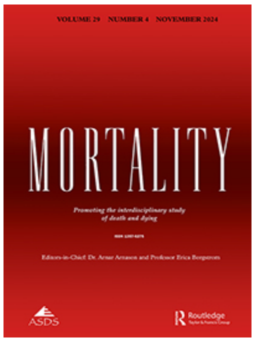

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Understanding impact and factors that improve postvention service delivery: findings from a study of a community-based suicide bereavement support service in England

Jo Bell, Katie Cunnah and Fiona Earle

School of Psychology and Social Work, University of Hull, Hull, UK

ABSTRACT
This article reports on a two-year study of a community-based suicide postvention support service in the UK. Attention centres on the implementation of four integrated elements within the service model: multi-agency working with real-time suicide surveillance, persistent pro-active contact; volunteer-led support; continuous open-ended support. Our approach involved analysing utilisation data and qualitative techniques, including in-depth interviews with a diverse group of stakeholders. The study is the first of its kind to provide an in-depth examination of an innovative approach focusing on the integrated model and its constituent components. Our findings offer evidence-based examples of collaborative service efforts in implementing real-time interventions, with agencies working together to provide timely, co-ordinated, proactive responses and support with the potential to alleviate suffering and prevent loss of life. The value of volunteer-led support and open-ended access and associated challenges are emphasised. Findings hold promise for international impact with policy implications for services worldwide.

KEYWORDS
Postvention; suicide bereavement; service evaluation; postvention service model; public health

Background

With an estimated annual toll of over 700,000 deaths by suicide across the world, addressing the care of those bereaved and affected by suicide is a globally recognised focus within Public Health (World Health Organization, 2023). Postvention refers to support, procedures and interventions that take place after a suicide to alleviate the distress of bereaved individuals, reduce the risk of imitative behaviour (copycat suicides), and promote the recovery of the affected community (E. Shneidman, 1969; E. S. Shneidman, 1972). Recent studies have demonstrated that exposure to the suicidality of a loved one is associated with subsequent increases in the risk for suicidality in people who are exposed (Bell et al., 2015; A. L. Pitman et al., 2016). Moreover, the impact of suicide on society can be far-reaching. Research has shown that, on average, five close family members (Berman, 2011) and up to 135 individuals (Cerel et al., 2019) can be exposed to the impact of a suicide and thus made vulnerable (Andriessen et al., 2019).

CONTACT Jo Bell j.bell@hull.ac.uk School of Psychology and Social Work, University of Hull, Hull HU6 7RX, UK

More recent research (Bell & Westoby, 2021) has suggested a significantly larger vulnerable population per death exposure.

Beyond the shock, disbelief, and disorientation that suicide often engenders, many of those affected feel stigmatised and isolated in their grief (Bell et al., 2012; Cerel et al., 2014, 2016). Many also experience intense feelings of guilt, responsibility, heightened levels of depression, suicide risk and complicated grief, making adaptation to this particular loss a formidable challenge (Neimeyer et al., 2018). Many countries have incorporated postvention into their suicide prevention strategies, a practice that is underscored by the influential World Health Organisation's seminal 2014 report *Preventing Suicide: A Global Imperative* (Andriessen et al., 2019). In England and Wales, a primary objective of the Suicide Prevention Strategy outlined by the Department of Health (2012) is to 'provide better information and support to those bereaved or affected by suicide' (p. 39). Government policy responses were established as part of a substantial financial commitment to suicide prevention under the National Health Service (NHS) Long Term Plan (National Health Service England, 2020). A key milestone of this plan is for all regional public health systems and services to have an accessible suicide postvention service in place by 2024.

However, much more needs to be done to understand what types of support are effective and for whom, as well as precisely which components of a support service are bringing about positive outcomes for adults and children, and how (Rolls, 2011; Schut & Stroebe, 2011). A systematic review by Andriessen et al. (2019) investigated what is known about the effectiveness of postvention service delivery models and component parts internationally. They found little evidence of effectiveness but highlighted the potential for support according to level of grief and the involvement of trained volunteers as promising components. They concurred that a public health approach to postvention should be adopted in order to tailor services to the needs of individuals and to align within wider suicide prevention programmes. A public health approach prioritises the needs of the public or specific population groups, aiming to enhance the overall health, safety, and well-being of communities. This involves addressing underlying risk factors that elevate the susceptibility of individuals to suicide and collaborating with local communities to safeguard those who are most vulnerable (Mercy et al., 1993). The intended primary outcome of postvention services is that all people bereaved and affected by suicide receive timely support and care to prevent further suicides (Department of Health, 2012, 2023).

