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**Evaluation of Counselling Partnership's 'Survivors  
of Suicide' service to inform future provision and  
commissioning**

**Final Report, January 2017**

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# **1. Executive Summary**

## **1.1 Scope of the report**

This is the final report of the evaluation of the Counselling Partnership - Survivors of Suicide service (SoS). SoS is based within the organisation Sussex Community Development Association (SCDA, Newhaven) and works in partnership with Counselling Plus (CP, Hastings); SCDA are fund holders and project managers, including for project development. SoS provides counselling services for those bereaved or affected by suicide. The evaluation was commissioned by East Sussex County Council (ESCC) Public Health; it is part of a programme of work funded by ESCC Public Health to reduce the high rate of suicide in East Sussex, with a particular focus on reducing deaths at the cliffs surrounding Beachy Head. An evaluation of Grassroots Training was undertaken alongside the evaluation of this project, with some shared methods and the findings of this evaluation are available in a separate report<sup>1</sup>

The evaluation was undertaken between September and December 2016. It assessed the following key areas: referrals, intake and assessment, experiences of the counselling process for 1-1 and group services, and outcomes. This report presents the findings.

## **1.2 Key findings**

1. Both the 1-1 counselling and bereavement services are making a distinctive contribution to suicide prevention.
2. Based on referrals received SoS meets the needs of significant numbers of people in the two categories of being affected by suicidal thoughts or behaviour, and being bereaved by suicide. Further publicity and networking is likely to increase referrals, and the full extent of the demand for the service is not yet known.
3. The service is well coordinated and managed in and across the two partner organisations, SCDA and CP. Data is captured adequately in each organisation and overall by the SCDA co-ordinator.
4. In the 1-1 counselling service, skilled counsellors work well with the time-limit of 8 sessions. They are trained and able to work effectively with suicide risks.
5. The counselling process is characterised by consistent features of holding,

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<sup>1</sup> Briggs, S., Farah, F., Hamblin-Opaluwa, L., Finch, J. Evaluation of Counselling Partnership 'Survivors of Suicide' Counselling Service to inform future provision and commissioning, Final Report November 2016, East Sussex County Council

- witnessing, hearing, and containing strong emotions.
6. The short timescale of 8 sessions ensures access to SoS for most people referred, but more sessions (up to 12) may be desirable for many, to provide more effective help for people with suicidal thoughts.
  7. Follow on counselling is desirable in many cases; this is more possible in CP where the generic counselling service is better resourced through external funding than in SCDA.
  8. The 1-1 service has good outcomes, including statistically significant reduction of problems and risks, as evidenced by the Clinical Outcomes in Routine Evaluation (CORE-OM) outcome data. Further assessment of outcomes, through a controlled study, would strengthen findings of outcomes, including at follow up.
  9. The service reaches those most in need of support for suicidal thoughts/behaviour and bereavement by suicide, including a wide age range and men and women in equal proportions. It is important that nearly half of the referrals to the 1-1 service are men; mainly women access the bereavement group.
  10. Work with family groups after a member has attempted suicide is an additional and valuable intervention that has been developed as a response to referrals to SoS.
  11. The 1-1 service appears to offer good value for money; the bereavement groupwork offers fair value for an emergent service
  12. Groupwork, in the form of an open, facilitated group, for people bereaved by suicide is an innovative intervention that is highly valued by people who attend. However, only a minority of people referred for support attend the group on a regular basis
  13. The bereavement service is evolving; the development of an early response following bereavement, outreach to individuals and families and peer support are key dynamic developments, undertaken with skill and commitment and valued by service users and referrers. 1-1 counselling is also needed for some of these referrals
  14. SoS is consistent with current thinking for supporting people bereaved by suicide, including coordination with other services, immediate outreach and the offer of group counselling.
  15. SoS currently works with bereavements experienced by family members; scoping whether there is a demand for bereavement for non-family members, including professionals working with suicidal people would assess whether the service can be expanded in this way.

### **1.3 Recommendations**

1. The counselling service meets important needs and continuing support is recommended. Future commissioning could pay attention particularly to the following recommendations
2. The possibility of greater demand for the service needs to be explored so that the service reaches more deeply into the community. Additional networking with primary care and other referrers is indicated to achieve this. This would also have resource implications for SCDA to undertake this additional work.
3. As greater demand for the service will impact on resources, support for coordination, and training and supervising counsellors to work with suicide risks need to reflect the scale of the service.
4. Offering more sessions (up to 12) in the 1-1 service is indicated clinically, though this should not be at the cost of reduced access to the service and will therefore increase the budget required
5. Work with family groups after a member has attempted suicide can be scoped to assess if this can be an aspect of commissioned services.
6. The service for people bereaved by suicide should continue to evolve. Future commissioning should recognise the part played in the service of the early response following bereavement, outreach to individuals and families, and peer support.
7. Scoping whether there is a demand for intervention for bereavements affecting non-family members can be undertaken to assess whether the service can develop in this direction.
8. The possibility of developing and delivering different kinds of group, including short-term, and possibly a group for men should be explored.
9. The initial findings for outcomes (through the CORE-OM data) for 1-1 counselling indicate that further and more robust evaluation is desirable, through a well-conducted controlled study with follow up. Materials that lead to more systematic evaluation of outcomes for the bereavement service should be introduced.
10. It is recommended that the achievements to date are reported nationally for the benefit of the communities and organisations working to prevent suicide.

## 2. Aims and Objectives

This evaluation was commissioned by East Sussex County Council (ESCC) to assess Counselling Partnership - 'Survivors of Suicide' (SoS) service established to support those bereaved or affected by suicide.

The overall objectives were to:

- assess whether the service is working effectively, being delivered in line with the aims and objectives, and how these contribute to reducing suicide in East Sussex
- to provide recommendations for future commissioning and delivery

The evaluation aimed to explore and assess how the project meets these objectives and thus contribute to suicide prevention and specifically how the service:

- reduces suicidal risks for individuals through counselling
- improves wellbeing through providing support for people bereaved by suicide

## 3. Background and contexts

### 3.1. National context

Preventing suicide is a social and health policy priority worldwide; studies show that most suicides are preventable. The National Suicide Prevention Strategy (NSPS), *Preventing suicide in England: A cross-government outcomes strategy to save lives* (HMG/DH 2012) provides an overarching strategic approach with the intention of achieving a reduction in the suicide rate in the general population in England. It focuses on:

- reducing the risk of suicide in high-risk groups
- improving mental health in specific groups
- reducing access to the means of suicide
- providing better information and support to those bereaved or affected by suicide.

Risks for suicide vary according to **gender** (males are three times more likely to complete suicide and females are more likely to make attempts) and **age** (people aged 35-49 now have the highest suicide rate). People with **mental ill health** are at elevated risks of suicide, and the **treatment and care** they receive after making a suicide attempt is an important factor in reducing repetition and completion. This recognises that a previous episode of self-harm significantly heightens the risks for ultimate completed suicide; a recent study showed that risks are 49 times greater after an episode of self-harm than for the general population (Hawton et al 2015). More than 30% of suicides take place in a public space (Owens et al 2009; PHE 2015). Prediction of suicide depends on making holistic assessments of risk and

need at the time of crisis, since risk assessments alone are inaccurate and inadequate; there are no scales that are reliable predictors, an individual's intention changes over time, and the factors that precipitate suicidal behaviour are wide ranging (NICE 2011).

