad needs so much more light shine on it - and compassion and all kinds of hope."

[ID: 5726]

6. DISCUSSION

Suicide has a devastating and long-lasting impact on families and communities.[4] Our findings illustrate the serious adverse consequences that impact on all aspects of a person's life after a suicide, from physical and mental health to workplace problems and financial wellbeing. The findings add to the growing evidence base explaining the impact that suicide has on the psychological health of those bereaved.[10-13]

Evidence of the effects on physical health is beginning to emerge, with some research showing an increased risk of cardiovascular disease, diabetes, hypertension and chronic obstructive pulmonary disease in those bereaved by suicide.[13] However, a systematic review of 24 studies by Spillane et al.[14] revealed mixed results on the association between suicide bereavement and adverse physical health outcomes therefore further research is needed to fully understand this relationship. This report adds to an earlier UK study by Pitman et al.[11] (2014) who found those bereaved by suicide were significantly more likely to attempt suicide than those bereaved by sudden natural causes. Important work has also been carried out in the US and Australia via random-digit dial studies or surveys and these have highlighted the detrimental effects of being exposed to suicide including suicidal ideation,[15] depression and anxiety,[16] and poorer physical health.[17]

6.1 RISK TAKING BEHAVIOURS FOLLOWING A SUICIDE

In our study, a small but significant proportion of respondents reported feeling suicidal and attempted to take their own life. We found 38% had reported suicidal thoughts; this is higher than a recent Australian study by Maple et al (2019)[15] who found 18.5% of people exposed to suicide reporting suicidal thoughts over the previous year. Our finding that high risk behaviours such as self-harm and suicide attempt were particular features among people aged under 25 corroborates those of Wilcox et al.[18] who found that following the suicide of a close friend or relative, young people had an increased risk of suicide attempts or hospitalisation due to mental illness. Young people and children, therefore, are particularly vulnerable and require specialised support. Similar to Maple et al.[15] we found exposure to multiple suicides was common and we support their recommendation for more research into the cumulative effect of exposure to multiple suicides.

A range of high risk behaviours occurred following the suicide including substance misuse, financial recklessness, sexual promiscuity and a lack of attention to road safety. Previous research has shown adolescents exposed to peer suicidal behaviour engage in substance misuse, physical fights and aggression [19] and our results are consistent with this in an adult population. We also found these respondents were more likely to exhibit such behaviours more than a year after the death, suggesting the length of time since the suicide did not lessen the impact of the grief.[19] In a small Australian study of young people with an average age of 24, reactions following the death of a friend included significant psychological distress and prolonged grief.[20] Whilst it is normal to experience grief following a loss to suicide, it is estimated that 10% experience a more severe reaction known as Persistent Complex Bereavement Disorder or Complicated Grief Disorder.[21] Therefore, to lessen the impact of suicide, it is essential we further our understanding of the needs of special populations such as children and young people who have been exposed to suicide or suicidal behaviour. We also need to establish which individuals have this kind of prolonged grief and offer more psychological intervention.

6.2 RELATIONSHIP TO THE DECEASED

A close relationship to the deceased has been associated with a higher risk of poor mental health outcomes including depression, anxiety, PTSD, and prolonged grief.[22] As suggested by Cleiren et al. [23], the intensity of the bond 'defines the extent to which the bereaved suffers a significant loss.' In our study, the loss of a spouse/partner was particularly linked with participants reporting adverse social and health-related outcomes. However, these outcomes were also common for those who had lost a friend to suicide, which was the most common relationship reported. We therefore concur with the research from Australia that non-familial connections are important and closeness should not be 'perceived' on the basis of kinship but on the basis of psychological closeness.[24,25] We are only beginning to understand the severe impact a death by suicide can have on this hidden cohort.[16,26] Our finding that those who experienced the death of a friend felt overlooked and neglected adds to this knowledge and highlights the importance of services being open and accessible to non-family members. This has been emphasised by Feigelman et al.[17] in a US study who concluded that high numbers who experience the death of friends by suicide will suffer distress that will go untreated. Support needs are 'unique and diverse'[27] therefore by expanding the reach of services help will become more accessible to people beyond the deceased's immediate family.