A systematic review of postvention service evaluation and acceptability of models of postvention internationally by Abbate et al. (2022) revealed a scarcity of qualitative research that involves experts, suicide prevention professionals, or individuals who have been affected by suicide. They also noted a lack of research evidence on interventions and suggested further studies of community-based postvention services in the UK are needed. M. McDonnell et al. (2020), conducted a survey to identify the experiences and perceived needs of those bereaved and affected by suicide. It was – and remains to date – the largest suicide bereavement survey internationally. The study identified a timely, positive and coordinated response and immediate proactive support as features of best postvention practice with 65% of respondents suggesting that help was most needed within a week of the death. These findings were also echoed in research by A. Pitman et al. (2018) and Ligier et al. (2020). Although these constituent elements have been endorsed as best practices for postvention and have been underscored in UK Public Health guidance documents (Hawton et al., 2019; Public Health England, 2016), there has been no prior investigation into their practical implementation and its effects.

This article seeks to fill these important gaps in the current body of knowledge of community-based postvention services, specifically regarding qualitative research and understanding which aspects of support services contribute to positive outcomes for service users. The article also explores how services can be customised to meet individual needs and align with broader suicide prevention programmes.

We report on a 2-year study of a community-based postvention support service in the UK (Bell & Cunnah, 2022). Our approach involved analysing utilisation data and employing qualitative data collection methods, including in-depth interviews with a diverse group of stakeholders including multi-agency professionals, volunteer support workers, and service users. Our attention centres on examining the implementation of four distinct integrated elements within the service model: multi-agency working with real-time suicide surveillance systems, persistent pro-active contact, volunteer-led support, and continuous support with open-ended access.

The study provides an in-depth examination of an innovative approach focusing on the integrated model and its constituent components. Our findings offer prime evidence-based examples of collaborative service efforts in implementing real-time interventions, with multiple agencies working together to provide timely, co-ordinated proactive responses with the potential to alleviate suffering and prevent loss of life. The value of volunteer-led support is emphasised, alongside the need for open-ended access and associated challenges with sustaining both approaches.

The postvention service model

The service was established in May 2020 to provide support to people of any age who are bereaved or affected by suicide, or suspected suicide, in a defined geographic region in the north of England. One service manager and two co-ordinators manage the service. Postvention support to users of the service is delivered by trained volunteers. The four component parts of the service model are outlined below:

Multi-agency working with real-time suicide surveillance (RTSS)

RTSS involves collecting a range of data about a suspected suicide across a locality from a variety of sources such as emergency responders, coroners, hospitals, schools and colleges in ‘real time’. It enables public health teams and local suicide prevention groups to rapidly identify if interventions are required after a suspected suicide. This approach has become increasingly important to support suicide prevention and postvention efforts as official suicide statistics are subject to considerable time-lags due to delays in coroners’ inquests and the time taken for registration of deaths and reporting of suicide statistics (Marzano et al., 2023). RTSS has been implemented in a number of countries worldwide and has been shown to allow public health teams and allied agencies to collate, share and review information following a suspected suicide promptly, identify patterns such as locations, methods or populations of concern and take immediate action in ‘real time’. The benefits include identifying clusters, timely bereavement support and information to mitigate risk (Doyle et al., 2023; Marzano et al., 2023). The most common model is led by police/first responders at the scene of the death. Typically, the attending officer will complete a report which is then sent to named agencies, where information can be gathered, shared, monitored, and used to aid decision-making.

In this study, for the purposes of suicide bereavement support, RTSS refers both to real-time referrals into the service and collection and sharing of information around the person who has died, the people closest to them, and the process following a suspected suicide from informing the next of kin onwards. To facilitate this, an information sharing agreement was set up with the Police service who were leading the RTSS system. This required Police officers who attend incidents to provide those close to the deceased (usually next of kin) but also others (i.e. those who might be witnesses at the scene) with information about the postvention service and seek consent for their contact details to be passed to the service. The aim was for referrals into the postvention service to be provided in 'real time' (within 72 hours of the suspected suicide being reported to the police).

