



Feidhmeannas Seirbhíse Sláinte
Health Service Executive



Responding to the Suicide Bereaved: The Mayo Model -

Full Report

October 2015



Gordon, E., McElvaney, R., MacGabhann, L., Farrelly, M., Casey, B. & Pulcherio, I.

Acknowledgments

The research team wish to acknowledge the valuable contribution provided by the following key parties who participated in this review:

The Liaison Worker who provided information about the service and shared her experiences of developing and delivering the Mayo Suicide Liaison Service over the past four years.

The Director of the Family Centre who made himself available to provide information at the request of the team and who participated in the project review.

The HSE Resource Officer for Suicide Prevention in Mayo who also provided important information at the request of the team and who participated in the project review.

The Stakeholders (Steering Group, Family Advisory Group, First Responders, Professional Groups) who contributed to the evaluation and brought attention to multiple important issues relating to the establishment of suicide bereavement services in Ireland.

The MSLS service users who shared their stories and provided insight into the unique experiences and needs of the suicide bereaved.

The Family Centre Clinical Supervisor who provided information on the role of the Family Centre in supporting MSLS.

The staff of the Family Centre who made the research team feel welcome, in particular the administrators, who arranged interview rooms and located required documentation.

Recommended referencing

Gordon, E., McElvaney, R., MacGabhann, L., Farrelly, M., Casey, B. & Pulcherio, I. (2015) *Responding to the Suicide Bereaved: The Mayo model – Full Report*, Dublin: Dublin City University.

Glossary of Terms

FAG – the Family Advisory Group, comprising families with personal experience of suicide also actively involved in the development of MSLS.

Family – nuclear and extended family and those in close relationship with the deceased who availed of the services of MSLS (nuclear family refers to immediate family – parents, siblings, children, while extended family refers to once removed members – in-laws, grandparents, aunts, uncles, cousins).

First Responders – the *“first emergency person to arrive at the scene of a traumatic or medical situation”* (MSLS, 2013, p.4).

LW – Liaison Worker - the person charged with managing and delivering the MSLS.

MSLS - Mayo Suicide Liaison Service - the designated postvention suicide bereavement service in Mayo, more laterally known as the Mayo Suicide Bereavement Liaison Service (MSBLS).

MSPA – The Mayo Suicide Prevention Alliance, a network of organisations involved in mental health supports and services and suicide prevention in Mayo.

NOSP – National Office for Suicide Prevention - the national body within the Health Service Executive (HSE) responsible for the design and implementation of suicide strategy and service development and delivery in the Republic of Ireland.

NOSP ROSP – HSE / NOSP Resource Officer for Suicide Prevention, the person charged with responsibility for promoting suicide awareness and supporting services in a designated region.

Postvention Response – *“...activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour”* (Andriessen & Krysinaka, 2012 p.43).

Service User – those who availed of MSLS or parts thereof, including bereaved family members and organisational groups that were associated with a suicide.

SG - the Steering Group, comprising professionals and community personnel with an interest in promoting postvention services and were actively involved in the development of MSLS.

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Executive Summary

The Context for a Postvention Response in Mayo

A significant number of people are profoundly affected by each suicide and those bereaved are reported to experience a more complex and prolonged grief process than those bereaved by other causes (Grad, 2005), sometimes leading to further complications such as mental health problems (Jordan & McIntosh, 2011) and higher risk of suicide (De Grott & Kollen, 2013).

In Ireland there has been a paucity of postvention initiatives therefore, in 2012 with the support of the National Office for Suicide Prevention (NOSP), the Family Centre in Castlebar established a designated postvention service - the Mayo Suicide Liaison Service (MSLS).

The brief of this service is to provide emotional and practical support to the bereaved and to help them to access follow on support and therapeutic services as required.

MSLS is accessed through those involved in the immediate aftermath of suicide (first responders), those who may be in contact with the bereaved (GPs, Schools etc.), and self-referral.

It is a part-time service (equivalent to 3 days per week) delivered by a Liaison Worker (LW).

Review of MSLS

The brief of this review was to: track the development of MSLS and explicate its model and operations; evaluate the usefulness and fit of MSLS within postvention services in Mayo; and ascertain how the MSLS response model may inform postvention strategy and service delivery in Ireland.

A Case Study (Willig, 2008) design was used. Qualitative data were analysed using Thematic Analysis (Braun and Clarke, 2006). Analysis of service documentation was also completed.

MSLS was benchmarked against key service performance indicators and the findings were synthesised.

There were three arms to the review: 1) Evolution and Explication of the MSLS Model; 2) Service Activity and Efficiency; and 3) Views and Experiences of MSLS.

In total 35 people contributed to the review representing all stakeholder groups.

Findings

Arm 1: Evolution and Explication of the MSLS Model

MSLS evolved organically within the Family Centre in Castlebar which provides a strong governance structure for MSLS and support for the LW. However, this raises issues concerning MSLS service identity locally, at county level and nationally.

The MSLS model delivers a co-ordinated postvention model that incorporates four key components: 1) a suicide crisis response; 2) ongoing support; 3) facilitated referral; and 4) community support.

The model fits with best practice as it is flexible, tailored to the needs of individuals and is informed by postvention research and national guidelines.

The liaison function is central in engaging the suicide bereaved with appropriate professional services and community supports. This work is multifaceted and demanding and requires good therapeutic, communication, interpersonal and leadership skills, and competencies in risk assessment and risk management.

Arm 2: Service Activity and Efficiency

During the evaluation period, 2012-2015, MSLS provided a response to 66 deaths by suicide.

A total of 85 referrals were activated, representing 77 cases (67 families and 10 organisations). Referrals came from a range of sources. The majority of referrals were made within six months of the bereavement.

Of the referred 77 cases 1 declined involvement and the remaining 76 engaged. A total of 255 individuals, (66 families comprising 168 individuals and 10 organisations comprising 87 individuals) availed of MSLS.

The initial support contact with the LW took place at the Family Centre, in a convenient location outside the centre, mostly in the family home or workplace, or by telephone only.

Protocols and processes established early in the development of MSLS require updating to reflect current service provision and the changing and complex context within which the service is situated.

The service maximised its resources by focusing its efforts on providing a timely, accessible and relevant response and promoting suicide and suicide bereavement awareness in the community. While resources are currently perceived as adequate this may need to be reviewed over time.

Resourcing similar postvention services needs to take account of factors impacting service configuration and delivery, such as; county and population size and spread, suicide rates and trends, and host organisation and local service resources.

Arm 3: Views and Experiences of MSLS

The qualitative analysis captured the essence of MSLS as being a timely, responsive, flexible and high quality service. Four key themes were identified: Suicide Bereavement is Different; Support Needs are Unique and Diverse; Responding Flexibly and Seamlessly; and Benefits are Tangible.

Aspects of the service identified as being particularly useful are its: unique focus on suicide bereavement; pro-active and responsive approach; informed and sensitive response; and stepped model of service delivery.

Concerns in relation to MSLS and the wider provision of postvention services in Ireland include: succession planning for the LW and longer term resource commitments for the service; making the service more visible in the community; promoting ownership of MSLS at county level and as part of a national response; and exercising caution in replicating services as service user needs, resources and structures vary hugely in each region.

Conclusions and Recommendations

Conclusions

MSLS was benchmarked against key performance dimensions as follows:

Acceptability: Those who availed of the service found it relevant to their needs.

Effectiveness: MSLS is experienced as beneficial to service users and the local community.

Capability: Appropriate skill and knowledge is evident in the response to service users and successful partnership arrangements.

Accessibility: While MSLS is being accessed by a significant proportion of the suicide bereaved in Mayo increased visibility is required.

Continuity: MSLS works collaboratively with other services and conforms to national plans for designated postvention services in Ireland.

Responsiveness: MSLS provides a timely, flexible and individualised response that promotes service user choice and autonomy.

Efficiency: MSLS operates a quality service on a modest budget and is currently adequately resourced.

Equitability: MSLS does not discriminate against any suicide bereaved person and delivers the service in the Irish language.

Advocacy: MSLS ensures that the voice of the suicide bereaved is represented at key forums.

Governance: MSLS operates within a well established and supportive host organisation. Accurate recording and easy retrieval of service information would enhance accountability.

Partnerships: MSLS was established on a partnership basis and review of current stakeholder roles, functions and relationships would be beneficial.

National Fit: MSLS adheres to national quality standards for postvention services (Console et al., 2012), is informed by postvention research, is underpinned by principles enshrined in national policy and fits with the national suicide prevention strategy (NOSP, 2015).

Recommendations

MSLS

Continuity - Continue to operate MSLS model of service delivery for the suicide bereaved throughout County Mayo.

Identity - Promote MSLS as a county wide suicide bereavement service that is part of a national response initiative, highlighting current service provision.

Visibility - Develop a strategy for ongoing service publicity and update publicity materials.

Quality Assurance and Standards – Establish systems for accurate recording and easy retrieval of service information for ongoing audit and evaluation.

Roll out of MSLS Model

The four core elements of the Mayo model (proactive crisis response, ongoing support, facilitated referral and community support) could be replicated in other postvention services.

Consider key factors that can impact on service configuration and delivery in each region, such as, county size, population size and spread, suicide patterns and trends, referral protocols, follow on service provision, local cultural context, and resources and commitment of the host organisation.

Establish postvention services: on a partnership basis to ensure a timely and informed response to the bereaved and appropriate and seamless onward referral; on established best practice guidelines and principles; and on criteria for host organisations and national standards for postvention services.

Clearly define and regularly review the role and competency requirements of the LW.

National

Establish a national database to promote informed, quality and standardised practice and to facilitate good quality audit, evaluation and research.

Promote routine evaluation of service activity, quality and outcomes, monitoring service user profile and needs, and measuring the impact of postvention services locally.

Promote research to: compare of service models across counties; Identify factors influencing service provision in different regions and with different groups; distinguish between those who need and benefit from and do not need or benefit from postvention services.

Introduction

This report outlines in detail the review of the Mayo Suicide Liaison Service (MSLS) (2012-2015). This independent retrospective review was commissioned by The Management Board of The Family Centre, Castlebar and was funded by the National Office for Suicide Prevention (NOSP). The brief of the review was to: track the development of MSLS and explicate its model and operations; evaluate the usefulness and fit of MSLS within postvention services in Mayo; and ascertain how the MSLS response model may inform postvention strategy and service delivery in Ireland. In meeting this brief, the research team sought to describe the development of the service and response model; establish service activity and resource requirements; and capture the views and experiences of key stakeholders.

The report and the recommendations herein are informed by service activity and financial data obtained from MSLS and The Family Centre, theoretical literature and international research and national policy and guidelines in the area of suicide and suicide postvention. The report is divided into the following sections:

Section 1 The Context: This section sets out the context for the evolution of MSLS and provides a brief outline of postvention literature and service provision.

Section 2 The Review: This section outlines the approach, aims, data gathering and analysis methods, study design and ethical processes of the review.

Section 3 Findings: This section of the report outlines the key findings in relation to each arm of the review.

Section 4 Conclusions and Recommendations: This final section of the report presents the conclusions of the review and offers recommendations at local and national level.

Section 1: The Context

A brief overview of suicide rates and trends, the evolution of MSLS and postvention literature is provided here to set the context for the service review.

Suicide Rates and Trends

The rate of suicide in Ireland has been a health and social concern for the past number of decades with approximately 500 recorded deaths by suicide annually. There are some trends of note within these statistics, for example the high rate of suicides among young people, with Ireland ranking fourth highest in the EU for deaths by suicide of 15-19 year olds, at 10.5 per 100,000 population. There is also a high rate of male suicides, for those aged 15 to 19 years and 44 to 64 years (NSRF, 2014; WHO, 2014). While suicide rates seem to indicate a levelling off from the rise between 2007-2012, which has been attributed to the impact of the economic recession, these figures need to be treated with caution as available data for 2013-2014 is provisional (NOSP, 2015).

Suicide rates fluctuate due to personal, interpersonal, community and socio-cultural factors leading to a disproportionately high rate of suicide in particular areas at times. For example, in Mayo the rate exceeded the national average of 11.1 in 2012 with 19.9 deaths by suicide per 100,000 (NOSP, 2013). Therefore, it was timely that, with the support of the National Office for Suicide Prevention (NOSP), the Family Centre in Castlebar formally established the Mayo Suicide Liaison Service (MSLS) in 2012.

The Mayo Suicide Liaison Service (MSLS)

MSLS is a designated postvention service that has developed its own unique response model over time and is now recognised as the formal national suicide bereavement service for County Mayo. It operates from the Family Centre in Castlebar, which is a voluntary organisation (NGO), under the direction of a Board of Management. The centre is located in premises that have been provided by the local Catholic Diocese. A Liaison Worker (LW) was appointed to plan and deliver the service, whose role was to: develop consultative partnerships with local services and service users to help co-ordinate and inform service delivery; develop protocols for service

access; provide support to bereaved families; and maintain service records (Appendix 1). MSLS was informed by a Northern Ireland Liaison Service (Appendix 2), which was in turn informed by the well-known Baton Rouge Crisis Intervention Model developed by Frank Campbell in the USA (www.lossteam.com). The LW role differs from other models in one important respect; it does not provide ongoing counselling to service users although it was initially envisaged that this might form part of the LW role. Instead service users are referred onwards for such interventions. This distinction is important as it facilitates a clear focus on the liaison function of the LW role.

Collaboration Groups and Processes

The service was established on a partnership model, therefore a number of stakeholders who were identified as actual and potential contributors to a postvention response in the area were invited to form consultative and advisory groups as follows:

The Steering Group (SG)

The SG comprises 10 people from different professional backgrounds, such as First Responders and professionals providing therapeutic services, who were involved in the establishment of MSLS. SG members do not necessarily represent their sector but rather have an individual interest and commitment to the success of MSLS. The SG has not functioned as a group for some time (approximately a year) and the role of the group has changed over time in response to the changing needs of the service, that is, from focussing on laying the groundwork for developing protocols, publicity materials and work systems, to providing an advisory role as individual members as and when the need arises.

The Family Advisory Group (FAG)

The FAG comprises 8 members with personal experience of suicide bereavement. It has had an evolving role with MSLS over the past 4 years, primarily assisting with marketing and media activities to raise awareness about MSLS and to provide community education about suicide and suicide bereavement. Initially their work centred on advising how the service would be set up and subsequently involved collaboration on establishing resources for the bereaved such as the Information Pack and a reading list with book reviews on different aspects of suicide bereavement. Currently they are involved in developing a Peer Mentoring system within the Family Centre and they meet with the LW on a regular basis.