6.3 POSTVENTION SUPPORT

Recent work has focused on the wider societal impact of suicide and the economic cost in terms of the increased use of health care.[28] Interventions such as the Australian 'StandBy' response service which provides immediate support and pathways to care for people impacted by suicide, has been shown to be cost-effective across a range of economic indicators including healthcare and employment.[28] Evidence has also shown clients of StandBy to have lower levels of suicidality and less social isolation compared to those not receiving the support.[29]

The economic costs of suicide bereavement to employers is often calculated by measuring absenteeism, presenteeism (i.e. being at work but not fully functioning) and lost productivity of unpaid work.[28] Although evidence for the cost-effectiveness of postvention services is limited, employers are beginning to recognise the impact suicide bereavement has in the workplace. For example, Business in the Community in association with Public Health England (PHE) has developed a postvention toolkit to equip employers responding to a suicide of a colleague at work or outside of the organisation.[30] In addition, the recent NHS Long Term Plan has made crisis care for mental health workers a priority.[31]

6.4 WORKPLACE SUICIDE BEREAVEMENT SUPPORT

Our findings show that although suicide affects people in all occupations, the healthcare sector and protective services such as the police and prison officers are often exposed to a higher number of suicides over their careers. Previous work has shown poor long-term health outcomes for staff and patients exposed to suicide in institutional settings.[32] Therefore, further longitudinal research is needed to explore the impact and support requirements following repeated exposure to suicide in the workplace. This may be particularly important for frontline staff who come into contact with those bereaved by suicide [33-35] yet few receive training on how to respond to them.[35,36] Studies have shown that frontline and healthcare staff feel anxious and uncertain when faced with those bereaved by suicide[37,38] and this can have a direct impact on the long-term resilience of those bereaved by suicide.[39] Specialist postvention training has been recommended for professionals who come into contact with those bereaved by suicide.[34,40,41] In the UK, evidence-based and evaluated suicide bereavement training 'Postvention Assisting those Bereaved By Suicide (PABBS)' was the first of its kind internationally which aimed to address this unmet need.[27,34]

6.5 ACCESSING SUPPORT

We found the majority of participants did not access support following suicide. For some this was because they were unaware of the help available or how to access it, for others, they felt adequate support was provided from family and friends, consistent with previous research.[42] We know that suicide has an enduring impact and the effects may take several months or even years to manifest with no optimal time to seek help. However, to mitigate the impact of suicide bereavement, access to support should not be time limited and be easily accessible to all. For those who feel they do not need support, further research could be undertaken to explore resilience and coping strategies in managing loss as has previously been examined with bereaved children.[43]

Participants commented that having a single point of access to immediate advice and information would have been invaluable in the early stages following the death. Those who received the support booklet 'Help is at Hand' found this helpful.

Having a central hub of postvention resources accessible to everyone was identified as potentially useful. The resource could provide a range of evidence based and quality assured material from practical advice on attending the coroner's inquest to information on how to access emotional help and contact with local support groups. Resources should also target particularly vulnerable individuals with lower levels of social support.[44]

As suggested by our participants, having appropriate, easily accessible and on-going support with a suicide bereavement support specialist for a period of months, or in some cases years, may help to reduce long-term negative outcomes. Evidence from Wilson and Marshall[45] showed 27% of bereaved participants required help from a professional for 12 months following the suicide and 19% for at least two years. In England, progress has been made in this area with the creation of Suicide Bereavement Worker posts as part of Rethink Mental Illness's Support After Suicide Service for those in certain boroughs of London. Personalised bereavement support initiatives will be implemented across England by 2024 as part of the Governments NHS Long Term Plan.[31] When considering future service development, it is important to consider the recommendations of those with lived experience and to recognise this unique grief and the prolonged levels of distress that can occur. Emphasis needs to be placed on accessible support services which are available long-term and to all those affected by the death, regardless of the relationship to the deceased.

6.6 STIGMA AND SUICIDE

There is strong empirical evidence to show that people bereaved by suicide are highly stigmatised and often experience negative reactions from family, friends and the community[46-47] at a time of high risk and intense need.[36] Stigmatisation can have a substantial impact on bereaved families and lead to psychological problems and difficulties in mourning.[48-50] Sheehan et al.[51] recommended future research should focus on stigma relating to suicide specifically and for this to be differentiated from mental health stigma. A more targeted approach is therefore needed to help increase our understanding around the complexities of suicide and the related stigma and discrimination.