There is increasing awareness nationally of the importance of support for people bereaved by suicide. People bereaved by suicide experience related mental health difficulties and increased suicidal ideation (Pitman et al 2014). Features of effective support include immediate outreach, to identify and provide information to those affected, access to one-to-one and group counselling, self-help support groups and longer-term support for some through counselling and psychotherapy (PHE 2016)

### **3.2 Local Context**

East Sussex has a higher than average suicide rate than England. Additionally, local suicide rates are increased by the impact of Beachy Head, a public place widely used for suicide attempts. For the period 2006 – 2013 there was an average 77 suicides per year in East Sussex, one third of which were of non-East Sussex residents. Of these deaths 32% (186 of the 584) took place at Beachy Head, accounting for 72% of all the non-resident deaths in East Sussex, an average of 23 per year (ESCC 2015).

In June 2013 the East Sussex Public Health team developed a proposal consisting of five interrelated strands of work in support of the suicide prevention agenda, with particular attention placed on the reduction of suicides from Beachy Head. Much of this work was developed with the help of the Beachy Head Risk Management Group. One of the proposals that the group put forward was to develop a service to support those affected by suicide, or attempted suicide, and their families and carers. Counselling Partnership was commissioned to provide this service.

The structures for delivering suicide prevention work in East Sussex are the East Sussex Suicide Prevention Steering Group and the Beachy Head Risk Management Group. The East Sussex Suicide Prevention Group, a multi-agency partnership chaired by Public Health, is responsible for co-ordinating suicide prevention work across the county and develops an annual action plan. The Beachy Head Risk Management Group is an advisory subgroup of the East Sussex Suicide Prevention Group which focuses on suicide prevention at Beachy Head. (see Appendix V for membership).

This evaluation, and the parallel evaluation of Grassroots training provision, follows on from an earlier evaluation of the Place of Calm (Briggs et al 2016).

### **3.3 Description of Counselling Partnership's Survivors of Suicide (SoS) Service**

The aim of the service is to improve outcomes for people who have been bereaved by suicide, or who have themselves attempted suicide or have suicidal thoughts, by offering effective and timely support. The objectives are to:

- Support individuals who are at immediate risk of suicide by offering services explicitly focused on suicidal and self-harming behaviour. These consist of up to 8 (initially 10) one-to-one counselling sessions for people with suicidal thoughts and intents and, secondly, supporting those bereaved by suicide through group work
- Ensure quick responses to referrals for those at risk leading to the offer of counselling by a specialist counsellor trained in working with suicidal risks and bereavement by suicide
- Provide information and support for families, friends and colleagues who are concerned about someone who may be at risk of suicide

Thus the service aims to reduce distress arising from and leading to suicidal intentions and actions, and the suffering following bereavement by suicide; it is also hoped that this might contribute in the longer term to reducing the number of people who go on to take their lives by suicide.

The SoS service is delivered in partnership between Sussex Community Development Association (SCDA) and Counselling Plus (CP). SCDA is the lead partner, being the fund holder and responsible for project management. SCDA serves Havens, Lewes and High Weald; Eastbourne, Hastings and Rother area are covered by CP. The group for people bereaved by suicide is coordinated for the whole of East Sussex by Sussex Community Development Association (SCDA).

All referrals flow through SCDA for all 1-1 clients and bereaved unless they have been referred from within CP's generic 1-1 service. The coordinators of the partner organisations allocate suitable referrals to counsellors in their areas (1-1 service) and link to cross-refer cases to ensure they are seen in the appropriate area. Rapid allocation of referrals to counsellors is a key priority for the service. Individuals referred following bereavement by suicide are initially met and assessed by the SCDA coordinator. Coordinators manage the boundaries around a counselling relationship, to support the counsellor, including monitoring and responding if necessary to suicide risks. The SoS 1-1 service is staffed by qualified counsellors, trained to work with suicide risks. Group work is facilitated by the SCDA coordinator. For clients/service users, the services are free at source.

### **3.4 The Evaluation Approach and Methodology**

The evaluation was undertaken between 1<sup>st</sup> September 2016 and 19<sup>th</sup> January 2017. The approach taken was to assess processes and outcomes, through robustly and sensitively capturing the available evidence, and using this to reach informed findings and recommendations for future development. This involved establishing cooperative working relationships with the key stakeholders in ESCC and the Counselling Service, and to apply both qualitative and quantitative methodologies to collecting and analysing data.

#### **3.4.1 Ethical issues**

An application was made to the University Research Ethics Committee (UREC) and was approved on 17<sup>th</sup> August 2016 (UREC 1516 67). Ethical issues included obtaining informed consent, and a participant information sheet and written consent form were prepared (Appendix III); the importance of sensitivity to potential individual distress experienced by participants; maintaining confidentiality of all data, safe data storage, and risk-assessment. A particular requirement was to attend to the safety of service users. Prior to all interviews, Service Coordinators were required to contact participants, clarify that they were willing to partake in the research and, if appropriate, that they were in a safe place to do so. Research team members then explained the reasons for the study, what it would involve and explained the informed consent procedures, for which participants were invited to provide written agreement.

3.4.2 Data collection and analysis: Data was gathered from a range of sources to explore and assess the experiences of service-users, staff, referrers and wider networks. The core evaluation activities consisted of:

- Analysis of written data
- Interviews with staff
- Interviews with referrers
- Interviews with representatives of organisations and services in the wider network
- Interviews with individuals that have received services

Data was gathered from the following sources:

Analysis of written data: Key sources examined were:

- Annual report covering the first year of the project, from October 2014 – September 2015.

- Case records: (detailed sessions notes of counselling sessions are held by the counsellors themselves). The coordinator monitors each case from referral through to closure by a case-notes system. This records referral, decisions about offering a service, allocation to a counsellor, sessions attended or not, closure and recommendations about future services.
- Referral data: All referrals are monitored and recorded, along with sources, initial responses and allocations to counsellors.
- Outcome monitoring data: SoS routinely collects data from CORE-OM (Clinical Outcomes in Routine Evaluation - Outcome Monitoring). This is an established tool with wide application in primary and secondary health care and for counselling and psychotherapy (Barkham et al, 2001, 2005, Connell et al 2007). It has demonstrated validity, and benchmarking with primary and secondary care and counselling and psychotherapy. The self-report measure (see Appendix 3) consists of 34 items that are all problem scored, producing ratings for overall score and in four dimensions:
  - specific problems (P) (depression, anxiety, physical problems, trauma), functioning
  - (F) (general day-to-day functioning, close relationships, social relationships); subjective well-being
  - (W) (feelings about self and optimism about the future);
  - (R) risk (risk to self, risk to others).

All items are scored on a five-point scale from 0 to 4 (anchored by: 'not at all', 'only occasionally', 'sometimes', 'often', 'all or most of the time')

In the SoS Counselling 1-1 service, CORE is completed by the client before the first counselling session and at the end of the last session to obtain before and after ratings. CORE is analysed by adding scores for items in each dimension and total scores, means are calculated and then compared at the two assessment time points. Differences between the two assessment points can be assessed statistically, using Student's T-test. Means for individuals and samples can be compared with benchmarks (Connell et al 2007) to assess the degree of clinical difficulty in the sample and the clinical meaning of reported changes over time.

- Qualitative survey at the end of counselling: Clients are asked to complete a questionnaire at the end of counselling to assess their satisfaction with, and experiences of, the service

- Group data: This consists of records of numbers attending each group session, and a rating scale undertaken by each attendee at the beginning and end of the group to assess how the group impacted on how they felt.
- Follow up-data: data from an exercise undertaken in November 2015 involving follow up of individuals who had accessed the service

### Interviews

Interviews with all participants were semi-structured, either face-to-face or by telephone, and interview schedules are appended (Appendix II). Interview data were recorded by note-taking or audio-recording and analysed using thematic analysis (Braun and Clarke 2006). Written data was analysed quantitatively through using simple statistics, thematic and content analysis (Krippendorff 2004).