The First Responders:

The First Responders comprise those who have a specific role to fulfil at an emergency scene, including a death by suicide, such as An Garda Síochána, Funeral Directors, Clergy, Coroner, and GPs. First Responders in the Mayo region worked collaboratively with MSLS and other stakeholder groups to develop a co-ordinated response to suicides in the region. Some First Responders continue to liaise closely with the LW regarding potential and actual referrals.

Protocols and Processes

Arising out of these collaborations a number of protocols and procedures were developed to help establish and deliver the service. A brief outline is provided below and they are evaluated in the documentary analysis that follows later in the report.

Referral Protocol

A protocol and process that can be initiated at the scene of the death was established for referring those bereaved by suicide to MSLS. The aim of the protocol is to facilitate a link with MSLS in a timely manner so that those who choose to avail of support can do so as early as possible following the death (Appendix 3).

Information Pack

These packs include an information brochure about MSLS in addition to information about bereavement, First Responder roles and the processes that follow a suicide death, such as the inquest. First Responders are provided with the packs, which they can give to the bereaved as deemed appropriate at the scene of death.

Brochures

There are two MSLS brochures, one designed for the bereaved (Appendix 4) and one designed for referral agents that has been distributed widely in County Mayo to inform potential referral agents about the service.

Suicide Bereavement & Postvention Responses

“...activities developed by, with or for suicide survivors, in order to facilitate recovery after suicide and to prevent adverse outcomes including suicidal behaviour.”

(Andriessen & Krynska, 2012, p.43)

The ripple effects of suicide are far reaching and a significant number of people are profoundly affected by each suicide such as family, friends, peers and the local community. Estimates of the number of people affected vary depending on the relationship they have with the deceased (Berman, 2011), for example when confined to the nuclear family the figure is six people (Clark & Goldney, 2000), while when friends are included this rises to about forty five people (O’Connell et al., 2014).

There has been some debate in the literature about if and how suicide bereavement differs from bereavement following other causes of death and if designated suicide bereavement services are required or indeed desirable. These divergent views are reflected within the Irish context. A report, commissioned by NOSP and published in 2008, concluded that *“No clear and compelling evidence-based justification has been identified that suggests that suicide bereavement support is sufficiently different so as to require a standalone, dedicated response”* (Petrus Consulting et al., 2008, p.4). On the other hand it has been suggested that postvention initiatives in Ireland are welcomed in some contexts (Begley & Quayle, 2007) and should be developed in line with international best practice (Console et al., 2012).

There is a growing body of evidence suggesting that suicide bereavement is a more prolonged and complex grief reaction than bereavement following other causes of death (Grad, 2005; Sveen and Walby, 2008) and is characterised by intense shame, stigma, confusion and self-blame (Begley & Quayle, 2007), anger (Tal Young et al., 2012) and rejection (Jordan, 2001). It is also proposed that this intense grieving process can lead to further complications, such as mental and physical health problems (Jordan & McIntosh, 2011), and that the suicide bereaved pose a higher risk of suicide than the general population (De Grott & Kollen, 2013). Some studies have identified specific factors contributing to traumatic grief responses of the suicide bereaved, such as the violent nature of the death or discovery of a mutilated body (Andriessen & Krynska, 2012). Others suggest that suicide bereavement entails different processes in relation to the thematic content of the grief, the social issues surrounding the survivor and the

impact on the family system (Pompili et al., 2013). The content of the grief frequently surrounds *“the haunting question – WHY?”* (Gordon, 2011), which results in an intense and sometimes prolonged search for answers as the bereaved seek to make sense of the death. From a social perspective, studies have suggested that perceived stigma influences the grief process by delaying recovery as the bereaved are less likely to talk openly about the death for fear of being blamed (Sudak, Maxim & Carpenter, 2008) and to discuss their traumatic experiences surrounding the death (Young et al., 2012). Finally, it has been reported that family interactions can be negatively impacted leading to communication shutdown, disrupted role functioning and relationships, and family conflict (Jordan, 2011).

While postvention services have been criticised for further stigmatising suicide and pathologising survivors by placing them within the domain of mental health (Walter, 2005), there has been a growing body of evidence related to the benefits of postvention services. Postvention responses have been identified as key in supporting those bereaved in their grieving process and reducing the risk of suicidal behaviour, thereby also serving as a suicide prevention measure. Studies have also shown that the provision of outreach supports at the time of a suicide assist in linking the bereaved with appropriate services and increase the likelihood of uptake of such services (Szumilas & Kutcher, 2011). This is important as feelings of isolation and disconnection increase suicidality while feeling connected serves to assist people in transcending suicidality (Gordon et al., 2011; 2014).

This evidence base in postvention, along with greater recognition of the unique needs of those bereaved has led to a gradual increase in postvention responses in recent years, with a fourfold increase between 1997 and 2005 when seventeen countries had some form of service in place (Grad, 2005). Services vary hugely in the nature, duration and configuration of the response model, and include outreach at the scene, bereavement support groups, professional mental health support, social support and literature on suicide and grief (McMenemy et al., 2008). More active postvention models (APMs) to suicide bereavement have begun to replace a historically passive model that required survivors to find and initiate contact with support resources (Campbell, 1997). The literature suggests that proactive responses are important as those bereaved by the suicide frequently experience intense shock and grief following the death and may be unable to identify, seek or access support (Dyregrov, 2002), or indeed access practical information regarding procedures such as arranging the funeral and preparing for the inquest. Furthermore, while social support may be forthcoming in the immediate aftermath this tends to fade away over time (Dyregrov, 2002), often leaving the bereaved isolated and alone

with no information on where to seek help if this has not been provided early in their bereavement process.

A challenge for effective postvention is ensuring all those bereaved persons, from close family members and friends to those indirectly exposed to suicide, receive the help and support they need. Another challenge is to promote postvention services in a non-stigmatising manner and to make them accessible to those who choose to use them, as uptake of existing services is low. While not all those bereaved require professional help, in countries where survivor movements are active it is estimated that only about 25% of the bereaved seek help (Grad, 2005). Some reasons proposed for low uptake are the bereaved person feeling that he / she does not need or deserve help, being uncertain about the kind of help that is available and / or fearing the impact of help (Grad, 2005). This combination of factors results in a substantial time delay between the bereavement and the bereaved person seeking and availing of help (Campbell 2011), increasing the likelihood of complicated grief and the development of negative coping strategies and posing a challenge to the provision of timely services.

The provision of effective and relevant postvention responses requires good understanding of the bereavement process and needs of survivors (Andriessen & Krynska, 2012). A further challenge for postvention is to target the suicide bereaved with a flexible, personalised approach that takes account of the variability in distress experience of each individual (Pompili et al., 2013).

Summary

MSLS was established as a designated postvention bereavement service for Mayo at a time when suicide rates in Ireland were on the increase and a LW was appointed to plan and deliver the service. MSLS was informed by international postvention research and existing postvention models, was planned in collaboration with a number of key stakeholder groups and protocols and procedures were developed to help establish the service in the region.

The literature suggests that there is a growing understanding of the unique features of suicide bereavement and recognition that well informed, accessible and non-stigmatising postvention responses are required to meet the needs of those bereaved. There exists a range of postvention models and initiatives and it is important that these are configured in a way that takes account of the shared and unique individual needs of this group. A growing body of research is emerging that indicates that proactive responses increase uptake of immediate and

longer term support services, and that those who avail of such services benefit in terms of their bereavement recovery and general physical and mental wellbeing.

Section 2: The Review

“Health services are increasingly required to provide evidence demonstrating that they are meeting the highest standards of quality while providing value for money.”

(Byrne, 2015, p.149)

The MSLS has evolved since its inception in late 2011 and this independent retrospective review examines its development and activity over a three year period between February 2012 and February 2015. This timeframe was chosen to capture the evolving nature of and changing demand for the service over time. It specifically set out to evaluate the contribution and fit of MSLS as the designated postvention service in Mayo and to ascertain how the MSLS response model may inform postvention strategy and service delivery in Ireland.

The review was completed over a seven month timeframe, between March and September 2015. It was divided into 3 phases. Phase 1: Set up, involved gaining ethical approval for the research through DCU and agreeing the evaluation structures and processes; Phase 2: Implementation, involved data gathering and analysis (interviews, focus group, online survey, documentary analysis) and preparation of the interim report; and Phase 3: Reporting and Dissemination, involved preparing and presenting the final reports, both a detailed and a summary report, to key stakeholder groups - the Family Centre, NOSP, the Evaluation Review Group and the MSLS LW.

Aims and Objectives

The overall aim of the review was to assess the contribution of MSLS in responding to the needs of those bereaved by suicide in County Mayo and to establish how the model may inform postvention service delivery in Ireland.

Objectives were to:

Track the evolution of MSLS, explicate the MSLS model and service delivery structures and processes and identify strengths, weaknesses, barriers and opportunities.

Establish the level and nature of service activity and outline resource requirements, use and management.

Explore key stakeholder views and experiences of MSLS (service users, external service providers, SG, FAG and First Responders) to help determine the acceptability and effectiveness of the MSLS model.

Evaluate the usefulness and fit of MSLS within postvention services in Mayo.

Establish the fit of MSLS with national policy and standards and make recommendations for the rollout of the model elsewhere.

Study Methodology, Methods & Design

Methodology

A Case Study design (Willig, 2008) was utilized in this review. This well established approach was chosen as the most sensitive and appropriate to the characteristics of the review. It takes an idiographic perspective in that it seeks to understand a specific “case” (individual, organisation, incident etc.) in its particularity; examines the case in context thereby taking account of local and wider issues that influence the case; facilitates triangulation of data or incorporation of data from multiple sources and perspectives; incorporates a temporal element with concern for how processes develop over time; and can generate insights into social and psychological processes giving rise to new hypotheses and theoretical perspectives. This enables a range of evaluation techniques and methods to be integrated.

The case study design also allows for smaller cases (e.g. individual, family, group) to be embedded within the larger case, for example, in this review MSLS comprises the main case whereas two service users - a bereaved family and a bereaved organisation - comprise unique cases therein. These small case studies were informed by a Narrative Analysis (NA) approach (Reissman, 1993) and provide a rich insight into the issues faced by those bereaved by suicide and to the lived experience of using the MSLS model. Narrative and anecdotal information have become increasingly valued in the context of project evaluation in recent years. Personal stories provide qualitative information that is not easily classified or categorised (Sole & Wilson, 2002). Stories are used in evaluations to provide insights into individual experiences, to show impact of services, and to identify areas for further consideration. Personal stories can also influence organisational processes such as programme planning, decision-making, and strategic management. The small case studies in this evaluation are situated in the context of other stakeholder views and experiences. Finally, contextual factors were examined to establish the

impetus for and evolution of MSLS over the three year period under review and identify factors contributing to and inhibiting its successful operation.

Within the overall case study design, there are three distinct yet interlinked arms, which together addressed the key study objectives:

1. Evolution and Explication of the MSLS Model - Track the evolution of MSLS and explicate the MSLS model and service delivery structures and processes.
2. Service Activity and Efficiency - Establish the nature and level of service activity and outline resources needs, use and management.
3. Views and Experiences of MSLS – Capture the views and experiences of key stakeholders (service users, external service providers, SG, FAG and First Responders) to get a range of perspectives on the MSLS model.

Finally, all data gathered was triangulated for the purpose of benchmarking MSLS against key service performance indicators and national policy.

Methods

Different data gathering and analysis methods were used in this review. Semi-structured qualitative interviews, one to one and a focus group, were carried out to allow for the emergence of rich descriptions of the phenomenon under study that are contextually relevant (Kvale, 1996), in this case, people's experiences and views of MSLS.

One to one interviews were conducted in person or by telephone, depending on the preference of participants, which increased access to those who might otherwise have been unable to participate. A Focus group was offered as it is a useful data gathering method to encourage participation from people who might be reluctant to be interviewed alone or who feel they have little to contribute. Focus groups capitalise on communication between participants in order to generate data (Kitzinger, 1997).

An online survey was designed to capture the views of service users who might not be available for interview or who preferred this method of participation. A survey is used in cross-sectional design studies that focus on a number of cases at a single point in time with a view to gathering both qualitative and quantitative data that relate to a range of variables that can then be analysed to examine patterns of associations in the data (Bryman, 2004). The advantages of an online survey are enhanced appearance, filter questions that can direct the respondent to

relevant questions with ease and efficiency, and ease of analysis as the survey can be programmed to download responses automatically into a database. Online surveys compared with postal questionnaires get a higher response rate, a faster response speed and are more economical (Cabanoglu et al., 2001).

Qualitative data were analysed using Thematic Analysis (Braun & Clarke, 2006), which involves coding the raw data for initial themes that are then clustered to form key themes. To enhance rigour and inter-rater reliability, data were analysed consecutively by two analysts who consulted and agreed final themes.

Documentary analysis was completed on: MSLS service user records and Family Centre client records accessed through the LW; service policy documents and protocols; and MSLS publicity materials. This helped to establish service activity, resource use and marketing strategy.

Design

Access & Recruitment

MSLS facilitated access and recruitment for the study. All those referred in the three year evaluation period, comprising, families (56) and organizational groups (10) were invited to participate, with the exception of those who were not contactable or were known to be unwell at the time of the review (11). A letter of invitation, information sheet and consent form were sent by post informing them in detail about the nature and purpose of the review, inviting them to express their interest in participating and outlining participation options. Issues of anonymity and confidentiality (including limits to confidentiality), voluntary participation and data management (recording, storage, access, retrieval, deletion) were also explained. Written consent was obtained prior to interview and those who completed the online survey were deemed to consent by virtue of their participation.

Sample and Data Set

The study sample comprised stakeholders from each of the core groups involved with the development and delivery of MSLS, as follows:

MSLS Liaison Worker (LW) (n=1)

Family Centre Staff - Family Centre Director (n=1); Clinical Supervisor (n=1)

Steering Group members (n=8)

Family Advisory Group members (n=5)

External Professionals: (e.g. HSE service providers, GPs) (n=3), representing 3 different professional groups.

First Responders: (Gardaí; Coroner; Undertaker; Clergy) (n=3), representing 3 different professional groups.