This should involve increasing awareness of the impact of suicide, challenging stereotypes and discrimination, and changing attitudes.[52] Lessons could also be learned from successful mental health awareness campaigns, such as the Time to Change campaign which reported a 3.1% improvement in attitudes towards mental illness between 2016/17 and 2019/20 with a target of a 5% improvement by 2021.[53]

6.7 DEVELOPMENT OF POSTVENTION SERVICES

Several countries have developed national standards for those delivering postvention services, including the USA,[54] the Republic of Ireland[55] and Australia.[56] UK governments are at various stages of developing such guidance and evidence suggests England is currently leading in this aspect. The National Institute for Health and Care Excellence (NICE), for example, published the 'Suicide Prevention Quality Standard' in which quality statement five: 'supporting people bereaved or affected by a suspected suicide' outlined measures on the structure of service provision, process of delivering support and the effectiveness of the outcome.[57] NICE (2018) have also published guidelines on how to respond to those bereaved by suicide in the community and custodial settings[58]; and a *Self-harm and Suicide Prevention Competence Framework* which refers to postvention has been developed.[59] Furthermore, Public Health England have published a suite of postvention documents in collaboration with several agencies and include i) guiding the development, ii) delivery, and iii) evaluation of postvention services.[60–63] In Northern Ireland, the Public Health Agency published 13 quality standards in 2020 for bereavement support services that include: (1) services are promoted and delivered with consistency and continuity; (2) support is provided in a timely manner; (3) service providers commit to self-care; and (4) the provision of education and training awareness.[64] The Welsh government is currently developing a national bereavement framework which will establish referral pathways, training for staff and volunteers, and a directory of available services.[65] The Scottish government is currently developing a 'Scottish Crisis Care Agreement across statutory and non-statutory bodies to develop standards and referral pathways for trauma-informed support' for those bereaved by suicide.[66]

Box 1: Study strengths

STUDY STRENGTHS

- This report represents the findings of the largest study internationally of people bereaved or affected by suicide to date.
- The use of a population-based survey avoids the biases that can come from collecting data using help-seeking samples. Also, the study includes participants recently bereaved and those bereaved over 20 years ago, reflecting a range of experiences.
- We obtained information from over 1,500 men who are traditionally recognised as a hard to reach sample, particularly in relation to discussing grief.[11] We were also able to gain insight from other important groups, including non-heterosexual populations, Black, Asian and Minority Ethnic populations, students, and those who have experienced multiple deaths by suicide.
- The survey enquired about the experience of being bereaved *or* affected by suicide, thereby taking a holistic approach and also capturing the views of individuals exposed to suicide through their occupation.
- These findings are impactful and highlight key populations and areas where specific postvention support could be offered. Our findings will inform and guide the development of existing and future postvention services which are standardised and evidence-based.

Box 2: Study limitations

STUDY LIMITATIONS

- We are unable to generalise the findings to those bereaved or affected by suicide who did not participate in the survey. This 'self-selection' bias is common in online surveys and means some groups are under-represented, e.g. those who do not have access to the Internet. We also had a lower participation rate by particular groups such as BAME individuals.
- Recall bias may have been introduced for some respondents who were asked to provide data based on an event that occurred many years previously.
- Clinical symptoms were self-reported and could not be compared with health records.
- The level of missing data was high for some variables and we are unable to determine whether those who did not respond to particular questions were different from those who responded (nonresponse bias).
- The age restriction of eligible participants (18 and over) means we cannot establish the grief experiences of younger individuals, but this will be an important area for future study.
- We are not able to determine whether participants had existing premorbid conditions such as depression or suicidal ideation, which were not attributed to the bereavement.

6.8 CONCLUSION

This report represents the collective voices of over 7,150 people bereaved and/or affected by suicide. The findings are of national and international importance and can be used to shape existing services, new services currently being funded by the NHS across England, as well as those being developed in other countries. It offers valuable insight into the lived experience of people bereaved or affected by suicide, which can contribute to the development of a new postvention service model.

Our results provide a compelling case, not only for crisis care, but also long-term support. We have presented considerable evidence illustrating how those with lived experience would like services to be designed, delivered and/or improved. It is crucial that we are able to translate the knowledge we have obtained to enhance future postvention efforts. Finally, the report provides a powerful argument for increasing research funding, specifically for studies which deepen our understanding of the needs of under-researched groups and developing and evaluating tailored evidence-based programmes for all people affected or bereaved by suicide.

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GLOSSARY OF TERMS

What do we mean by "postvention"
An intervention, care or support which is provided to address the needs of people bereaved or affected by suicide.

What do we mean by "bereaved by suicide?"
Individuals who have been bereaved by suicide can include, but is not in any way limited to: immediate, extended and adopted family, foster family, best friend, friends, close colleagues, school, college or university friend, teachers and ex-partner, etc.

