Scottish Government
Riaghaltas na h-Alba

# Evaluation of the Suicide Bereavement Support Service: Final Evaluation Report

HEALTH AND SOCIAL CARE

social research

**Contents**

# Executive summary

The findings of a 2018 research study suggest that up to 135 people are affected to some degree by a death by suicide. People bereaved by the suicide of a close friend or family member are estimated to be 65% more likely to attempt suicide than if the deceased had died by natural causes. In 2022, the number of people who died from suicide in Scotland was 762; a slight increase from the previous year (753), which was the lowest level since 2017.

The National Suicide Prevention Leadership Group (NSPLG) was established in 2018 to support the implementation of the Scottish Government's Suicide Prevention Action Plan 'Every Life Matters'. In 2019, the NSPLG's Annual Report included a recommendation that the Scottish Government should fund a pilot to test a new model of suicide bereavement support. In response to this recommendation, the Scottish Government funded a pilot support service for families bereaved by suicide - the Suicide Bereavement Support Service (SBSS).

Following a competitive tendering exercise, Penumbra and Change Mental Health, working in partnership, were commissioned to manage and deliver the pilot. Change Mental Health delivered the service in NHS Highland and Penumbra in NHS Ayrshire and Arran.

The Scottish Government commissioned The Lines Between to deliver an independent evaluation to run alongside the SBSS pilot. The main aims of the evaluation were to capture learning generated from the implementation and delivery of the pilot to inform any future rollout of the service and to explore the experiences of people receiving support from the service and evidence any outcomes achieved.

## Extension to the pilot and evaluation

The SBSS launched in August 2021 and was originally scheduled to end in April 2023. However, the pilot was extended to March 2024, and the evaluation extended to October 2023, to provide further learning that could inform decisions about any future service continuation and rollout.

## Overview of service activity and referrals

At the end of September 2023, 132 people were receiving support from the service. A total of 2,670 support sessions and 2,089 hours of support have been provided, which equates to an average of 12.4 sessions per person being supported, each lasting an average of 47 minutes. The service has supported more females (71%) than males (24%), with an average age of 43.5 across the people being supported. Most people accessing support are immediate family members of the deceased.

The SBSS received 242 referrals over 25 months of delivery, an average of almost ten referrals per month, an increase from the previous reporting point in April 2023 when the average was eight per month. The three most common referral pathways into the service are self-referral (30% of all referrals), Police Scotland (26%), and

health services (19%). Smaller levels of referrals from various other services and organisations make up the remaining referrals to the service.

Levels of referrals have not followed a consistent pattern, with periods where the average number of referrals has increased and periods when they have decreased. The most recent monitoring data for the period since the Year 2 evaluation report (Feb 2023 to end of Sept 2023) shows the highest level of referrals, with an average of 12 per month. This is a potential indicator that referral pathways are becoming more embedded, and awareness of the service is increasing.

Feedback from those who have referred people to the SBSS has been consistently positive, both in terms of the referral process and their perceptions of the service. The referral process is seen as straightforward, and communication from the service was reported to be effective. Referral organisations value the SBSS, believing it offers tailored support which meets the unique needs of people bereaved by suicide.

## Service structure and model of delivery

The service is structured around a hub and spoke model. The hub is responsible for centralised functions that enable a rapid response to referrals, consistency in the approach and overall quality assurance of the service. Local delivery is carried out collaboratively across the two partner organisations, with each area representing a spoke in the hub and spoke model.

In both areas, the delivery model was reported to be fully embedded and underpinned by a person-centred and person-led approach that is compassionate and responsive to people's needs and circumstances. The following critical components of the delivery model were identified:

- A compassionate, person-centred approach and having someone outside the immediate circle of friends and family to talk openly with.
- Being responsive to the changing practical and emotional needs of the supported person.
- The provision of flexible and person-led support in terms of session frequency, duration and format.
- Consistency in the person providing support, enabling the development of a trust-based relationship and an in-depth understanding of the person being supported.
- A rapid response to the initial referral and rapid access to support.
- No limit is placed on the length of time that someone can receive support.
- Robust and effective support for staff, coupled with opportunities for continuous development, which enables staff to carry out their role effectively.