MSLS Users: Family members (n=12, 11 families); Organisational Groups (n=2, 2 organisations).

Peer Mentor (n=1).

Peer Mentoree (n=1).

Some individuals belong to more than one group and therefore are represented in different data sets. In order to avoid excessive participant burden, data gathering involved conducting only one interview with each person, and where possible data were gathered in relation to their overlapping roles. Therefore, while a total of 35 individuals participated they made 38 contributions across groups that incorporated all stakeholders.

The data set comprised:

1. Qualitative Data

Qualitative data were gathered from LW, Family Centre staff, key stakeholders, and service users using one to one interviews, a focus group and an online survey. In total there were:

Individual Interviews (face to face and telephone) (n=27)

Focus Group (n=5)

Online Surveys (n=3)

2. Documentary data:

A documentary analysis was conducted to examine the service user profile, service activity, practice protocols and service publicity. This data set comprised: anonymised data from MSLS service user records (including demographic details, referral source, nature and duration of contact); anonymised data from the Family Centre client records to track uptake and nature of

follow-up services offered; materials outlining MSLS brief, provision and access (Referral Protocol, The LW role description); and promotional materials (Information Pack, Brochures).

Summary

The review used a Case Study methodology and involved gathering and analysing data from a range of sources using different methods. The review involved three distinct yet interlinked arms that tracked the evolution of MSLS and captured service activity and stakeholder experiences of the service. Data was synthesised across these three arms and the service was benchmarked against key service quality indicators and national policy, as outlined in the following sections of the report.

Section 3: Findings

In this section of the report the findings are presented under the three arms of the review and a summary of each arm is provided.

Arm 1: Evolution and Explication of the MSLS Model

This section reports on the evolution of MSLS; describes the host organisation and how it contributes to MSLS; outlines founding principles of MSLS; explicates the model of service provision; and articulates core competencies and skills for the LW role.

The Evolution of MSLS

MSLS emerged organically in the Family Centre, Castlebar. The centre has provided services for the bereaved for some years and in early 2000 began to offer psycho-educational programmes specifically on suicide bereavement. A suicide bereavement support group was established in 2004. Over time clients articulated the need for a more flexible and immediate suicide bereavement response providing the impetus for the development of MSLS.

“So I suppose our experience over the years is that people who have had suicide deaths in their family are desperate...They've never had a suicide before, or some cases may have had, and they just expected somebody to respond to them because they often have a whole lot of questions.”

Additionally, the perceived need for more co-ordination of postvention services nationally and collaboration among those involved in providing support locally led to the proposal to establish MSLS as a designated liaison service for suicide bereavement and to seek funding from the National Office for Suicide Prevention (NOSP) to support such a service.

“Initially a void out there in regard to services and for us a co-ordinated approach for families following a suicide...I think the feeling was from families...services were out there in general terms, there was no co-ordinated service, one point of contact could give some information, give some assistance, be pointed in the right direction, get counselling etc., if they wanted it.”

The MSLS response model was developed in collaboration with key stakeholders: The Steering Group to guide service development; the Family Advisory Group (FAG) to advise on the needs of those bereaved by suicide; and NOSP, who has responsibility for overseeing the development

and delivery of suicide response initiatives in the Republic of Ireland, to ensure coherence with national policy. MSLS continues to consult with and is supported by a wide range of interested parties in the community and nationally who share a passion for and commitment to postvention work.

The Host Organisation

MSLS operates out of the Family Centre and is delivered primarily by the designated Liaison Worker (LW). There are some advantages to having this arrangement, as follows:

MSLS Governance - The Director of the Family Centre holds an executive management function for MSLS, and provides a robust governance structure and support for the operations of MSLS. The decision making process runs smoothly and while the Director has ultimate authority, most decisions are made by consensus among key stakeholders.

Service Availability - MSLS is a part-time service delivered primarily by the LW, however the Director of the Family Centre provides the service in her absence. This is possible as the Family Centre has a long tradition in offering therapeutic suicide bereavement services, a support group and counselling, and therefore has skilled staff to do this work. This service is also available outside of regular working hours, if needed, thus, there is capacity to respond to service user needs in a flexible and timely manner.

LW Support - The LW receives formal supervision and informal support from colleagues in the Family Centre. This fosters a safe working environment for the LW, promotes personal safety and self-care and potentially impacts on the quality of the service.

Seamless Referral – The LW facilitates referral to appropriate services including the Family Centre, which provides a range of interventions for the suicide bereaved - individual counselling, a therapeutic bereavement support group and a peer mentoring support system.

“I have a tremendous confidence that it is overseen by [name]...having the back-up of the Centre here I think is massive.”

There are some challenges associated with configuring and delivering MSLS in this way. The identity of the host organisation influences the perceived ethos of MSLS. It has been noted that this is advantageous as the centre is held in high regard locally, being viewed as a professional and well organised service.

“The whole Family Centre in fact is an amazing organisation, amazing and inspiring”

Mixed views were expressed about the centre having religious affiliations. On the one hand it was thought that this connection might serve as a barrier to some people availing of the service.

“The Family Centre itself, that is considered going into a ... Catholic environment and that will definitely put some people off.”

Others spoke about the “calming” and “inviting” atmosphere in the Family Centre, making it easier for the suicide bereaved to engage with the service, and some saw it as advantageous that it is located in a neutral setting (non HSE non mental health).

“I don’t think the Liaison Service will be perceived to be aligned to the Church, it is not funded by the Church...the building is funded partially by the Church. I think what is an advantage here is, is that it is not in a HSE building...There is no cross over the door and there is no HSE emblem over the door and that makes it easier...you can drift in and out of these buildings without being noticed too much...this is not associated with psychiatric services and it is so much easier to get someone to come in the door here...than it is to get them through the door of a hospital....”

Choosing a host organisation is important as some associations limit accessibility because of public perception, which may adversely impact on service uptake. However, some guidelines are available to assist with this process. “Selection Criteria for Liaison Service” have been drawn up by HSE Resource Officers for Suicide Prevention (HSE ROSPs) to assist in the selection of suitable host organisations (Appendix 5). The Family Centre matches these in terms of: having a track record in the area of suicide bereavement; involving service users; working in partnership with other organisations; having project management experience; being inclusive of diverse groups, engaging with NOSP and adhering to national quality standards (Console et al., 2012). These standards were developed to promote the provision of designated, effective, relevant and quality services at different levels of intensity (Appendix 6).

“The Family Centre have also benchmarked themselves against and fully comply with the National Quality Standards for Suicide Bereavement Support Services.”

Founding Principles

MSLS is underpinned by the following principles:

Partnership: The MSLS was developed in partnership with a number of key stakeholders. This was viewed as important in establishing a co-ordinated and service user informed service. Involvement of the SG was useful as it was a multi-agency group that harnessed and reflected the diverse views of different professional and community groups.

“Initially it was good from the point of view that it was genuinely multidisciplinary... and you felt in the final document around the Service that was produced, you could see all the voices reflected in that. I suppose it was very clear with say that the families were reflected in it and it felt that the other voices were reflected in the document as well.”

The FAG provided a unique perspective on suicide bereavement and continues to provide support to MSLS. Importantly, they derive a great deal of therapeutic benefit and opportunities for growth in their involvement with each other and with MSLS and the Family Centre, viewing their contribution as an ongoing part of their recovery process.

“For me at least, I think...this group is part of our recovery. We are not just helping other people by being here we are helping ourselves....”

Collaboration with other services is paramount to ensure seamless and timely movement across services for the service user who chooses to avail of this and other follow up services.

Feedback: The response model was designed in collaboration with service users and is therefore tailored to meet their unique needs. MSLS continues to rely on feedback from service users to enhance and develop the service.

“I think a lot of the time it would really have come from the families, the families who were bereaved by suicide, their input. Basically it was felt obviously that there was a need otherwise it wouldn't have evolved as it did.”

Choice: MSLS operates on the basis that a “menu” of services is offered to service users from which they choose a particular intervention or combination of interventions that is best suited to their evolving needs, providing individually tailored responses.

“...and then they've a choice over whenever they want to look for that support. So that it wouldn't be...”

Accessibility: MSLS is designed to be an easily accessible service with a number of referral pathways that responds to all requests for support for the suicide bereaved in a timely manner, regardless of their personal circumstances or those surrounding the death.

"I mean to me it's actually primary care at one level because it's so accessible and it's self referral and it's open to everybody...."

Responsiveness: The referral protocol provides the opportunity for an early response as First Responders can signal the availability of the service. However, there are other routes into the service also which means that the bereaved can avail of the service when they are ready to do so regardless of the time lapse since their bereavement.

"...when I say time-limited, I suppose what I'm saying is that if a family is bereaved in the last month, or if it happens to be six years ago, or ten years ago - to me, if a family needs support, it doesn't matter."

Equity: MSLS is available to any suicide bereaved person in County Mayo, regardless of age, gender, circumstances of the death or relationship to the deceased. The service is provided in the Irish language, which may be a requirement for some people locally and materials are currently being developed in another language to facilitate non-national local residents.

"...anyone who is bereaved and requests the involvement of the service is responded to in the same manner, there is no discrimination between their circumstances or their relationship with the deceased..."

Quality: MSLS strives to provide a quality response informed by postvention knowledge and best practice. Strong governance structures and processes enhance quality while there is also flexibility and openness to critical feedback that will improve services.

"...we are confident that this evaluation will highlight important areas for revision..."

The Response Model

"...we're developing it all the time, because there isn't one support that we can give that will suit everybody. So it's about having a range of supports for people...."

The response model was informed by international and national postvention research and national policy and guidelines. MSLS operates as a proactive outreach community service that

provides four interlinked services including; 1) a suicide crisis response, 2) ongoing suicide bereavement support, 3) facilitated referral and 4) community support. Each of these service components is described in turn.

The Suicide Crisis Response

“There is a bond I suppose that's forged at that first meeting that can be an ongoing connection.”

The suicide crisis response refers to the initial response in the aftermath of a suicide, which may be initiated by a First Responder or by a family or organisational member. First Responders inform the bereaved about MSLS by providing verbal information and, where deemed appropriate, the Information Pack.

Once initiated, the MSLS crisis response involves connecting with the bereaved persons and offering information and emotional and psychological support, in the form of a home visit or an appointment with the LW in the Family Centre. This can occur any time following the death, which can vary between hours, days, months and in some rare cases, several years.

“She stayed there as long as we wanted her to, yes, because she talked to us and explained and asked us anything we wanted to ask and talk about and she sat there with us...”

Ongoing Suicide Bereavement Support

Ongoing suicide bereavement support is offered to the service user for as long as this is required and is delivered by the LW in person in the home, at the centre or by telephone, depending on the wishes and circumstances of the user.

“...There are some people that you might have contact with for long periods of time, or you might check in on every now and again...It depends, I suppose, on their own set-up, their own family support, friends and all the rest of it...”

While contact is sometimes initiated by the bereaved person, the LW keeps service users informed about relevant events, such as educational or memorial activities. They are also informed about services offered by the Family Centre through the mailing of a brochure outlining programmes and activities that might be suitable to their needs.

“...if somebody requests it, if somebody feels they need something then we will respond to...we’re led by the person who expresses the need or the desire to speak to somebody or meet with somebody...But we go by their need.”

Facilitated Referral

The term “facilitated referral” is used to emphasise the active role of the LW in making follow on referral. The LW supports the bereaved person to engage in services and has agreed referral arrangements with other services. This supported engagement is important as contact with MSLS is often at a time when the bereaved person may be ambivalent about receiving help, for example, due to their level of distress and / or the perceived stigma associated with the suicide. Follow on services include adult and youth counselling, other professional services and community groups. Being located in the Family Centre makes referral to the services they provide more fluid. The GP is consulted if a mental health assessment is required and he / she may refer on to the mental health services, unless the service user already has a connection with the mental health services that can be reactivated. Hence, the response is holistic and individually tailored depending on the needs and wishes of the service user.

Community Support

MSLS has been involved in a range of information sharing, support, educational and training activities over the past three years. Some of these activities are planned as part of ongoing marketing to enhance the profile of the service, some support the development of new services locally such as the peer mentoring system and some are designed in response to requests from local community groups or professionals working in the field.

Liaison Worker (LW) Competencies

The service offered is largely dependent on the particular needs of the individual or family and comprises: supportive listening; practical advice on dealing with issues related to the death for example dealing with the scene of death, the coroners court, the inquest; provision of information about referral options such as the Family Centre and supports and services in the community; provision of resources such as reading material; giving advice in relation to talking to children about the death; conducting risk assessment; and providing follow up support where necessary.

The review identified core competencies required to fulfil the role of LW, which are outlined below.

A therapeutic background to: engage with bereaved persons in an empathic manner at a very distressing time in their lives; understand the importance of and actively engage in supervision of their work; understand and operate within the scope and professional boundaries of the role and do not digress from this e.g. into a professional counselling role.

Assessment competencies to: assess therapeutic needs; conduct preliminary risk assessment and manage risk of harm to self or other.

Knowledge of support services to: identify and facilitate referral to appropriate follow on services.

Knowledge of suicide bereavement and related issues to: support others to become involved in postvention work, for example, minority groups who might be reluctant to avail of MSLS directly, such as the travelling community, non-national communities; provide information, education and training to dispel myths, advise about key issues, and signpost to relevant information and support.

Leadership Skills to: lead the service in a progressive and appropriate direction.

Communication and interpersonal skills to: liaise between service providers to co-ordinate service delivery; negotiate between competing inter-agency and inter-disciplinary agendas.

Personal Qualities such as warmth, flexibility, passion and commitment to: help sustain the LW in the role and to work effectively with a range of stakeholders.

“...somebody who, as a trained counsellor / psychotherapist has a very sensitive background... is able to engage with families, engage with individuals where they are to meet with their emotionality, to meet their grief, their anger, their trauma and to meet it in a way that’s very appropriate.”