What do we mean by "affected by suicide?"
Individuals who do not feel personally bereaved by suicide but still feel they have been affected by the death, for example, if you knew a neighbour who has lost their partner, son or daughter, if you were the passer-by who witnessed the death or found the person, if you are front line staff who respond to an emergency (e.g. ambulance personnel, emergency department staff, police, fire, air ambulance, lifeboat personnel, etc.), prison officers, train drivers, health professionals responsible for their care, and other people who may have had regular social contact with the person who died, such as shop keepers/hairdressers and other members of the local community.

What do we mean by disenfranchised?
Disenfranchised grief has been defined by Doka (1989, p. 4) as "the grief that persons experience when they incur a loss that is not or cannot be openly acknowledged, publicly mourned, or socially supported."[68]

Definitions of self-harm and suicide attempt
Self-harm or self-injury is defined as intentionally causing physical harm to oneself without intending to die by suicide. This differs to a suicide attempt where an individual has tried to die by suicide but survived.

APPENDIX A:

NATIONAL MINIMUM STANDARDS FOR THE DEVELOPMENT OF SUICIDE BEREAVEMENT SUPPORT SERVICES

The contributions made by participants in this research has led to the identification of areas of good practice and minimum standards required for suicide bereavement support services, which are summarised below.

- Nationwide standardised multi-agency postvention services are required for both adults and children.
- A multi-agency, holistic approach is required, which focuses on practical help (e.g. advice surrounding the inquest, financial advice), as well as support for physical health, substance misuse and psychological wellbeing.
- Guidance for services on how to inform and support children and young people bereaved by suicide should be widely available and used to support families at first contact. National guidelines could also be developed by working with current third sector organisations who provide support to bereaved children.
- An increased awareness of complex grief, trauma and adverse behavioural responses associated with suicide bereavement. Developing the skills to address these responses may help to reduce the adverse outcomes of complicated mourning.
- Ensure services are aware of both the immediate and long-term effects of suicide bereavement in relation to suicidal behaviour to effectively manage risk.
- Staff working in postvention services should be skilled and understand the complexity of suicide bereavement and that many people are likely to experience a range of adverse life events as a direct result of their loss and their relationship to the deceased.
- Services should acknowledge and address the unmet need of friends bereaved by suicide who often feel overlooked and not as well supported. Support should be widened to include extended family members, friends and communities.
- Agencies likely to come into contact with people bereaved by suicide (e.g. GPs, police, ambulance service, emergency department staff, funeral directors, coroner's officers, Citizen Advice Bureau, substance misuse services, job centres, etc.) need appropriate training to effectively signpost and offer support.
- Systems should be in place to ensure all families bereaved by suicide receive the Help is at Hand booklet (or 'After a Suicide' in Scotland) at the earliest opportunity. Other NHS approved online materials should also be signposted to.
- Local NHS services and third sector organisations should collaboratively develop evidence-based postvention pathways that are fit for purpose.
- Timely evidence-based, appropriate and easily accessible support is needed. The availability of practical support and guidance including helplines, support groups, literature, counselling, etc. should be consistent across systems of care.
- As well as responding to immediate support needs, ongoing multi-agency care and support should be provided to ensure risk can be safely managed over time.
- Dedicated suicide bereavement support specialists should be available nationally to proactively respond to those in need.
- A comprehensive research agenda is required to advance our understanding of suicide bereavement and its adverse impact on physical and mental health, as well as its social consequences.

APPENDIX B:

RECENT STRATEGIC DEVELOPMENTS

Identifying the needs of the bereaved has become a government priority. The key strategic developments impacting on postvention over the past two years in each UK country are outlined below:

ENGLAND:

1. October 2018: The National Suicide Prevention Strategy Delivery Group (NSPSDG) was established by the Department of Health and Social Care to develop a Cross-Government Suicide Prevention Workplan. It is also NSPSDG's responsibility to track, monitor and report on the implementation of the Workplan.

2. January 2019: The Cross-Government Suicide Prevention Workplan was published and sets out key areas for action across government. A main theme of the Workplan is to provide better information and support to those bereaved or affected by suicide.

3. January 2019: The NHS Long Term Plan set out priorities for the next ten years providing a vision for mental health services, suicide prevention and rolling out suicide bereavement services nationwide. Specific bereavement support includes:
   - Post-crisis support for families and staff who are bereaved by suicide, through the NHS 111 helpline system
   - Suicide bereavement support for [bereaved] families, and staff working in mental health crisis services in every area of the country.