## Caseload and capacity

At the end of September 2023, 132 people were receiving support, an increase of almost 50% since March 2023. Individual caseloads vary, though most service staff report that they are approaching capacity. While staff are approaching capacity, they reported an emerging pattern of flow through the service that enables new referrals to be accommodated. For example, a reduction in session frequency among some people they support, service exits or planning for exits provides capacity for new referrals. The regular caseload review sessions in the service were also seen by staff as helpful in identifying cases where exploratory discussions about support frequency and transitions towards exit could occur.

## Experience and outcomes for people supported by the service

Before the pilot extension, the evaluation had engaged with people receiving support from the service for periods ranging from three months to nine months to explore their experiences. This established that people using the service had positive experiences, receiving person-centred support delivered with sensitivity and compassion, which they found responsive to their changing needs. The support was found to positively impact the emotional and mental wellbeing of the people who access the service, as well as the extent to which they can cope with and return to day-to-day life and activities.

During this extension period, the evaluation explored the needs, experiences and outcomes of people receiving support from the service for a year or more. This found that the overall experience of those who had engaged with the service over a longer period remains positive. They value the trust-based relationship that develops through consistent support from the same staff member and the sensitive and compassionate delivery. The findings also suggest that outcomes reported by those who have engaged with the service over a longer duration mirror those identified in the shorter term among other supported people. While outcomes may be the same, the findings highlight the unique nature of each person’s experiences, needs and journey through trauma and grief.

## Local priorities and the wider support landscape

Stakeholders in both pilot areas reported that the SBSS had filled a significant gap in the support available for people affected by bereavement by suicide and that the service has been able to meet the needs of people bereaved by suicide that other types of provision would not be equipped to meet. However, in both pilot areas, further work is required to fully map and understand the different pathways into, through and across the various suicide-specific support services as well as the wider bereavement, mental and emotional wellbeing and other support services that have a role in suicide prevention.

Stakeholders expressed a strong desire to see the SBSS continue in the pilot areas and considered it a key component in achieving local suicide prevention aims and aspirations. Without the service, according to stakeholders, significant gaps in being able to meet the varied needs of people bereaved by suicide would exist.

Furthermore, the broader contribution of SBSS leads and managers in local suicide prevention planning and activity is highly valued by stakeholders.

## Outline options beyond the pilot period

While a full options appraisal has not been conducted, discussions with service staff and stakeholders identified three potential outline options for the future of the service. In summary, these are:

1. **Service rollout to all Health Board areas:** This option would see the SBSS delivery model replicated in each Health Board area with a physical presence and local referral pathways. Delivery in each health board area would represent new spokes in the current hub and spoke model.

2. **Single national service linked with local delivery to meet local priorities:** The creation of a national team covering the whole of Scotland, though without the option of face-to-face support. A combination of local and national referral routes would be developed and implemented, supported through a suicide prevention website facilitating referral into the service.

3. **Managed closure of the SBSS:** Closure of the SBSS, with steps taken to ensure those receiving support from the service experience as little negative impact as possible. The learning generated through the pilot is shared with local suicide prevention leads to inform any local developments.

## Overarching recommendation

The SBSS provides compassionate, sensitive, person-led and person-centred support that meets the preferences and needs of those bereaved by suicide. This approach has been critical to the positive experiences and outcomes reported by people who have accessed the service.

Based on the evidence and learning captured throughout this evaluation, the overarching recommendation is that the SBSS be made available to anyone in Scotland who has experienced a bereavement by suicide. In doing so, it is essential that the elements of the service delivery model identified as critical to providing a positive experience and generating outcomes for people receiving support are maintained.

# 1. Introduction

## 1.1 Background to the Suicide Bereavement Support Service (SBSS)

People who are bereaved by the suicide of a close friend or family member are estimated to be 65% more likely to attempt suicide than if the deceased had died by natural causes.[1] The findings of a 2018 research study suggest that up to 135 people are affected to some degree by a death by suicide.[2] In 2022, the number of people who died from suicide in Scotland was 762; a slight increase from the previous year (753), which was the lowest level since 2017.[3]

Bereavement by suicide can have a severely detrimental effect on emotional and mental wellbeing, and many practical and emotional barriers prevent people who have been bereaved by suicide from accessing or seeking support. These barriers include not knowing what support is available, where to look, or an inability to access support due to trauma and distress.