Summary

MSLS evolved organically from suicide bereavement work that was being conducted at the Family Centre where the need for a more proactive response was articulated by the bereaved, and an identified need in the local professional community for co-ordinated postvention

services. This culminated in a proposal to NOSP for funding for a designated liaison service. It is hosted in an environment that is committed to supporting this work. It evolved at a time when postvention services in Ireland did not exist as a formal entity, therefore, it has developed over time in response to emerging needs. It is underpinned by the core principles of: collaboration and partnership therefore relationship building and consensual decision-making are important; choice whereby each response is tailored made and negotiated with the service user; feedback so that it is informed by a number of stakeholders including experts by experience; and accessibility, responsiveness and quality which means that it is available in a timely manner and prides itself on providing a high quality and informed service to the target group. The MSLS model comprises four key elements; a suicide crisis response in the aftermath of a suicide, ongoing support by the LW, facilitated referral for follow on interventions as required, and community support for public and professional groups. Thus, the brief and scope of the service are clear and the role of the LW is defined within these parameters. It is a demanding role and some core competencies for this work include a sound knowledge base in postvention and service provision, good therapeutic, interpersonal, communication and leadership skills, and capabilities in the assessment and management of risk.

Arm 2: Service Activity and Efficiency

This section of the report outlines the level of activity for each component of MSLS. It provides an evaluation of operational documents and promotional materials. Resource requirements, use and management are also presented to address service efficiency. Key issues regarding service delivery are highlighted.

Service Activity

There is a substantial amount of data recorded on the service users who availed of MSLS, however this is not recorded in a systematic manner, which highlights the need for a more formal recording system. This is presented here in terms of MSLS referrals, service uptake and onward referral.

The Mayo Picture and MSLS

During the evaluation timeframe (1st February 2012 to 31st January 2015) there were 60 deaths by suicide recorded for County Mayo (9 females and 51 males) of which there were 25 in 2012, 16 in 2013, 18 in 2014 and 1 in the first month of 2015. MSLS was requested to provide a

support response in relation to 46 of these deaths, 17 in 2012 (16 male and 1 female), 14 in 2013 (11 male and 3 female), 14 in 2014 (13 male and 1 female) and 1 in 2015 (female) (Table 1).

Table 1: Mayo deaths and referrals to MSLS

Year	No. of deaths by suicide in Mayo	No. of deaths that resulted in referrals to MSLS
2012	25	17 (68%)
2013	16	14 (88%)
2014	18	14 (78%)
2015	1	1 (100%)
Total	60	46 (77%)

The LW was made aware of other suicide deaths in the county although referrals were not completed. In these cases either the families concerned did not wish to engage with support services as they perceived themselves as having adequate family supports, or they were already engaged with professional services with which they reconnected for support, or they resided in another County where they sought supports, access to which was facilitated by the LW in some instances.

The relatively high referral rate to MSLS may indicate that it is becoming recognised as a designated suicide bereavement service that is available at a county wide level. Over time, the number of people who avail of the service after their bereavement may increase, which facilitates early intervention as recommended in postvention literature on best practice in the area.

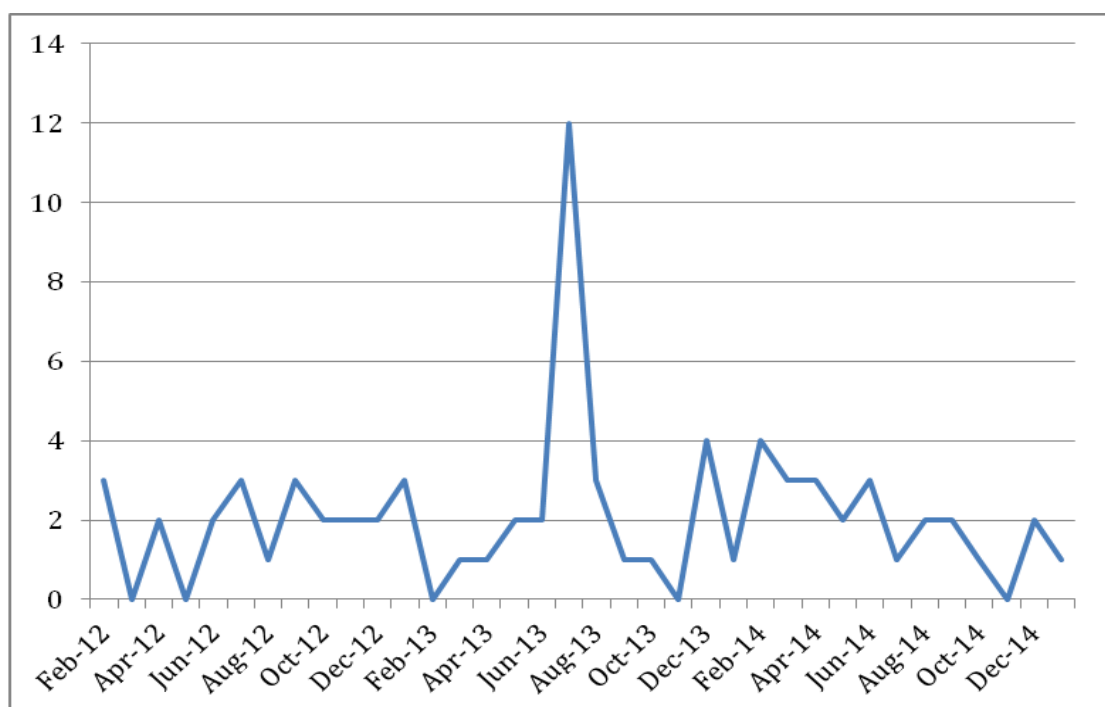
Suicide Crisis Response

MSLS referrals

During the three-year timeframe MSLS service activity related to 66 deaths by suicide, of which 46 related to Mayo deaths, 13 related to deaths outside County Mayo and 7 related to deaths that occurred prior to the evaluation period. With regard to the deaths that were recorded for other counties, 9 of the families resided in Mayo and 4 were referred to MSLS as there was no designated liaison service in their respective counties at that time.

A total of 77 referrals were made, representing 67 families (nuclear, extended, close relationship) and 10 organisational groups who were associated with a death by suicide. Figure 1 provides detail of the distribution of referrals by month.

Figure 1: No. of referrals to MSLS by month (n=77)



There is a noticeable increase in referrals in July 2013, which followed a radio interview with the LW that drew attention to the nature and availability of the service. This highlights the impact of positive publicity on service demand, thus the need to prepare for such a response when undertaking high visibility activities.

Referral Sources

Referral sources varied over the three years. The majority of referrals were self-referrals (30), where information about the service was provided through different secondary sources as follows: online search for supports (8), ex-MSLS service users (5), Family Centre clients (3), family members (3), friends (3), GPs (2), Clergy (2), Gardaí (1), School Principal (1) and through local knowledge of the service (2). It is noteworthy that 8 people accessed information on the internet, which highlights the importance of having accurate and easily accessible information available through this medium. The numbers receiving information from MSLS users and Family Centre clients may reflect their positive view of these services.

First Responders made a significant proportion of the referrals (30%). The remaining referrals were made by health care or other professionals and family and friends, which is consistent with the Referral Protocol (Table 2). Some service users were referred by more than one agent hence the number of referral events (85) exceeds the number of referred cases (77).

Table 2: Referral sources

Referral source	No. (percentage)
Self	30 (35%)
First Responders	26 (30%)
Family & Friends	15 (18%)
HSE Child Services	6 (7%)
Education and Training	4 (6%)
HSE Adult Services	3 (3%)
Voluntary Counselling services	1 (1%)
Total	85

Time of Referral

The time lapse between the most recent suicide death, where known, and referral to MSLS varied hugely (Table 3). The time of death was unknown in 8 cases, primarily because the death had happened many years previously or the service user did not provide the date of the death. Some service users also experienced more than one death by suicide, hence the calculation 'since most recent death'. Of the remaining 69 referrals, some were made soon after the bereavement, 7 within one week of the bereavement (2 families and 5 organisations), 17 between 1 week and 1 month (15 families and 2 organisation), 21 between 1 and 6 months (18 families and 3 organisations), 8 between 6 and 12 months (8 families) and the remaining 16 (16 families) were referred over 1 year after their bereavement.

Table 3: Time of referral (n=69)

Within 1 week	Between 1 week and 1 month	Between 1 and 6 months	Between 6 months and 1 year	Over 1 year
7 (10%)	17 (25%)	21 (30%)	8 (12%)	16 (23%)

The majority were referred within six months of their bereavement (65%), facilitating relatively early supports to be put in place by MSLS, in accordance with recommendations in the suicide bereavement literature.

Uptake of MSLS

Of the 77 referrals, one declined the services of MSLS and the remaining 76 became involved with MSLS (Table 4). In total, 255 people availed of the service, comprising family members (168) and members of organisations (87).

Table 4: MSLS uptake

	Referrals	Declined	Accepted
Number of families and friends, and organisations	77	1 (family)	76 (99%)

Venue of Initial Support Meeting

With regard to the venue for the initial support contact with the LW, the majority of service users were met at the Family Centre (37), while 34 were met in various locations outside the centre, mostly in the family home or workplace. The remaining 5 availed only of telephone support and did not have any face-to-face contact with the LW as they did not perceive a need for further support (Table 5).

Table 5: Venue and mode of initial support contact (n=76)

Venue and mode of first support contact	Number (percentage)
Family Centre	37 (48%)
Outside the Family Centre	34 (45%)
Phone Support only	5 (7%)
Total	76

The Bereaved

Data were available on the 255 bereaved service users involved with MSLS. This group comprised 214 adults and 41 children (under 18). The gender breakdown for adults was females (117) and males (97), and for children, females (19) and males (22) (Table 6).

Table 6: Gender of service users (n=255)

	Male adult	Female adult	Male child	Female child
Family and Friends	40 (16%)	87 (34%)	22 (9%)	19 (7%)
Organisations	57 (22%)	30 (12%)	0	0
Total	97 (38%)	117 (46%)	22 (9%)	19 (7%)

While the majority of those who availed of the service were female (136, 53%), a significant proportion were male (119, 47%). This breakdown is interesting as there is a prevailing belief that men do not avail of help. This points to the accessibility of the service to men, which services often find challenging.

Relationship to the Deceased

Five of the families (11 individuals, 8 adults and 3 children) and 3 of the organisations (9 adults) had experienced more than one suicide bereavement. The relationship between the bereaved and the deceased involved; nuclear family (144), extended family (22), close friends (2) and colleagues (87) (Table 7).

The data regarding relationship status indicates that given 66 deaths by suicide and an estimate of 6 nuclear family affected for each suicide, MSLS saw 36% (144) of nuclear family members. This compares favourably with the literature that suggests an average uptake of 25% (Grad, 2005). However, when the estimate is broadened to include wider family, friends and colleagues estimated at about 45 per death the percentage seen by MSLS is 9% (255), indicating that this might be an area for development. Acknowledging the wide ripple effect of suicide and the need to offer support to anyone seeking this regardless of the nature of their relationship to the deceased is important to emphasise. The MSLS operates on a non-rigid and non-exclusionary definition of “family”, which was welcomed by the participants in this study.

Table 7: Relationship to deceased (n=255)

Relationship to the deceased		No.	Total
Nuclear family	Wife/Partner	20	144 (56%)
	Husband/Partner	4	
	Father	11	
	Mother	19	
	Son	23	
	Daughter	19	
	Brother	12	
	Sister	36	
Extended family	Brother-in-law	3	22 (9%)
	Sister-in-law	1	
	Mother-in-law	2	
	Aunt	4	
	Cousin (male)	4	
	Cousin (female)	2	
	Nephew	3	
	Niece	3	
Friends	Friend (male)	2	2 (1%)
Organisations	Colleagues	87	87 (34%)
Total		255	

The Deceased

Information was also available on the deceased (66). In relation to gender the majority were male 56 (85%) with a considerably smaller number of females 10 (15%), which reflects the gender trend in Ireland and globally where the male female ratio is approximately 4:1. For those whose age was known (56) ages ranged from 16 to 67 years. The majority were young making the average age at the time of death 36 years. The age profile of the deceased also reflects general trends in Ireland where the highest rate of suicide occurs among younger people (HSE, 2005). High lethality methods were used in all cases. The main method was hanging (68%) followed by drowning (13%). The use of high lethality methods has been associated with the outcome of death rather than self-injury (Haughton, 2005). These statistics confirm that suicide trends in the Mayo region were consistent with national trends.

Ongoing support

Ongoing support is normally provided by the LW to those who are not referred on for therapeutic services or community supports, who may not have access to transport and live in rural Mayo, or who may have little social or family support. Follow up contact is also made with

all service users at times of increased stress related to the bereavement, such as the inquest, first anniversary or first Christmas after the bereavement. Service users voiced their appreciation of this ongoing contact, particularly at stressful times such as anniversaries.

Facilitated referral

The service offers facilitated referral on to other services where deemed necessary and as agreed with service users. A total of 115 referrals were made to other services for follow on interventions, including: one-to-one counselling (84), suicide bereavement support groups (17), community groups (non-counselling support) (5), GPs (4), peer mentoring (3) and mental health services (2). Three of those referred on came from organisational groups and the remaining 112 were family members.

The majority of referrals were made to the Family Centre (71), while 44 referrals were to a range of other adult (27) and child (17) services (Table 8).

Table 8: Onward referral outside the Family Centre (n=44)

Service	Number (percentage)
Bereavement Counselling (Adults)	16 (36%)
Bereavement Counselling (Children)	17 (39%)
Community Support Groups	5 (11%)
GP	4 (9%)
Mental Health Services	2 (5%)
Total	44

The Family Centre received a high number of referrals as it provides a range of specifically designed suicide bereavement services (one-to-one counselling, a suicide bereavement support group with monthly follow up meetings, peer mentoring). The Peer Mentoring system is not available through any other counselling service in Mayo, however, suicide bereavement support groups have been available in the past in other services.

A number of those who were not referred on became involved in alternative community activities such as a “Walk and Talk” group, a cycling event and fundraising activities. It is

important to note that not all bereaved people require in-depth interventions and that social support and connection is an important part of overcoming adversity (Watkins, 2007).

Engagement with Follow On Services

While it was not possible to track engagement and progress of all those referred for follow-on interventions, for the purposes of this review all those availing of Family Centre services were reviewed anonymously to ascertain the type, duration and outcome of the intervention offered. Of the 71 individuals the majority (51) were referred for one-to-one counselling, 17 were referred to the therapeutic Suicide Bereavement Support Group and 3 were referred for Peer Mentoring. Uptake for counselling and support group was high at 90% (Table 9), while 2 of the 3 referred for Peer Mentoring took up this offer. Of those who engaged in one-to-one counselling all completed treatment and all those who attended the therapeutic support group completed the programme (6 sessions over 6 weeks).