- Interviews with Coordinators: We met the project coordinator (Newhaven) at the start of the evaluation (12/09/16) and followed this with meetings and discussions in Newhaven (in person) and Hastings (by telephone) on, 03/10/16, 20/10/16, 31/10/16,10/11/16. Meetings explored the coordination and management of the services.
- Interviews with Counsellors: We undertook in-depth interviews with a sample of 5 counsellors working in the SoS project in Newhaven and Hastings. The interviews aimed to obtain a detailed understanding of how counselling worked in this project, how counsellors felt equipped to work with the suicidal risks, issues arising in the process of counselling and counsellors' assessments of outcomes, especially with regard to levels of suicide risk but also regarding changes in mental health and factors that had triggered the suicidal feelings or episode. Detailed case examples, provided by the counsellors, enabled us to access the details of the counselling process.
- Referrer Interviews: We interviewed two referrers, choosing those who have made repeated referrals to the service. We assessed how referrers heard about, and made decisions to refer, to the project and how they found the referral process.
- Interviews with service users: We undertook in-depth interviews with 6 individuals who have attended group meetings. The interview focused on how they accessed the group, experiences of the group sessions, feelings about the support provided in the group, its impact on their well-being, and positive and problematic aspects, and any views on how the service might be improved.

Before commencing the evaluation, we had intended to interview clients who had accessed the 1-1 counselling service. However on reflection we decided this would not be viable. Considerable practical and ethical issues would be involved in contacting people who were no longer involved in the service, and contacting clients currently undertaking counselling could be disadvantageous to the counselling process. Additionally, there were obstacles to achieving a meaningful sample that could represent the range of people being seen. Finally, we became aware of the high quality of outcome data that provided a robust way of assessing the impact of the service.

## **4. Findings**

### **4.1 Referrals to the counselling service**

A key finding from the evaluation is that the counselling service generated a significant number of referrals. There was uptake of the 1-1 service from the beginning, and the rate of referrals has been sustained over the two years. The service was provided in partnership between SCDA and CP, with SCDA the lead organisation; overall data was collated by the SCDA coordinator. Referrals were allocated to 1-1 counselling if the presentation was for suicidal thoughts or intentions; allocation for group work was made if the presentation was for bereavement by suicide. Overall, for referrals in both categories, a similar number were referred in both the first and second year (108, 111). In both years, referrals for the group were approximately constant (40, 38). In the second year, referrals for 1-1 counselling increased from 50 to 61, whilst those not allocated reduced from 18 to 12.

1-1 referrals were seen in both SCDA and CP, depending on location. CP, the larger organisation, saw more 1-1 cases (81) than SCDA (30). Additionally, individuals who access the CP generic service, but are considered high risk, are seen within the Survivors of Suicide service; these are included in the referral data. CP sends referrals for the group to SCDA, who coordinate all group referrals. Coordinators of the services in SCDA and CP work closely together to ensure that referrals are followed up by the appropriate service.

Table 1 shows the total number of referrals and the allocation to 1-1 and group counselling for both years

**Table 1: Referrals by year**

	Total clients referred	Group	SCDA 1-1	CP 1-1	Total clients seen 1-1	Not accepted
<b>Year 1</b>	108	40	15	35	50	18
<b>Year 2</b>	111	38	15	46	61	12
<b>Total</b>	219	78	30	81	111	30

SCDA data, accounting for all referrals following bereavement by suicide, show that, for the group there was a constant preponderance of female referrals over the two years (72.5% - 73.3%). This may reflect, and be consistent with the overall suicide rates, that more men die by suicide than women, for there to be more bereaved women who have lost partner, parent or son when referrals are for loss in the family. Bereavement also affects friends, colleagues and professionals and they too may need support, though in SoS the priority within available funding was placed on family relationships (PHE 2016). There is a case for scoping whether the service can be extended to non-family bereavement by suicide, with a view to extending the service in this way.

For 1-1 counselling, referrals to SCDA for males increased from year 1 to year 2, to the point that referrals in year 2 were almost equal by gender (47% male; 53% female). For CP cases, men and women were referred in the ration 2:3 for both years. Referrals to the 1-1 service indicate that the service is acceptable to men who have suicidal feelings and is successfully reaching them, see Table 2 below). This is important in the context of male suicide rates, and that they can be difficult to engage in services.:

**Table 2 referrals by gender and year**

	Year 1			Year 2		
	Male	Female	Total	Male	female	Total
<b>Group</b>	26.7%	73.3%	100%	27.5%	72.5%	100%
<b>1-1 SCDA</b>	39%	61%	100%	46.7%	53.3%	100%
<b>1-1 CP</b>	42%	58%	100%	41%	49%	100%

Referrals were made across the age range from under 18 to over 85 years. For cases where data is available most referrals occurred in the age bands between 19 and 65 years, reflecting a wide distribution. Under 18 referrals were solely for those

family members referred for bereavement support, and not for 1-1 counselling, where the lower age limit is 18 years.

**Table 3 Referrals by age and year**

Age range	Year 1		Year 2		Total: both years	
	Number	%	Number	%	Number	%
0-18	6	6	7	7	13	7
19-24	15	16	13	14	28	15
25-34	12	13	21	22	33	17
35-44	16	17	16	17	32	17
45-54	22	24	16	17	38	20
55-64	14	15	9	10	23	12
65-74	7	8	9	10	16	9
75-84	0	0	3	3	3	2
85+	1	1	0	0	1	1
<b>Total</b>	93	100	94	100	187	100

Reflecting the demography of the county, ethnicity of referrals was predominantly white (94%), composed of White British (88%) and white non-British (6%), with 2% being of mixed ethnicity and 2% Black/black British African.

Referrals to SCDA were made by a range of organisations, as shown in Table 4; the largest number were self-referrals (41) which includes individuals being signposted to the service by professionals. The second largest group were internal referrals referred from SCDA's generic service to the specialist service. The project recruited through professionals' awareness of the service, including from GPs and secondary health providers. Referrals were made from the start, and they quickly reached the capacity of SCDA to deliver counselling services within the project.

Referrers commented on the ease of making referrals, and that the process is quick with people being seen within 1 or two days. The service is not consistently known through primary care, though it is advertised in GPs practices. Further networking with GPs could increase knowledge of the service leading to more referrals. SoS is working from the understanding that GPs wish to continue to use their existing referral pathways and therefore referrals that originate with GPs are made to SoS through other organisations, e.g. Health in Mind. Future GP involvement requires further exploration

**Table 4: Referral sources – SCDA**

Referral Source	Number	%
Self	41	40%
Generic Service - CPC	23	22%
SCDA	6	6%
Health in Mind	6	6%
Counselling Plus	6	6%
CRHT – Hastings	4	4%
Psychiatric Liaison – Hastings	4	4%
Together	3	3%
Powher	2	2%
CAHMS	1	1%
Winston’s	1	1%
Safe from harm	1	1%
SCDA Generic	1	1%
Beachy Head Chaplains	1	1%
Cavendish House	1	1%
CRHT-Eastbourne	1	1%
SOBS	1	1%
TOTAL	<b>103</b>	<b>100%</b>

#### 4.2 Intake and Initial assessments

The service coordinator at SCDA is responsible for responding to initial contacts for the SoS service. This involves an initial assessment of suitability for the service, primarily whether there are suicidal risks or bereavement by suicide and the individual’s willingness to consider counselling. Where the individual appears suitable for the service, allocation to a counsellor follows.