The National Suicide Prevention Leadership Group (NSPLG) was established in 2018 to support the implementation of the Scottish Government's Suicide Prevention Action Plan 'Every Life Matters'.[4] In 2019, the NSPLG's Annual Report included a recommendation that the Scottish Government fund a pilot to test a new model of suicide bereavement support.

In response to this recommendation, a pilot support service for families bereaved by suicide - the Suicide Bereavement Support Service (SBSS) - was funded by the Scottish Government. The service requirements and the core components of the service model were informed through a research project[5] undertaken by the Mental Health Foundation (MHF), jointly funded by the Scottish Government and MHF.

Following a competitive tendering exercise, Penumbra and Change Mental Health, working in partnership, were commissioned to manage and deliver the pilot. Change Mental Health delivered the service in NHS Highland and Penumbra in NHS Ayrshire and Arran.

The SBSS launched in August 2021 and was originally scheduled to end in April 2023. The Lines Between was commissioned to carry out an independent evaluation of the pilot, beginning in February 2021 and ending in March 2023. During this period, two mid-year interim reports and two annual reports were produced detailing the findings and evidence captured. A summary of the first

[1] Pitman, A, et al. "Effects of suicide bereavement on mental health and suicide risk." *The Lancet Psychiatry* 1.1 (2014): 86-94.

[2] Cerel J, et al. "How Many People Are Exposed to Suicide? Not Six." Suicide Life Threat Behav. (2019) 49 (2):529-534.

[3] Public Health Scotland suicide statistics for Scotland for the year 2021

[4] Every Life Matters - Scotland's suicide prevention action plan

[5] Support for those bereaved by suicide | Mental Health Foundation

annual evaluation report was published in Autumn 2022[6] and a full report of Year 2 of the evaluation was published in September 2023[7].

In 2022, 'Creating Hope Together', Scotland's Suicide Prevention Action Plan (2022-2032), was launched. Outcome Three in this action plan sets out the ambition that: "Everyone affected by suicide is able to access high quality, compassionate, appropriate and timely support – which promotes wellbeing and recovery."

To enable further learning that could inform decisions about the longer-term future of the service, the pilot was extended to March 2024, and the evaluation extended to October 2023. The specific aims of the evaluation extension are detailed in the following section.

## 1.2 Purpose of the extension to the SBSS evaluation

Stakeholders highlighted specific areas of insight and learning to capture during the evaluation extension period. This included:

- What are the longer-term experiences of people engaging with the service, and what outcomes are achieved?
- To what extent has the following changed over time:
    - number of people being referred,
    - sources of referral,
    - reasons for referral,
    - frequency and length of sessions, and,
    - Different types of support and the impact they have
- What can the profile of those using the service tell us about who benefits most from the service and who may be missed within current approaches?
    - How has the profile of people accessing the service changed over time?
    - How recently have people experienced suicide bereavement before accessing the service and has this changed over time?
- What are the views, experiences and key learning amongst frontline practitioners, particularly on issues around training and supervision, and how can this inform the service rollout and support new practitioners?

[6] Suicide Bereavement Support Service - Year one evaluation summary report

[7] Suicide Bereavement Support Service - Year 2 evaluation report

- What are the barriers and opportunities associated with different referral pathways into the service? What is the key learning for the development of new pathways for referrals?
- What are the opportunities and limitations of the current ‘hub and spoke’ model for service delivery with respect to wider service rollout?
- How does the service fit within the wider ecosystem for support and provision for suicide bereavement and suicide prevention?
    - What do referrers say about the service and the referral processes?

## 1.3 Report structure

This final report presents findings generated from the extension period of the service evaluation, covering the period March 2023 to October 2023. It also recaps key findings and learning from previous reports to provide a summation of reflections that cover the 3 years of evaluation activity.