4. September 2019: Support after Suicide Partnership launched a NHS supported 'Central Hub of Resources, Information, Support' which provides best practice, guidance and professional support for all those involved in planning and delivering suicide bereavement and liaison services.

5. October 2019: Funding was provided to ten pilot areas in England to develop dedicated bereavement care including counselling, group support, or signposting to specialist mental health services. Services will be rolled out to every area of the country by 2023/24.

NORTHERN IRELAND:

1. September 2019: The Department of Health in Northern Ireland launched the Suicide Prevention Strategy 'Protect Life 2 - A Strategy for Preventing Suicide and Self Harm in Northern Ireland 2019-2024.'

2. Postvention support has been identified as an area for service enhancement and development and will be actioned under the Strategy. This will include:
   - revision of the Sudden Death Notification and the Community Response Plan process;
   - development of specialist bereavement support;
   - support for school staff to enable them to effectively help children affected by suicide;
   - 'enhance mechanisms for better psychological and professional support for those who experience suicide as part of their professional or voluntary practice, and for informal carers of someone who is suicidal'; and
   - guidelines on memorials/ public gatherings/ social media postings.

3. A new Strategy Steering Group will be set up to drive delivery and report on progress.

4. January 2020: The Public Health Agency has developed quality standards for service provision of mental and emotional wellbeing and suicide prevention to ensure consistency of approach.

SCOTLAND:

1. August 2018: The Scottish Government (2018) launched the Suicide Prevention Action Plan 'Every Life Matters.' A key area for action is to 'ensure that timely and effective support for those affected by suicide is available across Scotland.' The National Suicide Prevention Leadership Group (NSPLG) was established to support the delivery of the Action Plan.

2. September 2019: The NSPLG launched their first annual report. Eleven recommendations were made to Scottish Government and the Convention of Scottish Local Authorities (COSLA). Recommendation nine focused on suicide bereavement:

   'The Scottish Government should make funding available to pilot a new model of care for those bereaved by suicide which is effective in reducing distress, self-harm and suicide. It should include evaluation and appropriate mechanisms to ensure that learning is shared.'

3. March 2020: The Scottish Government requested expressions of interest from non-statutory organisations to develop a rapid response, suicide bereavement liaison service in two areas of Scotland. This two year pilot was due to commence in September 2020, but had to be temporarily postponed due to Covid-19. The timescales for implementing this service will be reviewed in September 2020 and will depend upon the pandemic situation at the time. The service is due to be evaluated by a separate organisation for the duration of the pilot.

WALES:

1. July 2015: The Welsh Government launched the 'Talk to Me 2' suicide prevention strategy, which sets out their aims and objectives covering the period 2015-2020 (recently extended to 2022). Objective three aims to provide 'information and support for those bereaved or affected by suicide and self-harm.' This objective differs slightly when compared to other UK government suicide prevention strategies, which place more prominence on those bereaved or affected by suicide.

2. March 2018: The Welsh Government commissioned Public Health Wales (PHW) and Swansea University to conduct a mid-point review of the implementation of the Welsh suicide and self-harm action plan (John et al, 2018). The review acknowledged that 'some progress' had been made in relation to providing 'information and support for those bereaved or affected by suicide and self-harm' (objective three):

- Help is at Hand Cymru resource (PHW, 2016) for those bereaved by suicide had been updated and circulated more widely (including on several websites, e.g. PHW and an online resource for GPs working in Wales (http://www.gpone.Wales.nhs.uk/nonclinical);

- CRUSE and the Samaritans jointly facilitated support groups for those bereaved by suicide on a Welsh Government funded partnership project; and

- CRUSE also provided one-to-one support for those bereaved by suicide. However, the review recommended that the Welsh government should immediately 'support the development of a Wales-wide postvention pathway' (recommendation three).

3. February 2020: The Welsh Government announced that they would provide funding to develop a national framework for bereavement care (for all types of deaths) in Wales, which will be in place in 2021. This will involve developing a national framework, referral pathways, training and standards.

APPENDIX C:

HELP AND SUPPORT

Below is a list of key organisations for help and support:

Samaritans

www.samaritans.org
Helpline 116 123 Everyday, 24 hours
SMS: 07725 909 090
Welsh language line: 0808 164 0123
Email: jo@samaritans.org

Samaritans provide emotional support to anyone who is struggling to cope and needs someone to listen. Local branches can be visited during the day.

Survivors of Bereavement by Suicide (SOBS)

www.uk-sobs.org.uk
Helpline 0300 111 5065
Monday to Friday 9.00am to 9.00pm
Email: email.support@uksobs.org

SOBS offers support for those bereaved or affected by suicide through a helpline answered by trained volunteers who have been bereaved by suicide and a network of local support groups.