Table 9: Family Centre referral and uptake (n=71).

One-to-one Counselling		Suicide Bereavement Support group		Peer Mentoring	
Referred	Availed	Referred	Availed	Referred	Availed
51 (72%) (34 females 17 males)	45 (88%) (28 females 17 males)	17 (24%) (13 females 4 males)	16 (94%) (12 females 4 males)	3 (4%) (1 female 2 males)	2 (67%) (1 female 1 male)

Community Support

The LW provides information, support, education and training for the community, which is frequently shared with and complements the work of others such as the HSE Resource Officer for Suicide Prevention, depending on the nature of this work. Therefore, good communications and avoidance of role confusion among those who are skilled in postvention work is essential to co-ordinate and bring richness to such activities.

While MSLS is not an emergency service or a designated prevention service a number of requests were made for advice on how to manage individuals who were deemed to be suicidal. These came from a range of sources including employers, teachers, friends and relatives. The MSLS response typically involved telephone advice and signposting appropriate prevention supports and services.

Informal support and information in relation to best practice issues is also provided to other professionals working in the area. Participants attested to the value of this.

“...we would ring up and that, we maybe just get a bit of support, just a bit of background. For example...the local Police and a few had met with (LW) initially just to see how to take it from there or whatever, so she is available at that level as well...”

On a more formal basis the LW provides education and training to individuals and organisations on issues related to suicide and suicide bereavement. For example, in 2013 seven sessions were conducted with various professional groups including, primary care teams, psychologists and counsellors/psychotherapists.

Documentary Analysis

Documentary analysis of publicity materials and media coverage was conducted to establish the manner in which the service is made visible to the public and stakeholders and the relevance of information provided. Operational documentation were also analysed to ascertain the extent to which these inform current practice.

Promotion of MSLS

From its inception a number of initiatives have been undertaken to market MSLS, raise awareness about suicide bereavement and promote the uptake of suicide prevention, intervention and postvention supports and services. Information about the service was communicated to a range of stakeholders and the public through different media. In addition to initial consultative meetings about the development of the service this involved: distribution of the Referral Protocol and Information Packs to First Responders; sending information letters and brochures to potential referral agents, informing them about the service provision and referral pathways; giving presentations about the service to professional groups and members of the general public; providing information in local newsletters about the service; and media involvement, including local radio interviews and articles in local and regional newspapers.

Promotional Materials

MSLS developed a number of key promotional materials, such as the Information Pack for bereaved people and a brochure outlining the service that is circulated widely to professionals.

The Information Pack

The Information Pack contains a series of documents that provide information about the grieving process, the role of the First Responders (e.g. coroner), and details of various support services available to people bereaved by suicide. The Information Pack also contains a booklet and CD (*When Someone You Love Dies by Suicide*) that provides practical guidance from people who have had experience of suicide bereavement. The pack is also available on the MSLS page of the Family Centre website, www.thefamilycentre.com/suicidebereavementsupport.html.

The pack and materials therein are high quality and are presented in an attractive and user-friendly manner. The inserted leaflets are in plain language that can be easily understood and can be used as standalone documents, which is suitable for a bereaved person who may feel overwhelmed or unable to concentrate on large volumes of text.

The Information Pack is heavily identified with the LW, who is referred to by name. This can be problematic as it focuses on the person of the LW rather than the service being provided. Some participants expressed concerns about the personalised content of the publicity materials. Thus, providing inviting materials that are not overly personalised is a consideration for MSLS, particularly given the possibility of the service being covered by another staff member from the Family Centre when the LW is unavailable.

The Information Pack is used by First Responders to signal MSLS to the bereaved. It was viewed as an invaluable resource, and both helpful and informative when talking to bereaved families.

"Like I have a couple of packs always in the back of my driver's seat so that they are there and as soon as something happens, you know...at least families can now be made aware of the service...I find it great from that point of view. To actually give something to a family...You can say, okay, the inquest is coming up, there is the bit on the Coroner or whatever and that gives some bit of clarification...That is a positive."

Some service users also found the Information Pack helpful in understanding the bereavement process but received it some considerable time after the death, when the help of MSLS had already been sought out.

"...That was too late when he came back. Far too late...the pack should be handed out much earlier than it is. I think even when an undertaker comes to the house or the guards come to the house, it has to be with them..."

Providing information that explicitly relates to suicide is complex for those at the scene, as discussed below, thus there are some issues that need to be considered regarding the use of the Information Pack in this way. Furthermore, the Information Pack contains a lot of information of which the MSLS brochure is only a small part, hence there is a danger that it will not be easily located by the bereaved.

Brochures

Two separate short brochures also provide information about the service. One is aimed at families (*Have You Been Affected by Suicide?*) and is included in the Information Pack and the other is aimed at professionals (*Supporting Families Following a Suicide*). Both brochures are attractively laid out and provide details of the service relevant to the target audience. They provide contact details for the LW and also refer to her by name.

While service activity records indicate an increase in demand following a radio interview, some stakeholders believe that there is insufficient activity publicising the service and that service visibility is low.

“If you were to ask me on an on-going basis, on a day-to-day basis, you know, do you hear about it etc., well no. It is not really out in the whole sort of public domain.”

There is ambivalence concerning publicising suicide bereavement services in the community. Some participants believe this kind of information only needs to be brought to attention if a person is in the unfortunate position to require such services. However, others believe that knowledge about postvention services is essential in awareness raising and stigma reduction.

Media Coverage

MSLS has also had media attention over the past three years. Local and regional newspaper coverage of the service has tended to centre on significant events such as the launch of the service and the publication of the Information Pack. Reports frequently contained contact information, telephone and email for the LW, however, website information was absent. News items also strongly referenced the LW and while contact information was given it did not always specify operational hours, which may lead to some confusion with regard to access to the service.

Operational Documentation

Some documents were drawn up to provide guidance on the operations of MSLS, including the Referral Protocol and the LW Job Description, each of which is discussed below.

Referral Protocol and Process

MSLS has developed, in collaboration with First Responders, a protocol to facilitate referral to MSLS. The protocol incorporates a one-page diagram outlining three referral pathways and contains a referral form. The referral protocol outlines three referral routes to MSLS. The first two refer to referral by First Responders, that is, referral by the investigating Garda or referral by another First Responder, such as GP or Clergy. If the family agrees that the death was a suicide the referral can be made by the First Responder. If the family is not in agreement, an Information Pack may be given to the family, who may contact MSLS at a later time. Option three outlines the self-referral option, whereby the family make direct contact with the LW. If they decide not to avail of MSLS at that stage they are provided with the Information Pack for future use.

“...the family are given the pack and they can either fill out the referral form there and then and send it in, or they can do it themselves later. So it is really having to come from the family member themselves. Obviously the first responder will support them in their application if they want to do it there and then. But for some people they may feel they want to take it away and think about it. So not everybody, even in that process, will engage.”

As noted above, provision of suicide related materials can be complex at the scene. The First Responders meet with the bereaved at a time of high distress and confusion, therefore they need to be sensitive and discerning in how they intervene. Those who arrive at the scene must decide how to work together with the family and judge the amount, type and timing of information provision. For example, some family members may not agree that the death resulted from a suicide despite clear evidence of this, hence acceptance of this cannot be assumed and caution in inferring a premature or unwanted verdict is imperative. Given the bereaved person's level of distress there needs to be consideration given to the potential for information overload. Thus, decisions regarding information sharing rely on the judgement of the First Responder in terms of the needs of the family and possibly their own comfort level in discussing such matters with the bereaved. Given this complexity and tension there is scope for confusion to arise between First Responders. Hence, referral processes need to be reviewed.

“So... it will be introduced as early as possible... the First Responders mightn’t be able to hand it over until the date of the funeral or whatever. And it might be a week or it might be months...And sometimes there are complications then around with that, complications regarding the death itself or regarding something that has come to light...They may need an outsider fairly much quicker, so in that situation, yeah, we would say, right, (name) might come in here...”

The protocol provides contact information for the service but does not give the web address of the Family Centre, which hosts the MSLS information page. Consideration should be given to amend this.

LW Role Description

The LW role description is outdated as it was drawn up on the basis of the tasks that needed to be completed in establishing MSLS. At that time it was also envisaged that the LW might provide counselling as part of the liaison role, however since then the service provision model has been consolidated with a clear focus on the liaison aspect of the role. There have also been changes in the role of Gardaí, with the rollout of “Family Liaison Officers” (FLOs), who provide support to families following a tragedy, including suicide. Therefore, it is important to differentiate between potentially overlapping roles of FLO and LW. In Mayo some preliminary discussion has taken place and it has been agreed that the FLO will facilitate an important supportive connection with families regarding procedures such as the inquest, while the LW will continue to provide emotional and practical support.

Service Efficiency

“I think the fact that it is backed as it is, you know what I mean, by a statutory agency I think is massive.”

Service efficiency was examined in relation to finance allocation and resource management and usage. MSLS was set up within a unique partnership arrangement between NOSP and the Family Centre therefore reporting structures and processes exist between the partners that ensure contractual compliance and accountability. For the purpose of this review the Family Centre provided information regarding how finances are sourced and managed and how resources are allocated and monitored.

Hosting a Suicide Bereavement Service

Introduction and Context

The MSLS is predominantly funded by a grant from NOSP the Family Centre. Current funding is largely based on the original application that the Family Centre made in 2011 to establish MSLS as a pilot project. Once approved by NOSP, a separate bank account was set up for MSLS and another NOSP funded initiative, which is also managed through the Family Centre (the Social Prescribing Project “HOPE” in Erris, Co. Mayo). It is from this account, that all expenditure is paid, enabling the Family Centre to track expenditure for both projects. In addition to NOSP funding, some MSLS running costs are absorbed by the Family Centre and some income from fundraising activities is allocated to MSLS to support specific projects therein.

Funding Application Process

Given the contractual arrangements between NOSP and the Family Centre it is necessary for the Family Centre to apply for the MSLS grant on an annual basis. While there is no guarantee of funding, in line with national postvention service development, there is an indication that the NOSP executive intends to continue to fund MSLS, at least in the short term. Thus, while it would be desirable in terms of financial security and for resource planning purposes to have a longer term funding arrangement, NOSP and the Family Centre have formed a strong partnership and good working relationship that allows the current arrangement to work well.

Costs Covered and Outstanding Costs

The annual MSLS grant from the NOSP typically covers the following costs:

1. The LW - The entire salary costs for the LW post, which accounts for a substantial proportion (81% approx) of the MSLS budget. As MSLS was the first service of its kind in Ireland an internal person took up this post, therefore, salary costs were based on the LW's existing salary. Time from her routine work has been back-filled by part time counsellors, whose salaries are paid directly from this dedicated account and take account of employer's costs such as Employers PRSI contributions.
2. Running Costs - The full costs of activities associated with MSLS delivery such as the mobile phone and travel costs.

3. Infrastructure – Operational systems and supports required to establish, co-ordinate and deliver the service such as technology (ICT) set-up costs, LW training costs, and a contribution towards Insurance, LW accommodation, ICT maintenance, provision of Supervision of the LW, administration and the management of the project, and printing and postage.

Therefore, in a typical year the LW salary absorbs approximately 81% of the total grant allocated by NOSF, while 16% is allocated to running costs and 3% to infrastructure to support the service.

This arrangement is fitting with the partnership approach taken by the Family Centre and with their commitment to promoting postvention initiatives in Mayo, hence, the centre makes a contribution towards MSLS by absorbing costs such as:

1. Staff Support Costs - Cover by Family Centre Director for the LW when on leave so that there is continuity of MSLS.
2. Service Support Costs – The Family Centre provides follow on services in the form of: an intensive “weekly” suicide bereavement therapeutic support group, which is facilitated by two counsellors, runs for six weeks twice a year and is followed up by a monthly support group; one-to-one counselling; and the Peer Mentoring System.
3. Running Costs – Some supervision, management, administration, LW accommodation and associated overhead costs.
4. Partnership Costs - Some costs associated with the work of Mayo Suicide Prevention Alliance (MSPA), which is an essential part of communicating the purpose and work of the MSLS as well as promoting service collaboration and co-ordination in the region.
5. Costs to support the evaluation e.g. office space, heat lighting, refreshments.

Costing Similar Services

The costings associated with the provision of MSLS provide a template for planning and implementing similar services across Ireland. However, ascertaining exact costs for a similar service is complex and depends on a range of variables. For example, the geographical size of the county, the population size and spread, suicide patterns and trends, the referral protocol and arrangements, the quality, nature and breadth of follow on service provision, the unique

local cultural context and the facilities available and commitment of the host organisation to support the service and the LW. These factors have direct implications for the nature and level of work involved in service provision. Therefore, flexibility is required to take account of such variables and a partnership approach to establishing and sustaining services is essential to respond to the needs in each area.

Summary

The activity levels for MSLS indicate that it is responding to a significant number of suicide deaths in Mayo and onward referrals to the Family Centre indicate high treatment uptake and completion rates.

There have been a range of promotional activities over the past four years, and there was a significant increase in referrals following a high profile activity. Therefore, it is important to plan for such responses. Documentary analysis revealed that while the promotional materials are of a high quality and are attractive and user-friendly, they personalise the service around the LW. This is problematic and consideration could be given to highlighting the service rather than the person. Developments regarding the role of the FLO need to be incorporated and the referral process needs to take account of the complexities associated with providing information about suicide to the bereaved. The LW role description and publicity materials also require some revision to reflect current service configuration.

The unique partnership arrangement between NOSP and the Family Centre allows for the provision of a designated postvention service for County Mayo that is embedded within and supported by the Family Centre. There are currently adequate resources for the provision of this part time service that is delivered in a flexible manner. The NOSP annual grant covers substantial costs and the host organisation is committed to MSLS and absorbs some costs that allow for service continuity in the absence of the LW and for her to be supported in a safe working environment. While costings for MSLS provide a template for service provision in other areas a number of factors need to be considered that influence service demand and provision.

Arm 3: Views and Experiences of MSLS

This section reports qualitative data analysis of key stakeholder views and experiences of MSLS. It incorporates two case studies, a family and an organization, that availed of the service followed by the four key themes that were identified in the analysis.