This report is structured as follows:

- Chapter 2 provides a summary of evaluation and data collection activity carried out over the full duration of the evaluation.
- Chapter 3 provides an overview of service delivery activity and the profile of people who accessed the service.
- Chapter 4 explores service delivery from the perspective of service staff, as well as discussing how the service fits into the wider support landscape and its alignment and contribution to local suicide prevention priorities and activities.
- Chapter 5 presents the experiences and outcomes of people who have received longer-term support from the service.
- Chapter 6 discusses the considerations and options for the future of the service.
- Chapter 7 presents conclusions aligned with the evaluation questions.
- Chapter 8 provides recommendations for the future of the service.

# 2. Evaluation fieldwork and data collection activity

A summary of the fieldwork and data collection activity that has been carried out over the duration of the 30-month evaluation of the service is provided in the following sections.

## 2.1 Collection and analysis of service monitoring data

Penumbra and Change Mental Health have provided the evaluation team with monitoring data relating to service activity and demographic information about the people the service has supported. This data spans the period from the service launch in August 2021, until the end of September 2023. The data was collated and analysed using Microsoft Excel.

## 2.2 Engagement with service staff

To explore the implementation and delivery of the service, a combination of one-to-one interviews and group discussions were used to engage with service leads and service managers from the two pilot sites. One-to-one interviews were conducted with frontline service practitioners in the pilot areas. This activity was repeated at five points (August/September 2021, 2022 and 2023, February/March 2022 and 2023) over the duration of the evaluation.

## 2.3 Engagement with local and National stakeholders

One-to-one interviews with 32 local and national stakeholders were undertaken over the duration of the evaluation, to explore their perceptions of the service and how it may have contributed to the support landscape and suicide prevention agenda in each locality.

Stakeholders included:

- Organisations that referred people to the service or received referrals from the service.
- Members of local steering groups for the service in each pilot area.
- Those with a role in suicide prevention in each pilot area.
- Members of the pilot's National Oversight Group.

## 2.3 Engagement with people receiving support from the service

One-to-one interviews were undertaken with a sample of people who had engaged with the service, and who had consented to participating in the evaluation, to explore their experiences of the support they had received and any outcomes that had been gained as a result.

Over the duration of the evaluation 46 supported people engaged with the evaluation. Of those 46 individuals, 17 engaged in a second one-to-one interview, and of those 17, six participated in a third. Interviews at multiple time points allowed the evaluation to explore people's experiences and outcomes at different stages of their engagement with the service. During the evaluation extension period, one-to-one interviews were undertaken with 13 people who had been receiving support from the service for 12 months or more, to explore their experiences of the service over the longer-term. Of that 13, nine had previously engaged with the evaluation.

## 2.4 Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) data

When commissioning the evaluation, the Scottish Government stated a preference that a validated tool was used to support the collection of outcome evidence. A wide range of validated tools that aligned with the anticipated pilot outcomes were identified and considered by the evaluation team. To inform the selection of a validated tool that would be most appropriate for the service and evaluation, consultation with a group of people with lived experience of suicide bereavement was undertaken. An options paper was developed by the evaluation team and presented to the Research Advisory Group established for the pilot, with agreement that Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS) would be used.