For those bereaved by suicide there is the added layer of assessing whether the group is appropriate for the individual and this is discussed further below (4.5). The asymmetry of the service means that those bereaved by suicide cannot be offered 1-1 counselling in the Survivors of Suicide project unless they themselves have suicidal thoughts or intentions. They can be referred to the low-cost counselling service and other services. Some individuals may not be ready or suitable for the group and this can lead to some innovative solutions, including suggestions, for example, of peer support, or family visits by the coordinator or volunteers with lived experience of suicidal bereavement. Some referrals have complex family situations and these can involve family support; the co-ordinator explores which are the best options for family members. One example which illustrates the dilemmas that can occur is of a family with a 19-year-old male on the autistic spectrum, where the

mother was emotionally involved in the son's suicidal behaviour, and their relationship was entangled, with mother speaking for son; support for both was needed before a referral for individual counselling or group attendance could be made. Home family visits are undertaken by the Co-ordinator to explore and discuss the available options and tease out the various needs and risks. Outreach appears to be a crucial element of the work with people bereaved by suicide (PHE 2016) and is discussed further below (4.5).

The co-ordinators' role includes managing the boundaries around a counselling relationship, tidying up the rough edges of the events, to support the counselling structure and therapeutic environment, or 'frame' as it is usually referred to (Langs 1982), including following up on missed sessions. They work closely with counsellors to ensure that any issues arising can be resolved quickly, and that new clients can be allocated quickly, and this absence of lengthy waiting to start counselling is a distinctive feature of the SoS service. As mentioned above, the coordinators at SCDA and CP have a close working relationship and frequent contact to ensure the links are effectively maintained, and that the service fulfils its objectives.

#### **4.3 The SoS 1-1 service: experiences of the counselling process**

Both SCDA and CP Plus have adopted the policy of employing only qualified counsellors in the SoS service. In CP it is the most experienced of the 40 available counsellors that are used in this service. Initially, counsellors working in SoS received training in working with suicide. The training, ASIST, was provided by Grassroots, and thus demonstrates a link facilitated by the commissioners between these two strands of the suicide prevention strategy in East Sussex. New counsellors receive similar training when they join SoS.

Written data provides an overview of the referrals, how they were initially responded to, allocation to a counsellor, sessions that were attended and missed, and how the counselling ended. The picture given by this data appeared typical of the processes of engagement in counselling, conveying a 'real world' view of the complex interactions that accompany the counselling process. Interviews with counsellors drew out these features to provide in-depth accounts of these relationships and the often-intense emotional experiences for both counsellors and clients. This data, above perhaps any other, demonstrates the emotional labour (Hochschild 1983) involved in counselling people who are suicidal, in order to reduce suicide risks and the factors in their lives that are troubling, distressing and potentially overwhelming.

Interviews with five counsellors demonstrated a team of dedicated skilled professionals rising to the undoubted challenge of short-term, intense counselling with suicidal people. The accounts they gave nuanced the overall picture of a service successfully recruiting and responding to suicidal people.

Counsellors all emphasised the intensity of working within a framework of a short-term intervention. The intensity was felt to increase when the number of sessions these reduced from 10 to 8. Most of the counsellors we interviewed felt that more sessions would be helpful; one view was that it was 'a shame' that the number of sessions was reduced, and that a longer period of time – up to 12 sessions was mentioned – would be advantageous for the work and the clients. On the other hand, another strand of thought was that the brief intervention provided a real focus and the counselling was a meaningful experience; it was difficult work, but 'we do incredibly well with 8 sessions' (counsellor B). Some clients were thought to need more than 8 sessions; for others 8 sessions can be enough. In addition to the time-limits, counsellors described the service as characterised by the issue of suicide being explicit from the outset, meaning that it was a clear focus for work, rather than perhaps hidden in the presenting problem and being more difficult to name. As suicide was out in the open and up-front it meant that a risk assessment could take place at the outset, with a collaborative approach being taken to discussing risks. It was also stressed that the fact that clients had not had to wait to receive counselling sessions was an important factor: it was like an 'A&E for clients' (Counsellor B). The rapid offer of a first session was thought to increase motivation and it was commented that these clients, who did not pay for their counselling, were as motivated as those in the fee-paying services. It was thought that paying a fee usually increases motivation and attendance.

The counsellors interviewed had all seen several clients, from 4 to 12, in the SoS service. They ranged in age from a young man in his teens to a woman in her 70's. All counsellors had seen male and female clients. People started counselling in urgent need, including those who were 'at absolute crisis point' (Counsellor B). As well as spanning the age range, clients came with diverse background factors that influenced their suicidal states, including traumatic bereavement, histories of being abused, relationship break ups, life stresses such as retirement, and environmental factors such as housing difficulties and poverty. Clients thus presented different challenges; young men's anger and destructiveness affected the counselling relationship, and these clients sometimes missed sessions. One counsellor reported a young man as having a painful but moving session (session 4) and then missing the next session. An older woman presented as having very severe psychological episodes and needing support from mental health services, and in this case the counselling provided a space to be and talk outside a medical context.

Counsellors approached their work from different theoretical perspectives, including humanist, integrative, TA, gestalt. However, counsellors all referred to some overlapping concepts when describing the process; clients needed to feel 'held', listened to and heard, receiving attention during the session, and having a space to

talk. The process was less about reacting to the suicidal thoughts, by 'doing', but more about letting clients say 'how it really is, witnessing despair and their worst thoughts' (Counsellor A). Being able to bear intense feelings was thus described as a core requirement of the counsellor in these cases, undertaking the emotional labour of being available in an open way to the client's emotional states. Feelings of shame and guilt frequently occurred; counsellors could also experience these feelings, and anxiety, which was present as anxiety that the client was not changing, or suicidal feelings shifting, that the counselling would not be enough, that a suicide might occur. One counsellor spoke of the fear of 'being dragged through the courts' (Counsellor E). On the other hand, counsellors could feel privileged to hear the clients' stories and witness their attempts to overcome their suicidal feelings. The quality of the counsellors' attention was evidenced by their ability in the interviews to recount each client's sessions in detail. The intensity of the work in this service can be represented by one counsellor's comment that 'what I went through is imprinted in my mind' (Counsellor C). Counsellors thus related rich accounts of their work.

Counsellors gave multi-layered assessments of the changes that occurred during the 1-1 counselling. Changes included reduced suicidal feelings, and being able to access possibilities other than suicide for expressing their thoughts and feelings. Impulses to kill oneself were assessed to diminish during the counselling; individuals could be more optimistic and find that an ability to manage their lives had returned to them. Counsellors also found that, for some clients, suicidal feelings and impulses persisted, though they had found the sessions helpful and were grateful. Counsellors discussed future support after the completion of the 8 sessions, both through further counselling or informal support. For others, a 'chink of light' appeared eventually. One counsellor (B) expressed the thought that there was something joyous in surviving the 8 sessions – 2 months is not insignificant for a suicidal person, and the ending allowed this to be recognised. Changes included feeling that the counselling relationship had offered something significantly different; some clients were surprised they could talk about themselves and their issues, and be more open than they had expected, or were used to.

Changes might not be clear cut, and there was a sense that continuing difficulties, including suicidal feelings, would continue to impact on some individuals. This was reflected in the view that more sessions would have been helpful for many clients and that further counselling would be recommended. Here there is a difference between SCDA and CP, since for the latter ongoing low cost counselling, sometimes with the same counsellor was more readily available. This led to CP counsellors positioning themselves as ready to continue working with the client after the SoS sessions, and, expecting that more counselling would be the norm, rather than the exception. One CP counsellor, for whom further counselling was not immediately possible, through the client moving out of area, spoke of feeling that they had

abandoned a client, who had made gains in the counselling, by not being able to offer continuing sessions; they had built up a relationship and helped the client trust, and then 'just sort of left him' (Counsellor D). A counsellor (C) reflected that on completing the CORE-OM forms with one client in the last session, it appeared that 'nothing had changed', but the client said the sessions had clarified things for him; he was no longer suicidal and needed to go on with more counselling to address the deeper issues. On the other hand, and this was commented on more by SCDA than CP counsellors, the ending was something to be managed and the feelings borne, if possible. Some clients may take a break from counselling and return later; one counsellor (A) mentioned a woman who returned to counselling 10 months after her SoS sessions, and she was not suicidal at this time.