Persistent pro-active contact

Within 2 days of receiving contact details, the service coordinator initiates contact with affected individuals, relevant communities, and organisations (e.g. workplace or school). Coordinators make three contact attempts within 10–14 days. If contact remains unestablished, they send a letter with additional information. This process recurs every 3 months for up to 2 years unless individuals express a desire to cease further contact. Those opting for support undergo an initial assessment to match them with a volunteer support worker or receive further information and referrals to other services based on their circumstances and needs. Self-referral is also an option for individuals seeking the same services.

Volunteer-led support

Volunteer support workers deliver support to individuals who access the service. They were recruited to the service from the local community and provided with in-house training. Many had lived experience of suicide bereavement (although this was not essential criteria). Volunteers are supervised and supported by service co-ordinators who also deliver some of the training.

Continuous support with open-ended access

The Service is needs led, offering a range of provisions from practical help with Coroner's inquests, funeral arrangements, and dealing with financial issues, to providing emotional support and a 'listening ear' and signposting or referring on to other services. It is open to anyone who identifies as being affected or bereaved by suicide or suspected suicide. This can include individuals and groups. There is no limit to the amount of support an individual can access, meaning they can seek help whenever required.

Methods

Quarterly Reports collated by the service provided descriptive demographic and utilisation data (including sources of referral, gender, age, and relationship to the deceased) and volunteer support workers who were recruited and trained from May 2020–April 2022.

In-depth interviews were conducted to gather a range of participant perspectives including key stakeholders, volunteers and users of the service. Key stakeholders were purposefully selected by the evaluation team and chosen according to specific perspectives they could provide (two of these participants were the Service Co-ordinators whose role was most central to the service, being the bridge between volunteers and users. These participants were interviewed twice approximately 6–9 months apart to give perspectives on how the service had changed over time). Volunteers and service users were identified by service co-ordinators who discussed the purpose of the study verbally at points when it felt appropriate and invited them to contact the research team or consent to sharing their contact details.

A semi-structured interview format was used for all interviews, which took place online or by telephone, were audio-recorded (with consent) and transcribed verbatim. Interviews lasted approximately 1 hour and probed experiences and perceptions of the service from the perspectives of different participant groups.

Interviews with key stakeholders aimed to establish perceptions of the wider background and context of the project; key issues, operational processes and procedures; areas of demand; current strengths and significant achievements; current challenges. Interviews with service volunteers explored their perceptions of how and why the service improves the wellbeing of service-users; how and why the service provides timely access to support; strengths, successes and achievements; barriers and challenges; training and support needs. Interviews with service users aimed to gain in-depth insight into the perceived changes and benefits resulting from engagement with the service, including: their perceptions of: types of support received; what they find most useful (why, how and ways in which this made a difference); ways in which the service could be improved (and why); reasons for seeking support; changes as a result of service intervention; types of information and resources shared.

During the interviews, we encouraged participants to tell us about their experiences openly and freely, using a semi-structured style (Bell et al., 2012; Cooper, 1999) which allowed for modification of the order of questions, capitalising on the responses of informants and promoting logical progression. In practice, this meant that the conversations were allowed to flow naturally.

Interview transcripts were coded and thematically analysed by the authors, following Braun and Clarke's (2006) approach and the constant comparative method (Glaser & Strauss, 1967). We coded the data within individual transcripts based on emerging themes, adhering to the principles of continuous and consistent data comparison. Each code was cross-referenced with earlier codes to ascertain the need for new codes or revisions. This iterative process was repeated until the themes were well formed. This practice also involved identifying and separating extraneous information and reconstructing the narratives to provide anonymised coherent accounts whilst trying to stay true to the phenomenology of participant experiences.

Ethical approval for the study was obtained from the Faculty of Health Sciences Research Ethics Committee at the University of Hull (REF FHS279). The data collection period covered January 2021–June 2022. Details of the number of interviews conducted are presented below. Real names have been replaced with pseudonyms to protect anonymity.

Findings

Utilisation data

Over the two-year study period (May 2020–April 2022), there were 537 referrals to the service. Table 1 demonstrates a steady increase in referrals over the period, except for a slight decrease in Q8. Police RTSS was the primary referral method, showing a consistent upward trend each quarter, followed by self-referral as the second most common method.