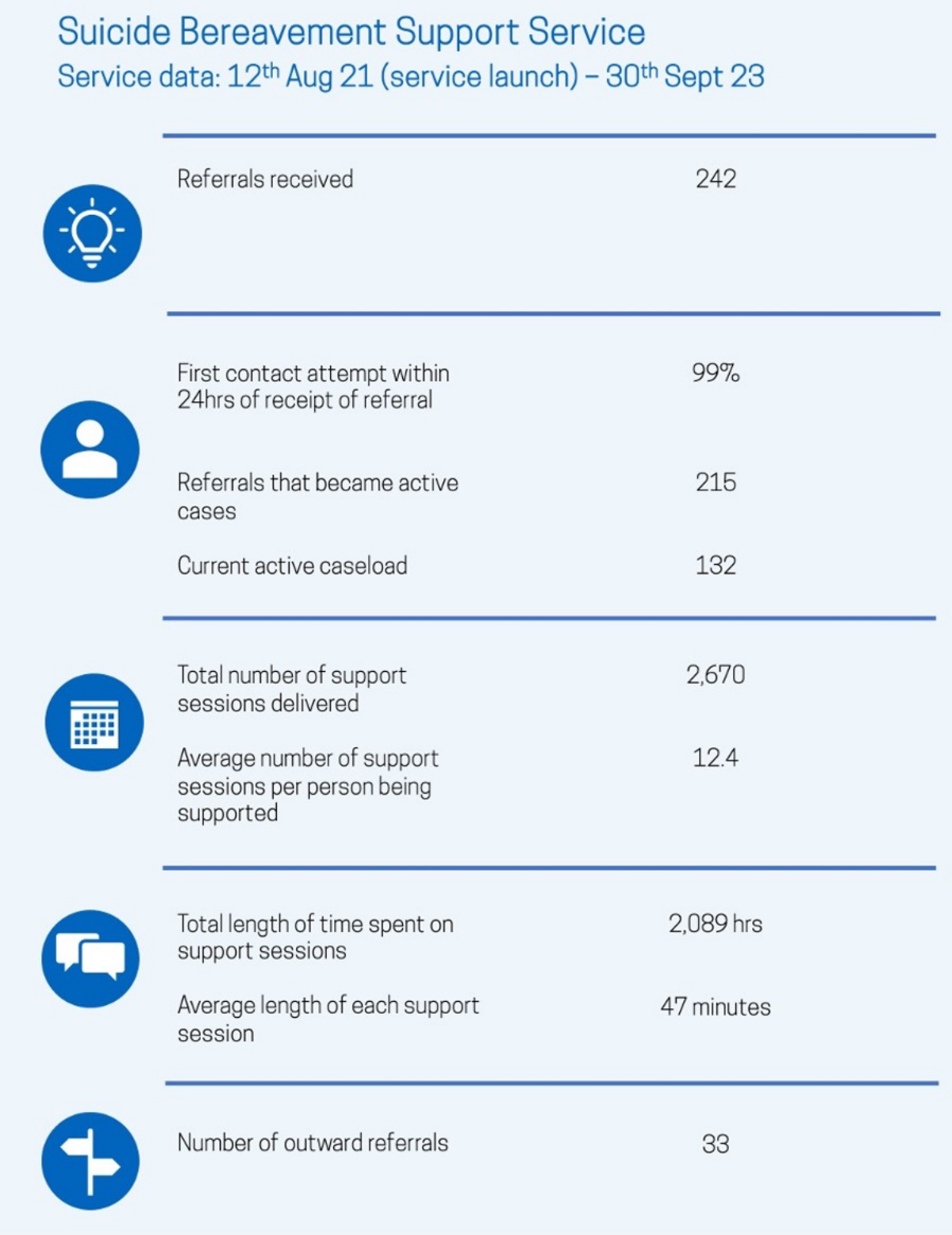
SWEMWBS was administered three times (baseline, three months, and six months) by service staff with each person they are supporting who provides consent to complete it. There were 45 people whose SWEMWBS scores were measured at the start of their engagement with the service (baseline) and again at three months. Their scores at baseline and after three months were compared using a two-sided paired t-test. Of those, 24 people were also measured at six months, and their SWEMWBS scores were compared to their baseline scores using a two-sided paired t-test. As all the individuals in the six-month group were also in the three-month group, a Bonferroni correction was applied.

# 3. Service activity and people supported

This chapter provides an overview of service delivery activity and a profile of the people supported by the SBSS.

## 3.1 Overview of service activity

The infographic below sets out the monitoring data covering the period since the service launched in August 2021 to the end of September 2023.



### Number of people supported and support sessions delivered

The SBSS received 242 referrals over 25 months of delivery, from August 2021 to September 2023, an average of almost 10 per month. This average represents an increase from the previous reporting point in April 2023 (using service data to the end of February 2023), where the monthly average was roughly eight referrals per month. From March 2023 to the end of September 2023, the service received 87 referrals (40 in Ayrshire and Arran, 47 in Highland), an average of just over 12 per month. This period represents the highest average level of referrals received by the service and is a good indication of increasing awareness and further embedding of referral pathways to the service.

At the end of September 2023, 132 people were receiving support from the service, 69 in Ayrshire and Arran and 63 in Highland. This is a marked increase in overall caseload in the service since the last reporting point in April 2023 (when a caseload of 90 was reported), and most notably in Highland, which had a caseload of 37 as of February 2023.