The Case Studies

Case Study 1: A Bereaved Family

An extended family was bereaved by the suicide of a young man who died by violent means. Initial responses were deep shock, devastation, and anger followed by numbness. A few weeks after the death some family members started to experience *“desperation and looking for an answer.”* Family members interviewed could not remember how they learned about MSLS; they knew they needed help and located the service. They were visited by the LW at their home, for which they prepared in anticipation of receiving help.

“We had even made scones that morning, you know, we had made an effort and I just think we were looking forward to someone to help us. And then you just felt that actually, you know, you were heading in the right direction afterwards.”

The LW was described as *“bright and cheery”* and the family felt relaxed and comfortable with her. The family felt that the LW *“understood the pain”* and *“got us.”* They felt they were able to trust her skill and knowledge. The LW encouraged them to talk about the person who had died using his name and to reflect on happy memories they had together. They found this a useful avenue into talking about more painful and confusing emotions.

“We sat around the table. I always remember it because I thought then...I was going to die. A heaviness...such a heaviness in my chest.”

The LW reassured them that their strong and sometimes negative feelings were a normal response in the context of suicide bereavement. She described this heaviness to the family member as a *“well of built up grief,”* which was reassuring *“because I didn’t know what it was and it was normal, yes.”*

In terms of follow on services the LW facilitated engagement by *“matching”* family members with individual counsellors and prioritised those most in need of help in collaboration with the family. Some of the younger family members attended individual counselling for a few months and found this extremely helpful.

“Well I think I just kind of got stuff off my chest, you know, I was angry, upset, I knew it was alright to kind of let it out. Even though I knew it was alright to let it out, I just found it so good to have my own, space to talk about it...”

This “space” was seen as particularly beneficial for a young male in the family as *“he found a place where he could say things that maybe he couldn’t say to anyone.”*

Some family members did not engage with MSLS or any other support service. A number of possible reasons were put forward for this; some were still finding it too painful to open up and verbalise their feelings, some were very private people who were not inclined towards help seeking, some, particularly the male members, viewed professional support as *“hocus pocus.”* A variety of other coping strategies were described as being employed instead, for example accessing friends, becoming more consumed with family / grandchildren, and engaging in physical activities such as gardening. Some family members were seen as coping less effectively than others. One person (not accessing formal support services) previously healthy, was experiencing stress related physical illness, requiring hospitalisation for the first time.

The family members interviewed realised that they have come a long way but spoke of significant times that were and are still difficult for example, the inquest, anniversaries and birthdays. One family member described being *“taken aback by the grief”* at these times. The loved and lost one would be *“forever...in our lives.”*

They described MSLS as invaluable and have signalled the service to other people. They also now feel empowered to support others and know that they can access further support for themselves in the future if they require it

“Yes. Life, I suppose, won’t ever be the same for us. We get on with life.”

Case Study 2: A Bereaved Organisation

An organisation experienced a suicide of a staff member and colleagues’ reactions and needs around this traumatic event varied.

“As the news unfolded we were all numb and weird and didn’t know how to react...we were in an awful heap. Initially it was shock and then numbness and then a real sadness. Real question marks for all of us. The whys and what happened...”

The senior staff wanted help with supporting their colleagues, particularly those that were closely involved with the person who had died and those deemed to be vulnerable, while also trying to get on with *“business as usual”*. The senior staff members were feeling quite desperate and wanted some expert advice.

"...I am not qualified to deal with what is going on here at the moment...this was the time to call in the expert."

They made inquiries and were directed to the Family Centre who referred them on to MSLS.

"So we rang people that we would know and got some feedback. And between them all there seemed to be one direction which was the Family Centre. So they wouldn't have heard of it [MSLS] as their proper title but they said 'get onto the Family Centre as they have got something'."

The organisation received a prompt response (within two hours) from MSLS. The LW advised them to observe staff and to caution them about over use of alcohol or other substances as a coping mechanism in the aftermath of the suicide. Accordingly, staff members were informed about the dangers in this kind of response, for example that this could cause further low mood and distress. This was perceived as useful advice and a useful intervention for staff.

"...I think that saved, you know? I don't necessarily think that we would have found anybody dead the next morning, but I definitely think that there would have been a row..."

Other useful immediate interventions suggested by the LW and taken up by the organisation was to get a candle and a picture of the deceased person and place them in the staff communal area.

"...you know, got a few ways of kind of trying to soothe people...I think they were solid gold...That was great for me to be able to bring in someone...I felt had a tool kit."

Staff members were offered group support by MSLS initially. The group session was experienced as extremely useful in helping people to come to terms with 'why' questions. Some staff disclosed unresolved grief from former bereavements by suicide and described being re-traumatised. They received support with this from colleagues and the LW. They were also offered individual support and there was a good uptake of this, with some staff progressing on to longer term counselling. The LW followed up with check in telephone calls and assurance of availability of support should the need arise. Staff experienced a high level of satisfaction with MSLS in terms of immediate response, ongoing support and assurance of future support if required.

"We knew that they would do something straightaway for us and they did, and they have done loads for us by the way, since then there has been a follow-up, they came and met with us again

and I think some people could be still engaging with them....I never feel alone here now. If I have a problem I pick up the phone and I know, abracadabra - there will be somebody with me."

The experience of suicide of a work colleague had longer term effects on staff and on the organisation as a whole resulting in: a person leaving the organisation; increased caution in taking on new staff; closer monitoring of staff who were perceived as vulnerable; increased care for each other; and a lasting sadness as a result of their shared experiences of bereavement.

"You are left with legacies and responsibilities that you didn't want."

Key Themes

Four key themes from an analysis of the qualitative data are presented here that reflect participants' overall views and experiences of becoming and being involved with MSLS. These themes highlight the uniqueness of suicide bereavement and diverse needs of the bereaved, the need for a personalised and flexible response and the benefits derived for involvement with MSLS and follow on services.

Suicide Bereavement is Different

Participants, many of whom experienced other forms of bereavement, viewed suicide bereavement as different. The intensity of the pain, the complex mix of emotions, the social issues surrounding suicide and being exposed to their own vulnerability and that of other family members or friends combine to make it a uniquely challenging experience.

"...but you don't know until you walk in that person's shoes you know what it is. It is a totally different bereavement."

As well as coping with the loss of their loved one, they feel laden with these additional concerns and complicated emotions such as shame, guilt, blame and anger.

"You don't even know how you are going to actually cope...we are going to explode or something. That was me...it's impossible to carry this load. Because I wasn't going to kill myself, I was determined to survive but I had no idea that you would actually pull through or how you would do it."

They see themselves as being thrust into a somewhat marginalised group while not desiring this status.

"We have become part of a club that we did not ask to join."

The trauma of the suicide leaves them feeling numb, shocked and confused. For some the suicide was totally unexpected, where on the surface the life of the deceased appeared normal, even successful and fulfilled. Sometimes there were signs that the deceased person was distressed and was struggling with life, nevertheless the suicide was an enormous shock.

"He had become another person if you like, a shadow of the person he had been. So bright, so full of hope, so full of aspirations, that he felt paralyzed I would say, life had paralyzed him, or his view of life had paralyzed him."

In the aftermath of suicide those affected by the death go through a period of torment trying to make sense of the death, trying to understand why the person resorted to suicide, what might have contributed to this and if they or anyone else could have prevented this outcome. This relentless questioning is distressing and troubling. They engage in the quest to get answers with other family members, with colleagues, with the LW and alone through researching the subject.

"Then you start thinking about 'Why? and Why didn't we see something?, Why didn't we do something? Why didn't we?', you know, but again [name] was a quiet, private guy..."

Over time there is realisation that there are no right answers, only stories of what might have been going on for the deceased person. Coming to this realisation is helpful, as it brings with it some relief and allows the searching to cease. However, it can also be daunting as it involves letting go of ever really knowing what 'caused' the suicide. Many of the bereaved eventually come to a place where the death makes some kind of unique sense to them.

"Because I know that at the end of the day from reading about people who take their lives, now he decided today I have enough pain and that would be the one thing that they all say, today I have had enough of the pain and today it is going to stop. It is not that I choose to die, I choose to stop the pain, because nothing else will."

There seems to be a particular burden on some participants, such as mothers, who judge themselves harshly for not being able to prevent the suicide of a child or help them in their distress.

"The weight on your shoulders...you're a mother number one..."

Participants want to talk about their feelings and thoughts but sometimes feel silenced. Others may not be able to listen to their pain or may not be able to talk about the death, therefore they avoid the topic. On occasion other people, including professionals, say or do things that are experienced as insensitive, adding to their sense of isolation and aloneness.

"But then again people that hadn't been through it, some people said, you know, 'now it is time to get on with your life'. I am sorry but I haven't even begun to."

Support Needs are Unique and Diverse

Participants recognised that support needs vary and that while some people desire professional support others prefer to get support from family or friends or to find their own personal ways of dealing with the bereavement. Some want to avail of help in the immediate aftermath of the suicide while others prefer to wait until some time has passed. Thus, needs are unique to each individual and diverse and finding the right response at the right time for an individual is complex.

"...obviously it is not something you realise at the time, that the grief you feel is like a roller coaster, it really is. And okay I will have a cry and I will, it will be gone and I will be okay..."

Some sought help and support out of a sense of devastation and desperation. They are experiencing profound grief and finding themselves unable to cope with daily life. Some are aware of their desire and that of others to block out the memory and emotions associated with the suicide and realising that this is unhelpful, decide to seek help. Thus, there is a sense that they are driven to seek help out of their unbearable torment and upset.

"Because we were so desperate...Desperation and looking for an answer I suppose...maybe somebody could explain something as to, you know, what happened. You hear the stories all the time but until it just, you get a phone call to say somebody has killed themselves..."

Being listened to, and being able to speak openly and freely about their concerns, their wishes, the death and their loved one, without judgement, despite the sometimes seemingly bizarre nature of these concerns, is a great relief. Being heard validates their emotions and thoughts, helps in their meaning-making process and brings comfort and calm.

"...I honestly do feel...that they found this very helpful...I am just holding onto that inner peace..."

Participants are acutely aware of the stigma associated with suicide and with seeking professional help, which influences their help seeking attitudes and behaviours and how they respond to offers of professional and community support.

"I suppose that counselling has a connotation in Irish culture that you are a fruitcake if you have to go for counselling..."

Therefore, some people did not seek help. While this issue is not confined to males it is certainly a pattern that female participants noted in their male family members.

"...now my husband is a different thing altogether, he thinks this is all a load of whatever."

The contagion effect of stigma is evident when some, who initially seek support, do not sustain the contact because they are influenced by other family members' negative attitudes towards professional help, despite finding it helpful themselves.

"I only came twice and why I didn't come again I don't know. I think that maybe I was influenced by [husband] as well in a way; do you know what I mean? Because he kind of, I would say I was coming to see [name] and he was like, you know...I did get a lot out of it."

The unique needs of each bereaved person and the importance of each individual deciding if, when and how they want to engage with professional help was acknowledged. However, due to excessive concern about other family members some participants try to encourage others to get help but may be unable to persuade them to do so. Thus, the timing needs to be right for people to avail of support following the suicide death.

"You cannot make a person do something, you try to force that, they will go, well teenagers will go so far away from it all. They know the service is here, I have mentioned it to them, (LW) spoke to them herself and it was all very raw at the time."

Seeking help is compounded by the fact that many do not know from whom or where this might be available. There is a lot of confusion among the public and professionals about service availability and some services are difficult to access, thus the LW is seen as central in assisting families to navigate this terrain.

"There's a lot of confusion out there even among professionals about who goes where, what kind of services are available, who can get what and how you go about accessing...there is a lot of confusion out there among the general public. I do think [name] is key in I suppose helping

families navigate these sometimes...quite difficult services to access or to gain information from, 'How do I get in, how do I get help?'

Many hear about MSLS by chance, word of mouth, a poster, or contacting the Family Centre who initiates contact with the LW. However, despite difficulties finding the right kind of support it is a great source of comfort to many to know that a dedicated service is available that they can contact at times of distress and that they can signal to others who experience a suicide bereavement.

"Yes. To know that someone is there and that the service is there and to me that is the most important thing."

Responding Flexibly and Seamlessly

Responding to the needs of the suicide bereaved is complex, multilayered and multifaceted and requires discrimination and navigation between the central parties involved, in addition to sensitively hearing the wishes and needs of the family.

"...I think they [bereaved families] give it measured consideration really, I think they do consider it..."

Participants viewed the "stepped approach" of MSLS as being both a unique and a necessary aspect of the service. This often moves from the initial information provided by First Responders, to the crisis response and ongoing support by the LW, to the facilitated referral to counselling and other supports. The liaison role works well as a safe pendulum between the bereaved and follow on supports and therapeutic services because good working alliances have been forged, coupled with knowledge of what respective services can offer.

"I think the relationships are there between the different agencies to make it happen a little easier than it would be in other areas."

The responsiveness of MSLS is considered a key positive feature of the service. When contact is initiated the LW responds quickly, within hours if possible and sometimes at weekends. Participants engaged more easily with follow on services as referral happened promptly and they were supported in the waiting period and during the process of engagement with the new service.

“Yes. At the time and we didn't have to wait like for months for anything...Everyone was fixed up very quickly...So I couldn't see anything wrong with it...We just saw they were there for us...”

Having a named central person and location is viewed as useful for service users as this makes the service inviting and user-friendly. However, it also raises anxieties about long term provision of the service, for instance if the LW were unable to continue in the role and the potential negative fall-out of this scenario for service users.

“Yes, that sort of cohesion and that support, I think the intense support, having one key person there...if that were to go I think particularly the families would really lose out.”

Participants perceive county wide ownership of the service as important so that the professional community and public view it as accessible to them regardless of their level of connection with the host organization.

“What I would like to see happen is that there would be a kind of sense of ownership if you like of the service...So a little bit of a worry that I would have is that whether or not then, if you know, the people that are involved in setting it up and putting it in place, that there is some way of getting ownership of it...”

Participants have concerns about the extent to which the model can be replicated in other areas and that perhaps this might be done in name only while the model is not actually followed through in its entirety and is therefore compromised.

“...The fear I would have is that, you know, that it maybe tried to be replicated elsewhere but not replicated.”

Benefits are Tangible

There were specific aspects of the MSLS that participants found beneficial and characteristics of the LW that allowed them to engage with the service. Thus, while a suicide bereavement liaison service may not suit the needs and wishes of every suicide bereaved individual, those who availed of MSLS attested to its value.