On the whole counsellors felt supported in their work through supervision. The norm is a supervision session every 4 weeks. This is an accepted and acceptable frequency for experienced counsellors. BACP guidance is that accredited counsellors should receive a minimum of 1.5 hours' supervision a month ([www.bacp.co.uk/supervision](http://www.bacp.co.uk/supervision)), but more frequent supervision might be expected for work of this intensity. One of the counsellors interviewed did express the view that more frequent supervision would be beneficial for the issues and intensities of this work.

#### **4.4 Outcomes from the 1-1 service**

Outcomes have been assessed through the number of sessions attended, the findings from the CORE-OM questionnaire and the qualitative assessments of counsellors, as described above.

Sessions attended: Clients attended on average 6.88 sessions in Year 1, when, for part of the time, 10 sessions were available. In Year 2, when the counselling was limited to 8 sessions for all, the average attendance was 6 sessions. These appear to represent good levels of engagement in the process.

CORE-OM data: SoS routinely gathers CORE-OM data at first and last sessions. The data examined is for 37 individuals, of which 25 completed the CORE questionnaire at both beginning and end of counselling. We focused on this sample of 25 to compare results for before and after counselling. We calculated mean scores for the four CORE dimensions and for the total score, and a paired-samples *t*-test was undertaken. This showed the reduction of the mean score, for the sample as a whole, from the pre-test to post-test condition was statistically significant for all 4 dimensions and for the total score ( $p < .001$ ). The results are shown in Table 5, below.

Benchmarking: CORE-OM benchmarking, based on study of over 7000 reports in 49 NHS sites, employs two cut-offs: a clinical cut-off CORE mean score (1.24) and a

severe cut-off at 2.5, for both men and women (Barkham et al 2005). There are additionally clinical and severe cut-offs for each dimension. Table 5 shows that applying these cut-off scores, at the first assessment (pre-test), the sample were above the clinical cut-off, and below but near to the severe clinical cut-off. At the final session of counselling (post-test), the sample remained above the clinical cut-off for the total score, and for the Risk dimension, but just below the clinical cut-off for the Wellbeing, Problems and Functioning. The Risk dimension remains high compared with the clinical cut-off, albeit significantly reduced.

The findings can be understood as the changes over the period of the 8 or 10 sessions of counselling reducing the problems in the clients' lives, and the risks, but these remain relatively high in this sample of people with suicidal issues. It is intriguing – and not answerable – how these would look at follow-up, as previous studies have consistently shown that the effects of counselling and psychotherapy continue after the end of treatment. A further study that includes follow-up data would be desirable.

**Table 5 Means for the four dimensions and total mean score, clinical cut off calculation of change (T Test) obtained at pre-test and post-test**

<b>Dimension</b>	<b>Pre-test</b>	<b>Post test</b>	<b>Clinical cut off</b>	<b>P value (T Test)</b>
<b>Wellbeing</b>	2.42	1.56	1.57	<0.001
<b>Problems</b>	2.03	1.26	1.53	<0.001
<b>Functioning</b>	2.12	1.24	1.30	<0.001
<b>Risk</b>	2.43	1.49	0.37	<0.001
<b>Total</b>	2.19	1.33	1.24	<0.001

The limitations of the findings need to be stated. The CORE-OM data analysed relate to a sub-sample of clients seen in the SoS service. The experimental condition is a simple pre- post- test, with no control group. The accepted gold standard for evaluating outcomes is a randomised controlled trial (RCT). As there was neither control group nor random allocation of subjects to experimental or control groups causal inferences cannot be made. In other words, it cannot be stated categorically that the counselling caused the changes recorded in the CORE-OM, as other variables – including other treatments - may have also contributed to the changes. Taking account of these limitations, the finding is that statistically significant changes occurred for this sample, using this measure, in the time between the first and last session of counselling, and this is indicative that counselling may have brought about the changes.

#### 4.5 Group work for people bereaved by suicide:

Findings for the group should be considered within the context of this new and developing field of interventions for bereavement after a suicide. The importance of postvention, as it is known, has been recognised for some years, stemming from the work of Ed Shneidman (2001) in the USA; in the UK it is a relatively new intervention, and it is important to learn about what works best, in which circumstances. Current thinking uses a pyramid metaphor (see Table 6 below); at its base, everyone bereaved needs information and signposting, most people will need access to peer support or open groups, some require 1-1 support and facilitated groups, whilst a few will benefit from in-depth therapy (PHE 2016). This is schematic, but conveys that not everyone needs therapeutic interventions, that services need to be individually sensitive and the need for a range of services to be available.

**Table 6: Types of support after bereavement by suicide**

For which people bereaved by suicide	Type of support	Provided by
<b>A few</b>	<b>Therapy</b> In-depth, one-to-one psychological support	mental health service (AMHS/CAMHS/ IAPT etc) and qualified practitioners
<b>Some</b>	<b>One-to-one or group support</b> therapeutic/ psychoeducational facilitated 'closed' group	qualified practitioners and trained facilitators
<b>Most</b>	<b>Groups – open</b> Self-help, peer support Remembrance events	voluntary groups and bereaved people as self help support
<b>All</b>	<b>Information</b> on grief and bereavement by suicide and signposting to sources of support	local or national organisations

SoS was not in a position to provide comprehensive bereavement services; instead it was important to identify provision that could evolve during the project. SoS chose to use a single, open, facilitated group as the main resource; people bereaved by suicide could be invited to attend the monthly group on an open-ended basis. Initially groups met in Bexhill and Newhaven on a weekly basis; the frequency was adjusted to monthly based on demand and feedback. The group also moved to an evening so that working people could attend. The group is facilitated by the SCDA coordinator. As with all group counselling or therapy, the process from referral to attendance at the group involves assessment, and information sharing, as discussed above (4.2). For this group, for people bereaved by suicide, the initial assessment includes individuals' current needs, their relationship to the deceased, and the time since the bereavement.

#### **4.6 Accessing the group, peer support and outreach.**

SoS's approach to assessing the needs of people referred for support after a bereavement by suicide has evolved during the project. Referrals are made by health care, voluntary organisations, and the coroner's office. Initial contact now often occurs soon after bereavement, when the traumatic loss is most raw, and support needs require exploration. The initial contact following referral forms an intervention in itself of 'practical bereavement type work', as the SCDA coordinator described it. An additional term might be 'outreach'. The Coordinator described contacting people soon after the bereavement, providing information, being receptive to the thoughts and feelings of the bereaved, and explaining ways in which they can be supported. The coordinator also provides information about the inquest process and attends inquests if appropriate. This includes describing and offering attendance at the group, or the offer of 1-1 counselling in the low-cost service; responding to the individual or family at an emotional level, and providing information about other services, including bereavement services such as Cruse, or Sobs.

Assessment for the group includes identifying together the optimum time to start attending; immediately after bereavement is thought to be not usually a suitable time for group attendance as feelings are too raw and the group may be experienced as too demanding emotionally. The coordinator found it was possible to link newly bereaved individuals to receive individual peer support from members, and ex members, of the group. For example, the coordinator made initial contact with a woman whose husband had died by suicide in the previous week; she put her in contact with someone who attends the group and whose husband died 3 years previously. The coordinator maintained contact with both. Individual peer support was felt to be more manageable for this person at this time, and it is possible she will in time attend the group. An impressive feature of the work, indicating the quality of networks being developed, is that some people who attend the group become peer supporters, volunteering to support newly bereaved, and others who are not able to attend the group. For example, one woman, who felt very much helped by the group, volunteered to offer support others, and she felt this was appreciated by the women she supported, as well as providing her with a valued role as a peer supporter. Additionally, informal peer support extends outside group sessions as some group members support each other between sessions. The group has thus the potential to develop networks of support.