A variety of different age categories was represented amongst those referred. This ranged from under 18 years to over 65 years. The majority across all ages were female (326 female, 211 male). One referral was for an individual identifying as non-binary.[1] Most people referred were in the deceased's immediate family, but there were referrals for people with other types of connections to the deceased such as professionals and colleagues. These types of referrals increased over time. In Quarter 4 (of 8 quarters) there was an increase in the number of witnesses to the death who were referred for support.

In-depth interview findings

Volunteer support workers

A total of 31 volunteers were trained during the period and a total of 14 left the service. In the initial year, (May 2020–July 2021), 18 were trained, but 3 left, leaving 15. In the following year (July 2021–April 2022), 13 were trained, but 11 departed. At the end point of the evaluation, 19 were active in the service, compared to 15 at the same point in the previous year.

Table 2 shows the full range of in-depth interviews undertaken. This comprises a total of 10 service users (6 female, 4 male), 8 volunteers (6 female and 2 male) and 6 professional key stakeholders. These included: The Service Manager; regional Public Health Lead; regional Suicide Prevention Lead; Police Mental Health Co-ordinator; and two Service Co-ordinators.

Table 1. Sources of referral.

Referral Source	Q1	Q2	Q3	Q4	Q5	Q6	Q7	Q8	Total
Police	28	54	44	67	62	70	67	54	446
Public Health	5	0	0	0	0	0	0	0	5
Self-referral	2	2	6	12	7	0	14	5	48
Internal/Other	1	1	5	3	13	5	6	4	38
Total	36	57	55	82	82	75	87	63	537

Table 2. Interviewees.

Interviewees	Female	Male	Total
Key stakeholders	6	0	8 (6 + 2)*
Volunteer support workers	6	2	8
Service users	6	4	10
Total	18	6	26

*Two of these participants were the Service Co-ordinators who were interviewed twice (approximately 6–9 months apart).

RTSS and multi-agency working

As shown in Table 1, referrals from police were by far the most common method of entry to the service, which increased steadily over the course of the study. The information sharing agreement with the police RTSS, which had been established from the outset (see above) was perceived by key stakeholder interviewees to be operating effectively. There was positive affirmation of the service in fulfilling an important need from a Police perspective with a radical shift in working practices: ‘For me is fantastic because for we’ve gone for years where we have … done a statement and then waved bye-bye to the family and they’ve been left in the dark thinking well what happens next?’ (Key Stakeholder – Police).

Over time, the service developed strong relationships with multiple agencies, organisations and mental health resources across the community. This also included offering services to staff, pupils and families in schools and colleges. These relationships were perceived to be important to the work of the service in connecting a wide range of people across the community to a wide range of timely support and crucially in responding in ‘real time’ to suicide clusters, as illustrated in the following extract when an emergency meeting amongst community stakeholders was convened:

> It really is a very quick and urgent response, and all sorts are happening … there was information coming in from all different places… all different concerns being raised with different people … in very quick time… we knew that there was a number of young people that had all talked about taking their own lives. (Key stakeholder – Public Health Lead)

The existence of these relationships alongside real-time surveillance made it possible to share intelligence across agencies and coordinate a rapid intervention, where vulnerable young people were identified and reached. In this example, multiple agencies (including schools and colleges) raised concerns about potential additional suicide attempts within that group. Engaging directly with the group became tougher for services due to community anger and distress. At this point, a local volunteer community project identified through Facebook, collaborated successfully, integrating with the group to gather safeguarding insights and take proactive, preventive measures (including signposting to the postvention service and other mental health resources). Emergency meetings united community stakeholders, Public Health, and other agencies to address the impact of media coverage on community distress and possible contagion. They engaged local media and implemented strategies to manage misinformation and negative social media discourse. This included flooding targeted platforms with support service details and accessible resources:

> Real-time surveillance has been absolutely key and crucial in us picking up clusters… as they’re happening… we really saw what it felt like to use Facebook as a positive because we were able to link into the [community]… there’s a [local community] Facebook page so we were able to alert people as to what we were doing. We were able to offer services to them and people knew that we were there. (Key stakeholder – Suicide Prevention Lead)

Persistent proactive contact

Interviews with Service Coordinators provided some insight into the workings of the proactive contact processes. As described earlier, co-ordinators typically make three attempts at contact within 10–14 days (the first within 2 days of receiving the referral). Following that, they will send a letter and more information. This is then repeated at three-monthly intervals. The Service Coordinator explained how they quickly learned that for some people the initial contact was premature, and that repeated contact and reminders of the availability of the service was successful in bringing people into the service at a later point:

> often on the first call there's a lot of shock involved, people don't necessarily take in the information so more often than not it's on the two-week check in that… we'll get a bit more engagement. (Service Co-ordinator)

The significance of the pro-active contact model is that the onus is on the service to initiate first contact. This eliminates the onus on the bereaved and other well-known barriers associated with help-seeking (such as anxiety and the need to psychologically build up the confidence to make contact) at a point in their life when such things would be too overwhelming. When asked how she might have responded if the police had provided her with contact details so that she could make the first call herself, this interviewee responded:

> I probably wouldn't have called them… because I just didn't want to go through it all … ringing me and offering the service … that was a better way. (Patricia – service user)

The point about timing and pro-active contact was reinforced by Daniel, who supported the idea of immediate outreach from the service:

> Straight away…definitely the sooner the better because…you blame yourself and no matter how much you try and tell yourself well I did everything, it keeps coming back…and I wouldn't like … nobody helping me through those thoughts. (Daniel – service user)

He shared with us his encounter of conversing with his doctor, who informed him that he would not qualify for grief support for a duration of 3 months. His remarks point to a significant needs gap in statutory service provision, where survivors are left in a liminal space, suspended between the point of loss and the point at which support is accessible. It is precisely within this timeframe that survivors may be at their most vulnerable and most in need of support, a point also reinforced by service user Debbie:

> I was really suicidal… so the sooner somebody could get in there the better… you're just lost.

The impact of volunteer support

Volunteer supporters were described as *'our most valuable resource'* by a service coordinator in the study. User interviews revealed that engaging with the service provided hope, positivity, coping strategies, and a focus, alleviating guilt and anxiety. Many service users emphasised the importance of a special relationship with a volunteer, describing it as mutually meaningful and essential for their recovery journey. Some sought a volunteer with personal lived experience of suicide bereavement, like Laura, who wanted *'an older mum who'd lost her son'*. She explained:

> They just understand it's so complex… this is so different… If my [volunteer] had been [different gender] I'm not sure they would have quite understood… I can just talk to her about how I'm feeling … she gets it … she's totally in tune with me. (Laura – service user)

For some service users this specific request was underpinned by a belief that professional experience and training cannot be a substitute for lived experience; that a genuine understanding of suicide bereavement (something viewed as essential to successful support) cannot be reached without it: *'I said… I don't want anybody ringing me who hasn't had any life experience of suicide…need to speak to somebody who's been in my position…because people don't understand unless they've been in your boat'*. (Debbie – service user). Service user Daniel explained: *'Talking to someone that has been through… the same pain… that has experienced it would be, in my opinion, far more helpful than somebody who's just read a text on what people might be going through'*.

Both Doug and Cathy also felt that their situation and feelings were much more understood because their volunteer supporters had lived experience of suicide bereavement:

> She was brilliant… she listened… she didn't judge me… she knew about the suicide part of it because she'd been through it… where people have experienced that, they have an inkling of what you're going through… they know it because they've been there… they know what it's like… what it feels like… (Doug – service user)

Cathy explained:

> I've known that I'm talking to and listening to someone who actually knows what it's like… and … is… living through it and surviving … this lady really does know, and I think that's the difference.

Continuous support with open-ended access

While the service did not routinely record user access, frequency and duration, interviews with service volunteers and staff highlighted that type and duration of support varied widely. Some users received support for over a year, with contact tapering from weekly to monthly over time but with an increase in support needs during events like anniversaries.

Daniel worked with his volunteer for nearly a year and described how regular communication helped him to understand the expectations of what he may go through and reassurance that what he is feeling is normal. His volunteer provided him with understanding and awareness of how to cope with various scenarios and how to prepare, for example, going back to work, how others might respond and how to anticipate how he might feel.

Volunteers reported that the types of issues that clients of the service were faced with included how to manage unanswered questions and associated complex emotions and thoughts (anger, feelings of failure, disapproval, guilt, shame) as well as financial difficulties, navigating media, police inquiries, preparing for anniversaries, and Coroner's inquests. Typically, issues can be multiple, intersecting, and unpredictable, which further underscores the need for a bespoke user-led service, as illustrated by Stella (volunteer): *'Everybody wants to talk about something different'*.