From August 2021 to September 2023 a total of 2,670 support sessions and 2,089 hours of support have been provided via a mix of telephone, video call, text message and face-to-face delivery, with most support sessions being delivered over telephone. Across both delivery areas this equates to an average of 12.4 sessions per person being supported, each lasting an average of 47 minutes. However, the average number of sessions is lower in Ayrshire and Arran (11 compared to 14 in Highland) though with a longer average session length (55 minutes compared to 41 minutes in Highland)

### Referral routes to the service

Referrals from Police Scotland account for 26% of all referrals received by the SBSS from August 2021 to September 2023, a slight decrease from the previous reporting point (30% as of the end of February 2023). However, there are differences across the two service areas. In Ayrshire and Arran, 14% of referrals came from Police Scotland, whereas in Highland, they account for 38% of referrals.

Levels of self-referral are similar in both areas, with this pathway resulting in 30% of all referrals in Ayrshire and Arran and 34% in Highland for the period August 2021 to September 2023. Referrals from health services such as GP/Medical practices, mental health professionals and community link workers account for 34% in Ayrshire and Arran (compared to 22% as at February 2023), which suggests those pathways are becoming more embedded. In Highland, health pathways account for 15% of all referrals. Small numbers of referrals from a range of other services and organisations in each locality make up the remaining referrals in both areas.

### Outward referrals

The data demonstrates that there has been a low level of outward referral activity, with 14 in Highland and 19 in Ayrshire and Arran. While there has been no change in the level of outward referrals in Highland during the extension period, Ayrshire

and Arran made 10 outward referrals during the same period. Overall, this equates to an average of less than one outward referral per month in each of the pilot areas since the service launched.

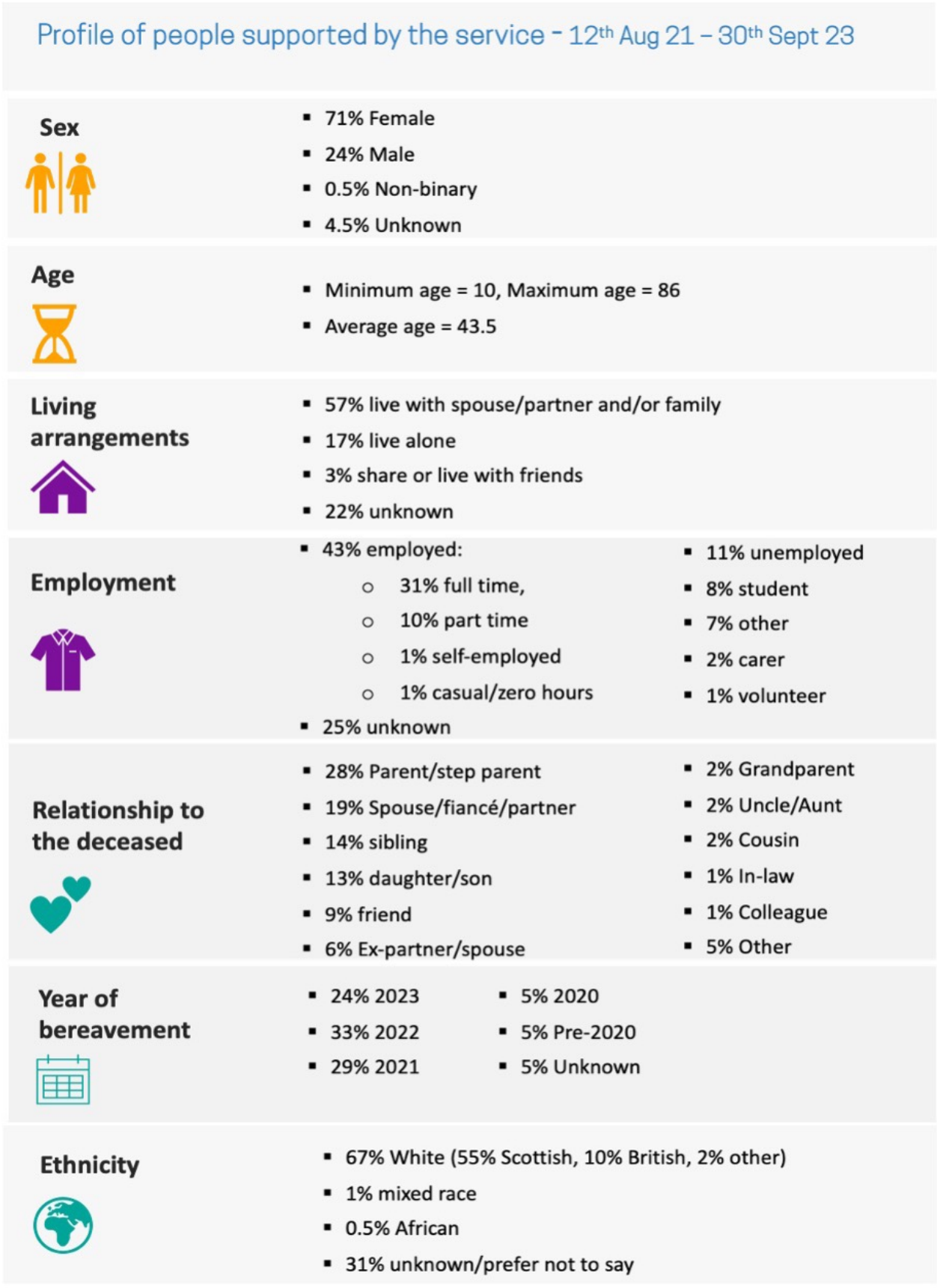
As detailed in the Year 2 evaluation report, SBSS staff explained that, as appropriate and necessary, they speak to the people they support about different support and external services that are available to meet their wider needs. SBSS staff reported that people often prefer to receive details about different external support options and then decide if and when they want to access it. When people supported by the SBSS would like a referral or help to contact and engage with another service, practitioners will do this. Examples of referrals made to other organisations and services include:

- Distress Brief Intervention Service
- The Lennox Partnership
- Hope Wellbeing Centre
- Circles Advocacy
- Change Mental Health Money and Advice Line
- Befrienders Highland

Signposting to resources and sources of information relevant to people's needs was reported to happen more frequently than formal referrals being made.

## 3.2 People supported by the SBSS

The infographic below sets out a profile of people supported by the SBSS, covering the period from August 2021 to the end of September 2023.




[Link to detailed description of infographic content]

**Differences in the profile of people supported across the two service delivery areas**

Demographic data for each pilot area is provided to demonstrate the differences and similarities in the profile of people accessing the service in each area, not to draw comparisons:

- **Sex:** In Ayrshire and Arran, the proportion of males receiving support is lower (18%) than in Highland (30%). However, 9% were recorded as unknown in Ayrshire and Arran, which could change the proportions.

- **Age:** The average age of supported people is slightly higher in Highland (44.5) than in Ayrshire and Arran (42.3). Ayrshire and Arran supported a higher proportion of people aged 31-40 (29%) than in Highland (16%). Highland had higher proportions of 18–30-year-olds and those aged 70+. All other age brackets had almost equal proportions across the two pilot areas.

- **Living arrangements:** Across both service areas, most people receiving support live with a spouse, partner or family (63% in Ayrshire and Arran, 52% in Highland). However, the proportion of 'unknown' in both areas prevents describing a fully accurate picture of this (16% in Ayrshire and Arran and 29% in Highland).

- **Employment:** There is a slightly higher proportion of employed people receiving support in Highland (45%) compared to Ayrshire and Arran (39%). In Ayrshire and Arran 14% are unemployed, while this figure is 7% in Highland. However, high proportions of unknown/prefer not to say or 'other' in both areas could be skewing the breakdown.

- **Relationship to the deceased:** Both areas have very similar levels of parents/step-parents, spouse/fiancé/partner, and siblings supported by the service. Highland have a higher proportion of daughter/sons (19% compared to 8% in Ayrshire and Arran), whereas Ayrshire and Arran have a higher proportion of ex-partners (10% compared to 2% in Highland).

- **Year of bereavement:** Bereavements occurring in 2021 are almost identical in both areas (28% in Ayrshire and Arran and 29% in Highland). There is a slight difference in the proportion of bereavements in 2022 (36% in Ayrshire and Arran and 30% in Highland) and 2023 (20% in Ayrshire and Arran and 27% in Highland). Pre-2021 represents smaller proportions in each of the service areas.