Outreach work also includes meeting families, as well as individuals and paying attention to the impacts of bereavement on children. Referrers commented on the value of the family work, as a factor that makes the service distinctive. The coordinator draws on a range of resources for children, including child bereavement

resources developed by the children's bereavement charity, Winston's Wish ([www.winstonswish.co.uk](http://www.winstonswish.co.uk)) and networking with local statutory and voluntary sector organisations. Work of this kind with families has become an important aspect of the coordinator's role, and underpins the process of introducing groupwork or other services. Outreach thus forms an essential basis for SoS's work with people bereaved by suicide, and maps closely on to current postvention models (PHE 2016).

Growing the peer-support aspect of the service appears to have the potential for offering support to more bereaved people. A distinct model is being developed by SoS, contributing to the development of postvention services nationally. This aspect of the coordinator's work is highly valued by these bereaved individuals, who comment on the positive effect she has on them; for example, 'I can't stress how good she is, very sympathetic and natural'. Others have commented on the coordinator's availability, often through phone calls, to individuals who are continuing to consider what bereavement support to choose.

As is the case for group work in most sectors, the group provision in this project is taken up by some individuals and not by others. Some individuals prefer 1-1 support, and in SoS, unless they have current suicidal feelings themselves, the alternative is the generic low-cost counselling service. The absence of 1-1 provision for those bereaved by suicide is felt by the coordinator to be a gap in provision, since it could help a few individuals who otherwise do not receive a service. These individuals do not find generic services appropriate. For example, one person said that a generic bereavement service was not helpful as bereavement by suicide is different.

Since it began in August 2015, the group has been attended by between 4 and 13 people, (mean = 7.9 median = 8), and monthly numbers and fluctuations are shown in Table 7, below. In effect the group is attended by a minority of people referred, in the region of 25%. However, all referred received at least an initial assessment (outreach), and signposting. As timing and obtaining a good fit between the resource and the individual's needs is vital in bereavement work, the proportion attending the group appears appropriate. Referencing the bereavement support pyramid, the expectation is that 'some of those bereaved by suicide' access a facilitated group or 1-1, and that is the picture seen here. The service could evolve to meet more people's needs, through peer support, 1-1 counselling and providing different kinds of groups. These could include short-term or time limited groups, or groups for sub-categories of bereaved people; men, having lost partners, or children, and so on.

#### **4.7 Interviews with people who attend the group**

We interviewed 5 people who attend the group, all of whom are female. Three of these have attended consistently for over a year. Two were involved from the group's

first session, though one of these has now stopped attending, because she moved home out of the immediate area. Two interviewees have joined the group more recently. The individuals expressed a range of feelings and attitudes to the group, as would be expected for this and any other group with a therapeutic aim and method.

For some of these participants, the group has become, or has been, a central part of their lives. These group members found an immediate rapport with the aims of the group, its facilitation and its members. As one participant said: “when I went to the first meeting I knew that’s where I belonged” (Participant A). For these participants, a key benefit is the similarity with others’ predicaments. Participants expressed strongly that they see the process of bereavement following suicide as different from other bereavements, and they felt ‘they were with other people who fully understand what it’s like to have suffered a suicide’ (Participant D). They prefer this group therefore to others that currently exist locally. These participants make space for the group in their lives, attend regularly, and feel it meets their needs. One participant, for example, said that she would need to create something similar if the group did not exist, and another commented that she saves her communication about her loss for the group meetings, and so it acts as a container for her grief.

Other group members, whilst also feeling that bereavement by suicide is different from other losses, have more mixed feelings, notice differences between the group members and are less regular in their attendance. Differences include the length of time people have been bereaved. One recently bereaved participant found it disconcerting that others attended so many years after their loss and wondered if this was what lay ahead of her, a long and seemingly endless bereavement process (Participant C). Others noticed differences about their bereavements, for example, differences between the loss of a spouse, child or sibling. These participants felt more able to relate to those who have experienced a similar kind of loss, and less able to identify with others whose loss is of a different family member. One participant was to an extent disconcerted by thinking about the loss of a child, when she had lost a spouse; this might be thought of as an early response to the factors in a group setting that may be worked through with facilitation, rather than a contraindication for group attendance.

All participants reported feeling that the group is well facilitated, with sensitivity and purpose. The group is described as informal, not placing pressure on anyone, but enabling individuals to express themselves, to relate their narratives and feelings. The atmosphere is described as emotionally rich, including tears and laughter. There is an absence of judgement of others and, as one participant put it, ‘I am not a burden on others’ (participant D). In the core group of regular attendees, there is appreciation that the group is inclusive, with space for all members. New people are welcomed in this spirit, and our participants commented that they are aware that it

does not suit everyone. One participant commented on some new people who attend and then don't return. This participant felt 'lucky to be there at the beginning when everyone was new' (participant A). These comments speak to the perennial dilemmas in group dynamics; amongst these are the difficulties of being a new member and the fear of being alone, or excluded. Anxieties about relating in groups are inevitable. Another participant echoed this when stating a preference for smaller groups, when less people attend. The importance of feeling the same as others is also expressed by participants who felt drawn towards those who had suffered a similar bereavement, as described above, and anxious or upset by the thought of a different loss. One participant commented on differences between those group members she felt she could help, and those she couldn't; a frame of reference from which peer support can develop. The wish to be in a helping role might be a way of dealing with intolerable feelings of helplessness, or a move towards developing more agency, as a way through the bereavement. The group does appear to be an important reference point, which is kept in mind - even when missing a meeting.

The group is mainly female and all our participants were female. Men do attend though they are in a small minority. There is a question about how to reach men. One participant, who had lost a son, described her husband as not being open or wanting to join the group. A man who attended and cried through the group was described by another female participant, whose husband had died, as not being comfortable in the group. He did not return, but he was followed up by the coordinator. It is possible an all-male group may have been easier for this man, or he may have been more comfortable in 1-1. On the other hand, these differences are part of the group process and cannot be totally legislated out, by trying for example to have groups that consist only of similarities and no differences. How the group works depend on facilitation and willingness to work on the task, of supporting individuals through bereavement by suicide. Strong emotions and their expression are inevitable and important.

The group was thought to be beneficial in different ways. Participants report the group as containing some extremely difficult feelings, of bewilderment, shock, guilt, shame and pain, and helping to manage defences, like denial. Participant E spoke about still being in pain, but the group 'has helped her move forwards'. Two participants feel the group helps them manage their lives, through containing their feelings on a regular basis. Two participants felt it opened up other ways of recovering through activities in their lives and helping others. They made new contacts with people in similar circumstances. For those less sure of the group, for example participant C, the group nevertheless exerted a pull - 'something is compelling me to go, but I am not sure why'. Attending the group requires overcoming anxiety and a measure of reluctance, and as Participant E said, she is 'glad she went out and did it'.

**4.5.3 Outcomes from the group:** Outcomes from the group are meaningfully described in qualitative terms based on the accounts of those who attend. The group provides continuing support for some people whose grief is long lasting, as is to be expected after a bereavement by suicide. It provides a haven, a sense of belonging, and a place where feelings can be expressed and contained. It can be the base from which new activities can develop that restore meaning and purpose in their lives. It is not for everyone, and some do not continue to attend whilst others attend from time to time rather than on a regular basis; there is no one way through bereavement after suicide. (PHE 2016).