As with service users, many volunteers identified the value of being able to offer support that is not time-limited as a unique and highly beneficial quality of service, which contrasts with other service models where delivery is short term and for which a period of time post-bereavement is necessary to qualify for access. Britney described the challenges faced by those connected in the (often chaotic) aftermath of a suspected suicide, emphasising where grief counselling and other helping service provision does not sit, and where the service is able to fill a gap: *'They feel why are the police coming? what's happening? . . . and that causes an awful lot of stress. . . there's no real in-depth conversations there, they don't get re-visits, there's no real care and attention given'*. (Britney – volunteer)

Some service users talked specifically about the benefits of open-ended access reporting that simply knowing that the service is available to them reduces their anxiety or anticipated anxiety.

Although Year 2 saw more active volunteers than Year 1, a greater number left in the second year. In follow-up interviews, service co-ordinators attributed this to the stresses of volunteering and the emotional toll of the work: *'Talking about a suicide bereavement for a full hour is very intense'*. This strain limits volunteers' involvement with the service. Several volunteers also experienced vicarious trauma through empathetic engagement with users. Britney (volunteer), for example, says: *'You can't help but see what they see once they're describing it'*. When the emotional and psychological toll becomes burdensome, individuals may need to step back for their well-being. Thus, whilst open-ended support is valuable, ensuring that the service can meet demand and support volunteers' well-being is crucial.

Discussion

The postvention service implemented a model in the UK which integrated important new elements that has not yet been tested. The model is one of the first of its kind to be studied in this way and provides, for the first time, an understanding of the perceived impact of these principles and integrated ways of working from the perspective of those with lived experience and practice expertise.

The findings align with recent research by A. Pitman et al. (2018) and M. McDonnell et al. (2020), emphasising the importance of timely and unlimited support for the bereaved, who are at their most vulnerable state between the loss of a loved one and their uncertain future. Our study also underscores the significance of proactive contact, in line with previous research in Sweden (Pettersen et al., 2015) and the UK (A. Pitman et al., 2018). However, proactive outreach hinges on obtaining consent, usually facilitated by external agencies such as the police. S. McDonnell et al. (2022) also highlight the need for a multi-agency approach to postvention and proactive outreach. Our study demonstrates that agencies can identify and reach affected individuals, preventing further suicides through collaborative efforts. This involves rapid, coordinated work, often utilising creative methods like responsible and sensitive use of social media (Bell & Westoby, 2021).

McDonnell et al. (2020) stress the necessity of confident, compassionate, and skilled workers to effectively support bereaved individuals and provide positive examples of post-bereavement recovery. Our data shows that personalised support relies on a unique volunteer relationship, often prioritising lived experience over professional training, aligning with prior research in the UK (Robertson et al., 2017), Canada (Barlow et al., 2010), and the US (Bartone et al., 2017). Volunteers play a crucial role as living proof that there is a way through suicide bereavement. The open-ended support principle in the study enabled volunteers to build unique and long-term relationships, making it easier to understand client needs and track positive changes, reducing client anxiety. This supports recommendations for tailored, flexible postvention service models (Ali &

Lucock, 2020; Andriessen et al., 2019). Long-term access to support is crucial, as highlighted by previous studies (M. McDonnell et al., 2020; Robertson et al., 2017; Wilson & Marshall, 2010).

However, maintaining continuous long-term support poses sustainability challenges for services. Coordinators must understand individual service user needs and volunteer qualities while also diversifying the pool of available volunteers. The strain on volunteers, regardless of experience, should not be underestimated, as observed in Australia (Maple et al., 2019) and the US (Bartone et al., 2017). High-quality support for volunteers and coordinators is essential for service sustainability.

The implementation of the RTSS information sharing agreement with police was perceived to be one of the most notable successes of the service in facilitating a timely and coordinated response. Securing the support of police and other first responders has been consistently emphasised in prior research as crucial for swift implementation (Campbell et al., 2004; Ligier et al., 2020; McGeechan et al., 2018). Research has also previously demonstrated that RTSS plays a pivotal role in providing timely assistance to individuals at risk of suicide (Doyle et al., 2023). Although international consensus on the potential advantages of RTSS is emerging (Baran et al., 2021), Doyle et al. (2023) pointed out the necessity for additional service evaluations to comprehend the various strengths and challenges associated with its use and integration. Our study contributes significantly to this knowledge base by offering proof of the efficacy of RTSS in connecting families, friends, caregivers, and loved ones with timely postvention support. This underscores the significance of garnering support from multiple agencies, communities, and the police to ensure a well-integrated implementation. This, in fact, constitutes the first critical aspect of the service model: identifying and collaborating with key local organisations, especially police, to establish and sustain referral processes and pathways into the service.