“I just wanted to, just to say how fantastic I just thought this was, and then I was able to give that information out to somebody else.”

Characteristics of the LW, such as the kindness, the sensitivity, care, concern and respect shown by her made engaging with the service nonthreatening and helped to build trust. The LW was viewed as professional but approachable, and the bereaved service users felt understood which brought with it a sense of calm and comfort.

"It was her way and just...and I just think we were looking forward to someone to help us...And then you just felt that actually, you know, you were heading in the right direction..."

The home visit is important as it allows participants to meet with the LW in the safety of their own home and with other family members at a time when they are feeling so mentally depleted that they do not have the energy to pursue or attend appointments elsewhere, or to travel to a place that is not familiar to them.

"...and we felt relaxed straightaway. Just felt comfortable with her...and she had this very positive, you know, outlook and she understood. You know, she recognised our pain and knew what it was all about."

The ongoing support provided in the form of telephone calls, texts, emails or in person at times of distress, such as anniversaries, were much appreciated and served as a reminder that support was available should they need to reengage, particularly valuable given the unpredictable nature of their bereavement.

"Yes. It comes in waves, I think. [name] was very distressed at the anniversary...."

Participants also benefitted from the follow on interventions, such as counselling, that resulted in reduced levels of psychological distress, better family communication and functioning and improved coping mechanisms.

"Well, I think I just kind of got stuff off my chest, you know, I was angry, upset...I just found it so good to have my own, own space to talk about it..."

Others attended a suicide bereavement support group, which they found invaluable, as they were able to share their stories and experiences with others who understood their pain and the unique issues associated with death by suicide.

"For me it was the bereavement group that I came to, it went on for a period of six weeks...there was myself and there was four of us...There was one sister and there was one parent... a wife...they were all lovely people..."

However, it was also stressed that the timing of becoming involved in a group is important, as the person must be ready listen to other stories of loss and distress.

"...we have come to a meeting, this was months later and three people spoke...but I think [name] just found it, you know, just too much...even to this day...."

The peer mentoring system, where by a bereaved person provides support to another who is more recently bereaved, was also experienced as helpful to both the person providing support and the person receiving support. The mentor benefits from providing support to another as they move further in their own recovery path. The importance of being ready to take on such a role was also stressed.

"...if I knew somebody was in the same position as we were [number] years ago, I would do anything to be able to help...I would be able to now whereas I couldn't have done anything like this, it was just too raw..."

Peer contact and support is viewed as important as it allows the bereaved to form a bond and also keeps to the forefront of people's minds that the suicide bereaved are an important group that should not be forgotten after the initial crisis period has passed.

"It's important we are not forgotten"

Some participants reflected upon the wider impact of having a positive experience with MSLS, influencing their views about seeking professional help and perhaps reducing the stigma associated with this.

"...I had never been to counselling session before. So for me it kind of debunked it and took away the issues...this was a big learning curve for me. So if someone said to me now, you should see someone for counselling, I would be much more open to it. I would break down their barriers about it too..."

Another community level influence was that of increased knowledge and skill in the area of suicide bereavement. However, some desire more of this kind of expert input.

"A bit of sharing of information, you know how does [LW name] work with families...a little bit of training might be useful..."

Summary

Two small case studies, one of a family and one of an organisation captured the essence of the MSLS as being timely, responsive, flexible and high quality service. Participants felt understood, benefited from the provision of information, the individually tailored response, choice of services that acknowledge the diversity of needs of the bereaved, and flexibility of the service in terms of timeliness and nature of response. The four key themes highlight the unique nature of the experience of being bereaved by suicide and thus the need for uniquely designed responses. These experiences underscore the complexity of needs and responses required that fit well with a stepped approach to service provision, ranging from information sharing to individual or group support, to securing therapeutic services.

Summary of Findings

Arm 1: Evolution and Explication of the MSLS Model

MSLS evolved organically within the Family Centre based on the articulated needs of clients attending the service and recognition that postvention suicide responses in the region lacked co-ordination. This resulted in a proposal to NOSP for funding for a designated liaison service, which was established in 2012.

The Host Organisation is committed to supporting a quality postvention bereavement service for Mayo and actively contributes to service co-ordination in the county in addition to working closely with national bodies. It meets the criteria for selecting a host organisation and operates within national standards. Operating under the umbrella of the Family Centre provides a strong governance structure for MSLS and support for the LW. A key consideration with regard to service identity and ownership is the promotion of MSLS at a county wide service that forms part of a national suicide bereavement response.

The MSLS model delivers a co-ordinated postvention model that incorporates four components: 1) a suicide crisis service - a timely and flexible contact with the bereaved that provides bereavement support and information on available services in the aftermath of suicide; 2) ongoing one to one and family support that is delivered through various modes of contact and with choices about venue; 3) facilitated referral to appropriate services in the region; and 4) community support - information, support, education and training for the community. The

model fits with best practice as it is timely, flexible, tailored to the needs of individuals and is informed by postvention research.

The LW provides a central focal point engaging the suicide bereaved with appropriate services. This work is multifaceted and demanding and requires good therapeutic, communication, interpersonal and leadership skills, and competencies in risk assessment and risk management.

Arm 2: Service Activity and Efficiency

During the evaluation period, 2012-2015, there were 60 recorded deaths by suicide in Mayo. MSLS was requested to provide a response in 46 of these cases in addition to responding to 13 deaths from outside the county and 7 deaths that occurred prior to the review period. Thus, all service activity related to 66 deaths by suicide.

A total of 85 referrals were activated, representing 77 cases (67 families and 10 organisations), some of whom were referred through more than one source. Referrals came from a range of sources including; self-referral (30), First Responders (26), family / friends (15), HSE child services (6), educational settings (4), HSE adult services (3), and voluntary counselling services (1). The majority were referred within six months of their bereavement, facilitating relatively early supports to be put in place by MSLS, in accordance with recommendations in the suicide bereavement literature.

Of the 77 cases referred 1 declined involvement with MSLS and the remaining 76 engaged. A total of 255 individuals, (representing 66 families and comprising 168 individuals and 10 organisations comprising 87 individuals) engaged with MSLS. The first support contact with the LW took place at the FC (37) or in various locations outside the centre (34), mostly in the family home or workplace. The remaining 5 availed only of telephone support and did not have any face-to-face contact with the LW as they did not perceive the need for further support.

Ongoing support is normally provided by the LW to those who are not referred on for therapeutic services or community support, those who may not have access to transport and live in rural Mayo, or those who may have little social or family support. Follow up contact is also made with all service users at times of increased stress related to the bereavement, such as the inquest, first anniversary or first Christmas after the bereavement. They are also informed about support activities locally, such as memorial services. Service users voiced their appreciation of this ongoing contact, particularly at stressful times such as anniversaries.

A total of 115 referrals were made to other services for follow on interventions, including: one-to-one counselling (84), suicide bereavement support groups (17), community groups (non-counselling support) (5), GPs (4), peer mentoring (3) and mental health services (2). Three of those referred on came from organisational groups and the remaining 112 were family members.

The majority of referrals were made to the Family Centre (71), while the remaining 44 were referred to other adult (27) and child (17) services. The Family Centre received a high number of referrals as it provides a range of specifically designed suicide bereavement services (one-to-one counselling, a suicide bereavement support group with monthly follow up meetings, peer mentoring). The Peer Mentoring system is not available through any other counselling service in Mayo, however, suicide bereavement support groups have been available in other services in the past.

A number of protocols and processes were established early in the development of MSLS. Documentary analysis revealed that referral protocols and processes need to be clarified and updated in light of new developments in postvention responses in the area, such as the development of the Garda Family Liaison Officer (FLO), and the complexities involved in provision of suicide related information to the bereaved at the scene. The role description of the LW also needs to be updated to reflect current service provision, which does not involve the provision of counselling as was originally considered.

Publicity materials are high quality and attractive. However, they need to be updated to reflect current service provision, which has been consolidated over time. While it was originally viewed as important to make person of the LW visible in promotional materials these need to be amended to increase visibility of the service. Given the development of postvention services a strategy for promoting the visibility of the service as a county wide service that is part of a national response is now needed.

The service maximised its resources during this evaluation period by focusing its efforts on providing a timely, accessible and relevant response to those who availed of the service and promoting suicide and suicide bereavement awareness in the community. Suicide trends are unpredictable therefore the precise resource requirements for MSLS in the future are hard to predict. Thus, while resources are currently perceived as adequate this may need to be reviewed over time.

The costings associated with the provision of MSLS provide a template for planning and implementing similar services across Ireland. However, ascertaining exact costs for developing postvention services elsewhere is complex and depends on a range of variables. For example, the geographical size of the county, the population size and spread, suicide patterns and trends, the referral protocol and arrangements, the quality, nature and breadth of follow on service provision, the unique local cultural context and the facilities available and commitment of the host organisation to support the service and the LW. As these variables have direct implications for the nature and level of work involved in service provision, flexibility and a partnership approach is important in establishing and sustaining services in each area.

Arm 3: Views and Experiences of MSLS

Qualitative analysis revealed four key themes: the first theme highlights that suicide bereavement is experienced as different from other forms of bereavement and therefore requires a uniquely tailored response; the second theme draws attention for the need for flexibility and choice as the needs to the suicide bereaved are diverse; the third theme highlights the complex nature of responding to the suicide bereaved and confirms that a stepped approach is a useful model of provision; and the final theme reflects that those involved with MSLS experiences it as beneficial.

These themes together with the case studies highlight the intense pain and devastation experienced by the suicide bereaved, which is compounded by the social stigma associated with suicide and availing of professional help. They also attest to the value of MSLS as a designated suicide bereavement service that is responsive, informed and flexible in meeting the needs of individuals.

The stepped approach is helpful and allows people to avail of the level of service with which they are ready to engage as they move through the bereavement process. The participants clearly outlined the benefits associated with each component of the service, from the initial response at a time of crisis to referral onwards. MSLS addresses their core concerns such as worries about their own vulnerability and that of other family members and their subjective experiences as suicide bereaved such as the profound pain and distress they endured in their bereavement process. Aspects of the service identified as being particularly useful are its unique focus on suicide bereavement, pro-active and responsive approach and informed and sensitive response.

Peer contact and support was identified as hugely important and the mutuality of helping and being helped was highlighted. This reflects the importance of reciprocity in help seeking, which allows those who have sought help to 'pay back' for help received. This is important particularly for men who are reported to be less likely to avail of traditional talking therapies where the expectation is to engage in "emoting" (Cleary, 2005), but who may benefit from mutually supportive activities (Gordon, 2010). Therefore, it is a key consideration in planning and developing suicide bereavement services.

Participants also identified characteristics of the LW that allowed them to engage with her as a person and with the service, for example her warmth, compassion, and wisdom. She is viewed as professional yet approachable and sensitive to their pain and needs. The role of the LW is seen as providing a crucial link between the bereaved and a range of supports and services in a context where there is sometimes confusion about service provision and access.

Some concerns were expressed that MSLS is overly identified with the LW who is currently in the post and with the Family Centre, causing anxieties about future service provision and quality if the post holder was to change. However, in reality MSLS is well embedded in the Family Centre, which shares the ethos of MSLS and provides continuity of the service. Concerns were also expressed in relation to: succession planning for the LW and resource commitments for the service in the longer term; promoting ownership of the MSLS model at county level; making the service more visible in the community; and exercising caution in replicating services where service user needs, resources and structures vary hugely.

Section 4: Conclusions & Recommendations

This final section of the report outlines conclusions in relation to service performance, structures and processes, and outlines key recommendations locally and nationally.

Conclusions

Service Performance

Key performance indicators against which MSLS was benchmarked include acceptability, effectiveness, capability, accessibility, responsiveness, equity, continuity, efficiency and advocacy.

Acceptability: Those who availed of the service found it relevant to their needs. Specific strengths of the service identified are its: clear focus on the needs of the suicide bereaved; high quality response; location within an organisation with an established reputation in service provision; and centrality as a liaison between the bereaved and other services and supports.

Effectiveness: MSLS is experienced as beneficial to service users who felt supported in their bereavement recovery process. The local community, public and other service providers, benefited from increased awareness about suicide and suicide bereavement and from skill enhancement. The potential overlapping of roles between LW and others (Garda FLO who provides crisis response, and the HSE ROSP who provides community support and education) needs to be given some consideration to ensure that such overlap does not impinge on the effectiveness of service delivery.

Capability: The response model and service user experiences highlight the skills and knowledge base of MSLS. The successful partnership arrangements that have been established are essential for success of the liaison function.

Accessibility: MSLS activity records indicate that it is being accessed by a significant proportion of the suicide bereaved in Mayo. Areas for future development are increasing the visibility of the service among both the public and relevant professionals and highlighting that a bereavement response needs to be flexible in how it defines the bereaved so that important groups are not excluded, such as colleagues.

Continuity: MSLS works collaboratively with other services in Mayo, which has facilitated seamless movement across services for service users. In terms of longevity the service conforms to national plans for the expansion of designated postvention services in Ireland.

Responsiveness: The responsiveness of MSLS is a key strength as it provides a timely, flexible and individualised response that promotes service user choice and autonomy.

Efficiency: MSLS operates a quality service on a modest budget and is currently adequately resourced.

Equitability: MSLS is available to any suicide bereaved person in County Mayo, regardless of age, gender, socio-economic status, circumstances of the death or relationship to the deceased. The service is available in the Irish language and materials are currently being translated into another language. Therefore it strives to provide a non-discriminatory and equitable service.

Advocacy: MSLS plays an important advocacy role for the suicide bereaved in County Mayo ensuring that their voice is represented at key decision-making forums.

Service Structures and Processes

Core service structures and processes were considered in terms of governance, partnerships and how the service is aligned with national policy.

Governance: MSLS operates within a host organisation that provides support for the service and the LW. The host organisation is well established, informed and is actively involved in service developments locally and nationally. A systematic system for recording service information would enhance accountability with accurate and easily retrieved data for ongoing audit and evaluation purposes.