A quantitative measure of group outcomes is the feedback that all group members provide for each session, a self-report using a scale of 1-10, (where 10 is the best feeling and 1 is the worst) of how they feel at the beginning and the end of the group. Table 7 below, shows that individuals rate more positively at the end of the group, on average scores rise from 4.86 to 6.74; this shows that members report better states of feeling at the end of the group. It would be advantageous to further develop and introduce materials for more systematically evaluating the bereavement service.

**Table 7: Attendance at the group and before and after ratings**

Month	Number of attendees	Before Group		After group	
		Range	Mean	Range	Mean
<b>Aug-15</b>	9	2-5	3.77	4-8	6.22
<b>Sep-15</b>	13	2-6	4.08	2-8	5.00
<b>Oct-15</b>	10	2-8	6.20	5-10	8.20
<b>Nov-15</b>	8	4-7	5.50	7-8.5	7.25
<b>Dec-15</b>	8	2-7	4.25	3-10	6.88
<b>Jan-16</b>	9	2-7	4.88	6-8	6.66
<b>Feb-16</b>	4	4-5	4.75	7-8	7.75
<b>Mar-16</b>	8	2-8	4.38	3-9	6.75
<b>Apr-16</b>	8	1-8	4.88	3-9	6.13
<b>May-16</b>	10	3-8	5.40	5-9	6.80
<b>Jun-16</b>	6	3-8	5.83	5-9	7.50
<b>Jul-16</b>	8	2-5	3.75	5-9	6.38
<b>Aug-16</b>	4	3-8	5.50	1-9	6.25
<b>Sep-16</b>	6	3-7	4.83	3-9	6.66
<b>Overall means</b>	7.93		4.86		6.74

#### 4.8 Value for Money

Value for money can be assessed through calculating the cost per client and cost per session and group. The following calculations are indicative, and to an extent approximate. SoS was undertaken within an overall budget of £100,371 (£49,250 p.a. for 2 years; in the first year they received an additional £1,871), and received 219 referrals over the two years (see section 4.1). The cost for each referral is therefore £458.32. If the 30 unallocated cases are excluded, the cost per referred and accepted referral is £531.06.

Costs for each service can also be calculated. The 1-1 service received 109 referrals, 58% of the total (unallocated referrals excluded), costing £58,215 whilst the group received 78 referrals, 41% of the total, costing £41,152. For the 1-1 service, taking 8 sessions as the norm for each client (although initially there were 10 sessions) so 872 sessions in total, the cost per session was £66.76. This is at the upper end of the range of fees for counselling; BACP guidelines are that counselling costs between £10 and £60 per session (<http://www.itsgoodtotalk.org.uk/what-is-therapy/cost>), though this is the cost for the end-user and does not equate to the cost of the service as most counselling organisations receive some funding other than from client's fees. It would be important to access full financial data from comparable counselling organisations to complete this analysis, and that is beyond the scope of this evaluation. The comparison with standard counselling does not account for the added value that this service works with suicide risks, and is therefore more demanding and specialised.

For clients bereaved by suicide the 78 referrals led to 100 attendances at the group in the year between August 2015 and July 2016, so each attendance cost £205.76. This cost appears relatively high, but it must be kept in mind that the service for those bereaved by suicide involves more than group attendance, i.e. the outreach and support work for families, and the facilitation of peer support. Additionally, there is no readily available benchmark with other services for comparing costs.

The 1-1 service appears to represent good value for money, based on the calculations above; the bereavement service, whilst apparently more expensive, is an evolving and innovative provision. Further development of the bereaved service is recommended by this evaluation.

## **5. Discussion of findings**

Based on the number of referrals, and characteristics of those referred, SoS clearly meets the needs of significant numbers of people in the two categories of experiencing suicidal thoughts and intentions and being bereaved by suicide. Because referrals rapidly reached the capacity of the service to deliver within its funding, the full demand for the service is not known. It is a highly plausible assumption that there is scope to expand the provision, were there capacity in the service to undertake more extensive publicity. The websites of the partner organisations could be used for these purposes, and more details of the services could be posted here. The SOBS (Survivors of Bereavement by Suicide) provides an example, including posting more details about the group. More referrals could be generated through further networking with key referrers, especially in primary care. The potential for expansion of the service is an important consideration for future commissioning.

The services are well-coordinated and organised, not only in the allocation and provision of counselling on a 1-1 and group basis, but also in the imaginative and innovative work undertaken around referrals, including family work and linking people for peer support. Data is captured adequately, though there is a need for greater consistency between the partners, SCDA and CP. Evaluative measures are useful for the tasks; the CORE-OM is a good, established measure to use to assess outcomes and levels of difficulty in counselling. It would be beneficial to include follow-up data to assess whether changes are sustained over time.

In SoS the focus of provision is an 8-session 1-1 counselling approach and a facilitated open group for those bereaved. The 1-1 service operates within a strictly time-limited model. The intention initially was to offer 10 sessions of counselling and this was reduced to 8 to meet the demand for the service within its funding. Mixed feelings have been expressed by counsellors about the duration, and there are different expectations in CP and SCDA as to what will happen after the sessions end; in CP there is a strong expectation that many individuals will continue to attend counselling, whilst this is not necessarily the case in SCDA, where fewer counsellors are available. The current number of sessions is manageable and provides for a clearly focused piece of work. The rapid uptake of service, with no waiting time, the explicit focus on suicide and the time-limits combine to make a meaningful experience of work preventing suicide. Counselling is provided by experienced and skilful counsellors, who give vivid accounts of the quality and intensity of their work. They repeatedly commented on the core elements of 'holding', emotional availability, listening and sense making as being integral to the process. Outcomes, particularly evidenced by the CORE data give an initial evaluation of the effectiveness of counselling in this service for preventing suicide. Further studies for evaluating outcomes are indicated. The 1-1 service represents good value for money, when costs are compared with standard counselling, and the added factor of working with

suicide risks adds value.

The group work approach to offering support for those bereaved by suicide contributes to the provision in this emerging field. The open, facilitated group demonstrates an innovative approach. The group is well held and facilitated. Attendance at the group is by a minority of those referred, approximately 25% of which attend, either on a regular or intermittent basis. Amongst users of this service, we found a wide range of attitudes to the group. Some people found it extremely important in providing a secure base, from which they could face the painfulness of their losses and seek to work through their grief. Most people attending expressed the view that they left the group in a better state of feeling than they began. Some people felt less committed to the group, and there were also reports that some found it either too demanding or difficult. This is not surprising; groups do generate mixed responses.

The provision of support for those bereaved by suicide evolved over the time of the project. It has become clear that in addition to offering the open-ended group, the coordinator fulfils a networking outreach role, making contact with people soon after their bereavement, providing information, an ongoing contact and assessing what might help and when. This role is important in the 'pyramid' of support and should be recognised as central to the overall process, and an intervention in its own right, in future commissioning. It is emerging too that the group can provide opportunities for peer support, both between group members and by group members for newly bereaved people. This is a valuable outcome that could be further developed. SoS was not in the position to offer comprehensive bereavement services within its funding; as well as outreach and peer support, different kinds of group could be offered. Nationally, there are different models emerging. Short-term weekly groups are being offered in a few locations by Cruse/Samaritans, for example. Here, data suggest that some new models could be explored, including a group for bereaved men. There is, a case for suggesting the availability of a 1-1 option for people who have been bereaved by suicide, for those who are for a range of reasons not keen or able to take up the offer of a group. Some people can make use of low cost 1-1 counselling, but recognition of the distinctive nature of bereavement by suicide and the need to reduce stigma suggest that a discrete 1-1 service would be of benefit for some.