Further evidence for the success and utilisation of RTSS implemented in this way comes from comparing it with data obtained in a recent study that integrated the evaluation of two postvention services in Scotland (Scottish Government, 2023). In both regions of the Scottish assessment, the suicide rates were comparable to the area under examination in this research. However, the Scottish programmes had a significantly lower number of referrals, with just over a quarter of the referrals ($n = 155$) as compared to this study ($n = 537$) over the two-year period. Moreover, in the Scottish evaluations, the number of referrals from the police equalled the number of self-referrals ($n = 47$ for each), whereas in this study, referrals from the police ($n = 446$) greatly exceeded self-referrals ($n = 48$).

Interestingly, within the Scottish evaluations, there were signs of reluctance among police personnel when it came to sharing contact details of recently bereaved individuals with the postvention service. The Scottish study reported that police felt it was inappropriate to discuss a referral during early engagement with the bereaved. Instead, they would provide an information pack with service details and contact information. This highlights a clear distinction between signposting and proactive referral. In the current study, police officers were instructed to actively engage in referral discussions and obtain consent to share contact information with the postvention service from the very beginning of their interactions. The police oversaw and managed this process to maintain uniformity. Consequently, this approach enabled the service to promptly initiate proactive outreach to those affected.

While acknowledging the challenges in comparing data from this study with aggregated results from the Scottish evaluation, the difference in police referrals between the two studies is nevertheless stark. It underscores the effectiveness of RTSS and information sharing agreements. Our results indicate that for this approach to succeed, it is essential to have the multiagency agreements and organisational infrastructure to support police officers in actively engaging individuals in early referral discussions and obtaining consent to share contact details. This requires top-level backing and resource allocation. This knowledge holds significance for policymakers and service commissioners, demonstrating how such a method, when coupled with proactive persistent contact, effectively engages individuals and underscores the transformative potential of this strategy.

Two key study limitations are worth noting. Firstly, the sample selection, focusing on volunteer support workers and service users, may have introduced bias, potentially leading to overly positive findings about the success and delivery of the service. Due to the sensitive nature of the topic, we were not able to employ random participant selection, relying partly on service staff to identify interviewees. Secondly, despite the two-year study duration, we could not assess the long-term impact of the service or factors improving its long-term delivery. Our findings highlighted challenges in implementing certain components that may accumulate over time, affecting the model's sustainability.

Nevertheless, taken together, our findings support Andriessen et al. (2019) call for a public approach postvention service delivery that emphasises multi-agency working and tailored timely support. They provide evidence-based justification for adopting the four distinct and innovative components within community-based suicide postvention services. Future services and policies should integrate the RTSS and persistent proactive contact components, highlighting the importance of multi-agency collaboration from the outset. Our study demonstrates the achievability of timely intervention and identifies essential model components. This initiative has significant potential, impacting policies and services worldwide.

Note

1. There were reporting errors in the original service data; total referral numbers were 537, recorded gender data totalled 538.

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Notes on contributors

Jo Bell is a Reader in Psychology and Social Work at the University of Hull, UK. Her work as a social scientist is dedicated to research that seeks to understand adversity and human experience and research that makes a difference to the lives of vulnerable people, particularly young people. Her research integrates three main strandes: menta lhealth, suicide prevention, and trauma and loss. She has published on the subjects of mental health, self-harm, suicide prevention and postvention, suicide bereavement and suicide-related internet use, including online suicide memorialisation and the use of social media in the aftermath of a suicide.

Katie Cunnah is a Research Tutor and Postdoctoral Research Fellow in the School of Psychology and Social Work at the University of Hull, UK. As a Chartered Psychologist, Katie specialises in organisational psychology, mental health and wellbeing, and qualitative research methods.

Fiona Earle is Professor of Occupational Psychology at the University of Hull, UK. Fiona is a Chartered Occupational Psychologist with 25 years' experience of working across academia, business and industry. Fiona specialises in stress research in applied settings.

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