Winston's Wish

www.winstonswish.org
Helpline 08088 020 021
Monday to Friday: 9.00am to 5.00pm
Email: ask@winstonswish.org

Winston's Wish offers support and guidance to bereaved children and families. They have produced Beyond the Rough Rock, a booklet on supporting a young person or child bereaved through suicide, and can provide information on children attending funerals.

PAPYRUS Prevention of Young Suicide

www.papyrus-uk.org
Helpline 0800 068 4141
Monday-Friday 9.00am to 10.00pm
Weekends and Bank Holidays 2.00pm to 10.00pm
SMS: 07860 039 967
Email: pat@papyrus-uk.org

PAPYRUS Prevention of Young Suicide offers support and advice to young people who may be at risk of suicide and to those concerned about a vulnerable young person.

CALM (campaign against living miserably)

www.thecalmzone.net
Helpline 0800 58 58 58 / London 080 802 58 58
Open 7 days a week 5.00pm to midnight
Email: info@thecalmzone.net
Webchat: www.thecalmzone.net/help/webchat/

CALM is a registered charity, which exists to prevent male suicide in the UK. The helpline is free, anonymous and confidential.

Cruse Bereavement Care

www.cruse.org.uk
Helpline 0808 808 1677
Monday to Friday 9.30am to 5pm
Tuesday, Wednesday & Thursday 9.30am to 8pm
Weekends 10am to 2pm

CRUSE Bereavement Care is a leading bereavement charity in the UK and provides support and counselling to people suffering from grief.

APPENDIX D:

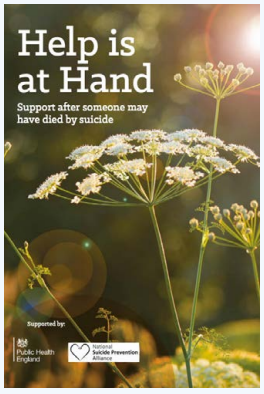
KEY RESOURCES FOR PEOPLE BEREAVED BY SUICIDE

The following resources have been written for those bereaved by suicide. They describe the common grief responses when bereaved by suicide. They also provide telephone numbers of organisations who are able to provide guidance and support. They are free to download from a computer or you can ring and ask for a free copy. Details are noted below:

Support
After Suicide
Partnership

Support After Suicide Partnership
www.supportaftersuicide.org.uk
@AfterSuicideUK
Email: info@supportaftersuicide.org.uk

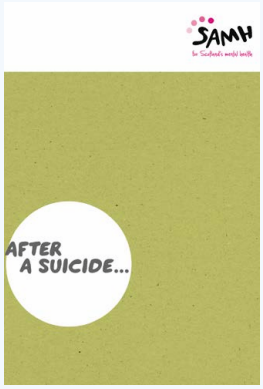
The Support after Suicide Partnership is a national network of organisations, that support anyone bereaved or affected by suicide. The website provides information, resources and signposting to services. The Partnership also supports NHS England in the implementation of suicide bereavement support services across England, as set out in the NHS Long Term Plan (2019). You can find more information by visiting **hub.supportaftersuicide.org.uk**



England – Help is at Hand
Produced by the Department of Health, this is a resource for people bereaved by suicide and other sudden, traumatic death in England and Wales. The booklet can be read online at: **www.supportaftersuicide.org.uk/support-guides/help-is-at-hand/** or printed copies can be ordered by phoning 0300 123 1002 quoting 2901502/Help is at Hand.

Northern Ireland – Help is at Hand

This booklet can be read online at: **https://www.publichealth.hscni.net/sites/default/files/2020-01/Help_is_at_hand_B5_Booklet_01_20.pdf** or printed copies can be ordered by contacting Public Health Agency on 0300 555 0114.



Scotland – After a Suicide

This booklet can be read online at:
https://www.samh.org.uk/documents/After_a_suicide.pdf
or printed copies can be ordered by contacting the Scottish Association for Mental Health (SAMH) Information Service or calling 0800 917 3466.

Wales – Help is at Hand

This is the Welsh version of the Help is at Hand resource and can be read online and downloaded at: **http://www.wales.nhs.uk/sitesplus/documents/888/HelpIsAtHand%20English%20web.pdf**

THE COLLECTIVE VOICE
OF THOSE BEREAVED
OR AFFECTED BY
SUICIDE IN THE UK

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