Both the 1-1 counselling and bereavement services are making a distinctive contribution to suicide prevention. Both services need to continue, to develop and evolve. It is important that the achievements to date are reported nationally for the benefit of the communities and organisations working to prevent suicide.

## **6. Recommendations**

1. The counselling service meets important needs and continuing support is recommended. Future commissioning could pay attention particularly to the following recommendations
2. The possibility of greater demand for the service needs to be explored so that the service reaches more deeply into the community. Additional networking with primary care and other referrers is indicated to achieve this. This would also have resource implications for SCDA to undertake this additional work.
3. As greater demand for the service will impact on resources, support for coordination, and training and supervising counsellors to work with suicide risks need to reflect the scale of the service.
4. Offering more sessions (up to 12) in the 1-1 service is indicated clinically, though this should not be at the cost of reduced access to the service and will therefore increase the budget required
5. Work with family groups after a member has attempted suicide can be scoped to assess if this can be an aspect of commissioned services.
6. The service for people bereaved by suicide should continue to evolve. Future commissioning should recognise the part played in the service of the early response following bereavement, outreach to individuals and families, and peer support.
7. Scoping whether there is a demand for intervention for bereavements affecting non-family members can be undertaken to assess whether the service can develop in this direction.
8. The possibility of developing and delivering different kinds of group, including short-term, and possibly a group for men should be explored.
9. The initial findings for outcomes (through the CORE-OM data) for 1-1 counselling indicate that further and more robust evaluation is desirable, through a well-conducted controlled study with follow up. Materials that lead to more systematic evaluation of outcomes for the bereavement service should be introduced.
10. It is recommended that the achievements to date are reported nationally for the benefit of the communities and organisations working to prevent suicide.

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## Appendices

### Appendix I: Participant Information Sheet and Consent Form

**University Research Ethics Committee:** If you have any queries regarding the conduct of the programme in which you are being asked to participate, please contact:

**Catherine Fieulleau, Research Integrity and Ethics Manager, Graduate School, EB 1.43, University of East London, Docklands Campus, London E16 2RD (Telephone: 020 8223 6683, Email: [researchethics@uel.ac.uk](mailto:researchethics@uel.ac.uk)).**

**The Principal Investigator:** Professor Stephen Briggs (researcher)  
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**Funding:** This research evaluation is commissioned and funded by East Sussex County Council

#### **Consent to Participate in a Research Study**

The purpose of this letter is to provide you with the information that you need to consider in deciding whether to participate in this study.

**Project Title: Evaluation of Counselling Partnership - Survivors of Suicide counselling service to inform future provision and commissioning**

**Project Description:** This research project aims to evaluate Counselling Partnership Survivors of Suicide counselling service to assess how it improves outcomes for people, their families and carers who have been bereaved by suicide, or who have themselves attempted suicide, by offering effective and timely support.. We will review and evaluate the work undertaken by the service over the past two years. The research will consist of a comprehensive evaluation of the service with the focus on identifying positive factors and any emerging obstacles that can be addressed through refinements. We will aim to reach informed findings and recommendations for future development of the service.

Your participation in this project will involve meeting with the one of the researchers in the team at a suitable agreed venue for an interview lasting not more than 1 hour. The interview will consist of some open questions about your experiences and reflections of the service. It is possible you may experience distressing or thought provoking feelings and we will ask you if you are experiencing any of these feelings during the interview. If this is the case we will be pleased to discuss how you may be supported.

#### **Confidentiality of the Data**

We will transcribe interviews and store these on a password protected UEL computer using a numbered key to protect confidentiality. Once the interview has been transcribed, the tape will be erased. When the evaluation has been completed the data will be retained in accordance with the University's Data Protection Policy. The data will be available only to members of the research team. Confidentiality of all stored data can be subject to legal limitations e.g. freedom of information enquiries.

We will protect your confidentiality in written and any conference reports by using pseudonyms and removing any identifying information. Anonymised quotes from your interviews may be used in publications.

However, as this is a small study with few participants it will not be possible to wholly protect your confidentiality and you may be recognizable. We will take every step to minimize the risks of recognition and we will offer you the opportunity to read and comment on any report involving your interviews. Should the interviews involve information about risks of imminent harm to anyone (yourself or others), we will need to ensure with you that these are acted upon appropriately and we may be obliged to inform the relevant authorities.

**Location:**

We will undertake the interviews at the Service's offices, but if for any reason this is not possible an alternative location will be identified. Some interviews will take place by telephone by mutual agreement.

**Disclaimer:**

You are not obliged to take part in this study, and are free to withdraw at any time during tests. Should you choose to withdraw from the programme you may do so without disadvantage to yourself and without any obligation to give a reason. If you do withdraw any information you have already provided will be safely destroyed and will not be used in the study.

**UNIVERSITY OF EAST LONDON**

**Consent to Participate in a Programme Involving the Use of Human Participants.**

**Evaluation of Counselling Partnership - Survivors of Suicide Counselling Service**

I have read the information leaflet relating to the above programme of research in which I have been asked to participate and have been given a copy to keep. The nature and purposes of the research have been explained to me, and I have had the opportunity to discuss the details and ask questions about this information. I understand what is being proposed and the procedures in which I will be involved have been explained to me.

I understand that my involvement in this study, and particular data from this research, will remain strictly confidential. Only the researchers involved in the study will have access to the data. It has been explained to me what will happen once the programme has been completed. It has been explained that full anonymity may not be possible in this study and that there are legal limitations to data confidentiality

I hereby freely and fully consent to participate in the study which has been fully explained to me and for the information obtained to be used in relevant research publications.

Having given this consent I understand that I have the right to withdraw from the study at any time without disadvantage to myself and without being obliged to give any reason.

Participant's Name (BLOCK CAPITALS)

.....

Participant's Signature

.....

Investigator's Name (BLOCK CAPITALS)

.....

Investigator's Signature

.....

Date: .....

## **Appendix II Interview Schedules**

### Staff interviews

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of the Counselling Partnership Survivors of Suicide counselling service. Is that OK? Do feel free to stop the interview at any point and ask any questions along the way if you want to

So the first question is

1. What is your role with the Service and how have you been involved in counselling survivors?

(prompt for feelings about the role)

2. Can you tell us about which kinds of counselling you have been involved with?

(prompt for individual or group, quality of experiences)

3. What were the main things you felt the service users gained from the counselling?

(prompt for detailed examples, positive experiences, challenges and obstacles)

4. Do you have thoughts about how the Service could change and develop in the future?

(prompt for examples)

5. Do you have any further thoughts, points or questions?

## Service Users

Thank you for agreeing to take part in this project. Confirm that participant information has been read and consent form has been signed. Any questions before we begin?

We are interested in your experiences of the Counselling Service and we would like to hear your thoughts about what it was like before during and after [adapt as appropriate] your counselling. Is that OK? Do feel free to stop the interview at any point and ask any questions along the way if you want to

So the first question is

1. How are things for you now?

(prompt for good/positive aspects and things that might be more difficult)

2. What was it like just before you started counselling/attending the group?

(empathic prompts especially if/when talking about difficulties/distress)

3. How did you come to approach the Counselling Service?

(prompt about how did the participant hear about it, who was involved?  
prompt about factors in decision)

4. What is/was it like having counselling/attending the group?

(prompt for kind of counselling, individual or group; feelings; positive and more challenging aspects; quality of relationship with counsellor)

5. How do you think the Service helped you?

(Prompt: What differences in life now, what ongoing challenges, was the duration enough, could be longer? Shorter? Any criticisms and what might be different? )

6. How do you see things going from now and into the future?

(Prompt – what supports you – relationships/ work/things you do/interests etc

Prompt: Relationships – how do you feel about people closest to you?

e.g. helpful/supportive?)

7. Are there any other comments you would like to make?

Thank you for your time