Partnerships: MSLS was established on a partnership basis with: First Responders to develop protocols and procedures for a timely response to the bereaved; local service providers to facilitate appropriate and seamless follow on interventions; service users to promote an informed insider response; and national bodies to ensure conformity to the national agenda. This worked well as all stakeholder views were incorporated into establishing the service. However, while some of these groups remain actively involved, the current role and function of others is unclear. Revisiting the role of each of these groups at this stage in its development could enhance governance and strength of partnerships. Importantly, in collaboration with First Responders the referral protocol needs consideration in relation to wider changes in service

provision and the complexities associated with providing information to the suicide bereaved. There are also a number of issues to be advanced at a national level in collaboration with NOSP, such as a national postvention database.

National Fit: MSLS is informed by the national standards for postvention services (Console et al., 2012) and literature on best practice in postvention. It is underpinned by principles enshrined in national policy, as outlined in ‘*A Vision for Change*’ such as: service user involvement in service planning, implementation and evaluation; responsiveness in terms of choice and timeliness of service provision and individually tailored responses; and a collaborative approach to service provision (Government of Ireland, 2006). It also fits with the national suicide prevention strategy, specifically Goal 4 objective 4.3 to “*Improve the uniformity, effectiveness and timeliness of support services to families and communities bereaved by suicide*” (HSE, 2015, p.33) by providing a co-ordinated, high quality and dedicated suicide bereavement service.

Recommendations

Recommendations for MSLS, the roll out of the MSLS model and issues for consideration in terms of the provision of suicide bereavement liaison services nationally are provided.

MSLS

Continuity - Continue to operate the MSLS model of service delivery for the suicide bereaved throughout County Mayo. It operates a quality and relevant service within a supportive host organisation, a service resource environment that responds to requests for follow on services and a socio cultural context with specific needs, such as language and population spread, to which it responds appropriately.

Identity – Emphasise that MSLS is a county wide suicide bereavement service that is part of a national response initiative. Promotional materials need to highlight current service provision and the role and important liaison function of the LW.

Visibility - Develop a strategy for ongoing service publicity, particularly for extended family and friends who may be underrepresented in service uptake.

Quality Assurance and Standards – Develop systems for accurately recording service information that allow for regular review and audit of service provision, structures and operational procedures and processes.

Roll out of MSLS Model

The Mayo model provides a robust template for the design and delivery of other postvention services throughout Ireland. The four core elements of the model (proactive crisis response, ongoing support by LW, facilitated referral and community support) could be replicated.

Consideration should be given to factors that can potentially impact on service configuration and activity in each region, such as; county size, population size and spread, suicide patterns and trends, referral protocols, follow on service provision, local cultural context, resources and commitment of the host organization.

A partnership to establishing postvention services is preferable as it ensures a timely response to the bereaved, appropriate and seamless follow on, and an informed response.

To promote standardised service provision services should be based on established best practice guidelines and principles and adhere to the proposed criteria for host organisations and national standards and strategy for postvention services.

Clarify and regularly review the role of the LW. Key competencies for such a role include good therapeutic, communication, interpersonal and leadership skills, and risk assessment and management competencies.

National

Establish a national database to promote informed, quality and standardised practice and to facilitate good quality audit, evaluation and research.

Promote routine evaluation of service activity, quality and outcomes in addition to monitoring service user profile, response offered and availed of and impact of the service in relation to local suicide rates and trends.

Promote research that addresses: Comparison of service delivery models across counties; Identification of factors influencing the provision of postvention services in different regions and

with different groups; Identification of factors that distinguish between those who need and benefit from and do not need or benefit from postvention services.

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Appendices

Appendix 1: LW Role Description

(This is the original LW job description that has changed significantly since it was developed as described in the main text)

JOB DESCRIPTION (2011)

Family Support Coordinator Role. Suicide Postvention.

To develop an interagency protocol that will provide a structured means of pro-active contact of a family where a “suicide death” has occurred so as to make them aware of the menu of support services that are available to them.

To work collaboratively with the interagency steering group of this project.

To liaise with, and coordinate where possible, the services that are available to families where a suicide death has occurred including both voluntary and statutory services.

To devise a means by which initial information regarding a suicide death, or a suspected suicide death, can be collected and communicated to an agreed set of individuals and organisations.

To assist in the dissemination of an agreed set of information to individuals and families affected by death through suicide and where necessary to supplement existing available information.

To be the “key worker” for a number of families affected by a suicide death in the “piloting period” of this project so as to evaluate the services or information that they wish to access. This may involve the direct provision of counselling services to the family.

To assist in the dissemination of information to their related stakeholders regarding the nature of the project and how it can be utilised for client benefit.

To participate in an active evaluation of the project on an ongoing basis.

Where necessary, and when possible, to provide priority counselling services to individuals and families who contact Family Life Services.

To examine the potential for setting up a panel of people who have been affected by suicide so as utilize their opinions and experiences to inform the overall project.

To gather good quality information regarding the services available to individuals and families where a suicide death has occurred.

To ensure that the project work is carried out in accordance within the Mission and Ethos of Family Life Services.

Note: The scope of this project and its ultimate success will depend not only on the work of the project worker but also the level of cooperation and commitment provided by all the services that are available to individuals and families affected by a suicide death.

Appendix 2: Family Liaison Service (NI)

Who to contact

If you wish to make a referral to the service or for further information please contact either

Barry McGale
Suicide Liaison Officer
Old Bridge House
Glendermott Road
Waterside
Londonderry
Northern Ireland
BT47 6AU

Tel: 028 71 320138
Mobile: 07949 914100

Or

Dermot Lynch
Suicide Liaison Officer
Omagh Community Mental Health Team
41A Dublin Road,
Omagh,
BT78 1HE

Tel: (028) 82 252202
Mobile: 07949 914144



If you're in distress or despair contact
Lifeline free on:

0808 808 8000

For further information on
Mental Health issues log on to:

www.mentalhealthwest.com

**Family
Liaison
Service**

Supporting families bereaved by suicide

Design and Illustration: Michael @ WHSCT Health Promotion.

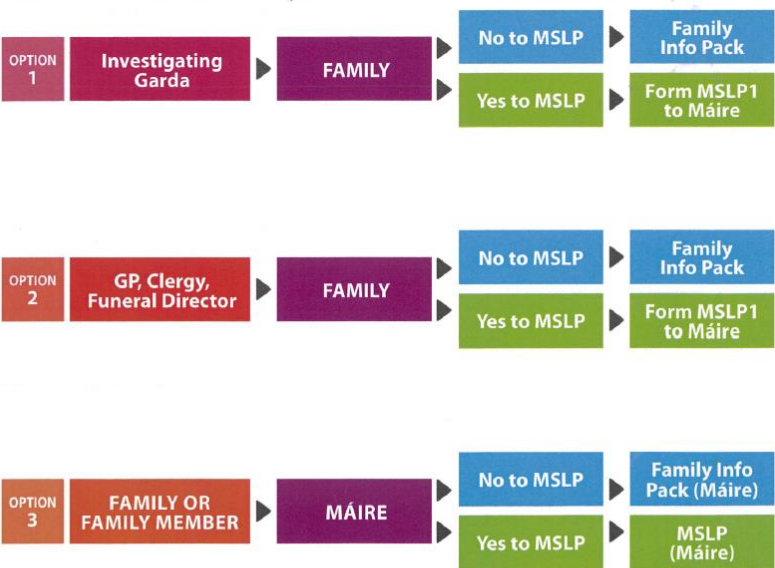
The poster features a teal background with white text. At the bottom, there is a silhouette illustration of four people standing with their arms raised in a celebratory gesture. The overall design is clean and professional.

Appendix 3: MSLS Referral Pathways

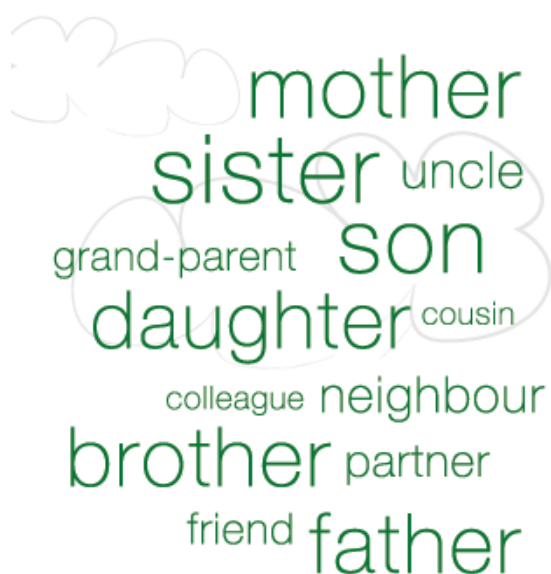
Referral to Mayo Suicide Liaison Project

The main aim of the Mayo Suicide Liaison Project (MSLP) is that following a suspected suicide a liaison person will be available to the family **if they so wish** to discuss with them the menu of supports and services available to them, linking them with and/or referring them to the most appropriate service within and outside the county.

One of the first responders (Gardaí, GP's, Clergy or Funeral Director) will **take the lead** in asking the family if they would like a liaison person to meet with them. It is VERY IMPORTANT that ALL the family are accepting it is a suicide. If they agree; the liaison person will be informed, she will contact the family directly and set up a meeting (See Option 1). If the family does not wish to meet the liaison person, a family information pack will be given to them by the lead first responder, containing contact details for MSLP and other relevant information. If for any reason the Gardaí are deemed not to be the best placed first responder to explain this service to a family, another first responder will take the lead in this situation (See Option 2). There will be no time limit to avail of this service.



Appendix 4: Service User Brochure



Have you lost a loved one to suicide?

Suicide has ended the life of a person you loved dearly. You are in grievous shock, numbed with disbelief, perhaps even careless as to whether you live or die yourself.

How could they have done this? Is there something you could have done to save them? How can you possibly cope with the enormity of this event? These are some of the many questions which torment those bereaved by suicide and make them feel utterly helpless.

If you are bereaved by suicide and you would like to know more about the services/supports in the county for you, your family, friends or colleagues please contact

Máire Ní Dhomhnaill at

Phone: 094 9025900

Mobile: 087 2172866



have you
been
affected by
suicide?

Mayo Suicide Liaison Project
Family Centre, Chapel Street,
Castlebar, Co. Mayo.
Monday to Friday: 9.30am - 5.30pm

Appendix 5: Selection Criteria for Liaison Service

- Have standards in place which comply with the National Quality Standards for the Provision of Suicide Bereavement Services: A Practical Resource for Organisations (NOSP, HSE, Console, & Turas Le Cheile, 2012);
- Have a proven track record of working in the area of suicide bereavement i.e. one-to-one, families, groups, offering general support and a professional counselling service;
- Have well-established direct supportive relationships with families and individuals bereaved by suicide, who would now be open to working towards the development of this suicide bereavement service;
- Have an established suicide bereavement support service already in place in the county or wish to establish a dedicated suicide bereavement support service in the county based on an identified need in the area;
- Have a proven track record of working with other services at local level - open to co-ordinating and communicating plans and sharing resources;
- Have project management experience including the development of a new service, as well as the expansion of an existing service, delivering on agreed goals and sharing the learning from this process;
- Be already providing an inclusive service to marginalized or diverse groups and can offer support in languages other than English e.g. Irish, etc;
- Recognise the National Office for Suicide Prevention, HSE as the Co-ordinating Centre for Suicide Prevention in Ireland.

(This information was provided by the HSE Resource Officer for Suicide Prevention in Mayo)

Appendix 6: National Quality Standards for the Provision of Suicide Bereavement Services

Console, National Office for Suicide Prevention & Turas le Chéile (2012). National Quality Standards for the provision of suicide bereavement services: A Practical Resource.

Guiding Principles

These Guiding Principles reflect strong core values that should underpin all services provided for those bereaved by suicide. Services / organisations should, at all times;

1. Ensure they “do no harm” to those who come to them for support
2. Ensure the needs of the person(s) bereaved by suicide are central to the service / organisation
3. Ensure the self-care needs and welfare of staff, service providers or support personnel involved with the service /organisation are an important aspect of service governance
4. Deliver services in an appropriate, safe and helpful manner and environment
5. Provide services that are readily accessible to those bereaved by suicide
6. Commit to providing sustainable, consistent and continuous services for the person(s) bereaved by suicide
7. Promote inclusivity and equality in all dealings with the person(s) bereaved by suicide
8. Acknowledge that there is a collective responsibility in supporting those bereaved by suicide and draw on and collaborate with communities and other agencies where possible to affect change
9. Recognise the preventative value of sound suicide postvention practices
10. Commit to the continuous training, improvement of their services and adhere to best practice standards.

Project Management

The project incorporated a number of governance structures and processes to ensure rigour, transparency and accountability, which included:

The Research Team

This group met on a regular basis to plan each stage of the review, to evaluate progress and to respond to emergent issues. The Principal Investigator communicated directly with the Director of the Family Centre and other team members liaised with the Liaison Worker as required. The team, from the School of Nursing and Human Sciences, Dublin City University, comprised the following members:

Principal Investigator (PI):

Dr Evelyn Gordon, M.Sc. (Psychotherapy), M.Sc. (Organisational Management), Ph.D. (Suicidology), R.P.N., Reg. Fam. Ther. & Supervisor (FTAI, ICP)

Co-Investigators:

Dr Rosaleen McElvaney, B.A., M.Psych.Sc. (clinical specialisation), Dip. Integrative Psychotherapy, Ph.D., Reg. Clin. Psychol, F.Ps.S.I.

Dr Liam MacGabhann, B.Sc., M.Sc. Sociology, Health & Healthcare, Ph.D., R.P.N.

Dr Briege Casey, B.A., M.Sc., PG Higher Ed., Ed.D., R.N.T., R.P.N., R.G.N.

Dr Mary Farrelly, B.Ns., M.Med.Sc. (Nursing), Ph.D., B.Ns, R.P.N., R.G.N.

Research Co-ordinator:

Issabele Pulcherio, student nurse on placement at DCU.

The Project Team

This group comprised the DCU research team, the Liaison Worker and key members of the Family Centre (the host organization) who consulted on a regular basis to monitor and assist with the evaluation.

The Project Review Group

This group comprised the PI, the Director of The Family Centre and the HSE Resource Officer for Suicide Prevention in Mayo. This group consulted three times during the project, at the time of the interim and final reports to review the progress of the project.

DCU Governance

There are systems in place within DCU to monitor and approve the ethical and financial aspects of all research projects.

The Report

This report was submitted to: The Family Centre, Castlebar, the National Office of Suicide Prevention, The MSLS Evaluation Review Group, and The MSLS Liaison Worker in October, 2015.