- **Ethnicity:** The high proportion of 'unknown/prefer not to say' in the service data from Ayrshire and Arran (37%) and from Highland (25%) means an accurate description of supported people's ethnicity is not possible.

**Differences in the profile of people supported by the SBSS over time**

Some changes are evident when the data for the period August 2021 to September 2023 is compared to data for the period August 2021 to February 2023:

- **Sex:** The proportion of males accessing the service in Ayrshire and Arran has reduced from 25% to 18%, though the level of unknown (9%) categorisations may be skewing this. In Highland, there has been very little change (30% male, 70% female compared to 32% male and 68% female in February 2023).

- **Age:** The average age of supported people has increased slightly in Ayrshire and Arran, rising to 42.3 compared to 41.6 previously. In Highland, the average age has decreased slightly, from 46.5 previously to a current average of 44.5.

- **Relationship to the deceased:** Immediate family members remain the most commonly supported people by the service in both areas, though there have been some changes in relationship type. In Highland, there has been a reduction in the proportion of parents/step-parents (29% compared to 39% previously). Very slight increases in the proportions of grandparents, uncle/aunt, daughter/son and friends of the deceased were observed. In Ayrshire and Arran, there were very slight changes across most categories (less than or equal to 3% variation), though the service in this area is now also supporting colleagues, in-laws, cousins and grandparents.

- **Year of bereavement:** The proportion of supported people that experienced a bereavement in 2023 has increased in both service areas (Ayrshire and Arran 4% up to 20%, Highland 3% up to 27%). This has reduced the proportions of prior-year bereavements across both areas, indicating that recent referrals are likely related to recent bereavements.

# 4. Service model and delivery

This chapter summarises the overarching service structure and delivery model and presents key learning about the needs of those accessing the service detailed in previous evaluation reports. It also presents reflections from service staff and stakeholders based on service delivery during the evaluation extension period (February 2023 to August 2023), how the service fits in the wider support landscape and its alignment and contribution to local suicide prevention priorities and activities.

## 4.1 Overarching service structure – Hub and spoke model

The overarching service structure reflects a hub and spoke model. The hub is responsible for centralised functions, which are managed and delivered in collaboration by the service leads and managers from Penumbra and Change Mental Health. The centralised functions of the hub support and enable local delivery and include:

- Quality assurance of service delivery.
- Links with national networks and partnerships.
- Receipt and allocation of referrals.
- Core staff training and development.
- Service team meetings.
- Service branding.
- Service monitoring and data collection.

Service leads reported that the centralised functions helped to facilitate a rapid response to referrals that are received, while ensuring consistency in terms of the approach to delivering the service and the quality of support that is provided.

The spokes in the service structure represent each of the two pilot delivery areas. Each spoke is responsible for various local functions, which include:

- Staff recruitment, and ongoing development and support.
- Providing support to people bereaved by suicide.
- Developing local referral pathways.
- Local networking, awareness raising and promotion.
- Developing internal policies.
- Local team meetings.

Service leads reported being confident that the hub and spoke model, with defined central and local functions, would support the rollout of the service into other areas. Each new area would represent an additional spoke, benefitting from the centralised functions carried out by the hub.

## 4.2 The service delivery model and meeting practical and emotional support needs

A consistent delivery model has been implemented across both pilot areas. The delivery model is underpinned by the following core components:

- Rapid response to referrals/self-referrals received (24-hour target for initial contact from receipt of the referral).
- Provision of person-centred emotional and practical support aligned to individual needs.
- Person-led approach to providing support which accommodates and responds to individual preferences in relation to the format, frequency, timings and duration of support sessions.

The components listed above mirror the original service specification for the pilot. These aspects were identified as being critical by people with lived experience of suicide bereavement who were engaged in consultation to inform the development of the service specification.

## 4.3 Reflections on the delivery of support

Service staff described the delivery model as fully embedded and underpinned by a person-centred and person-led approach, with the provision of support tailored to individual needs and preferences.

As described in the Year 2 annual report, a wide range of practical support has been provided to people who have accessed the service. However, over the duration of the pilot, service staff reported that practical support needs are expressed less frequently than emotional support needs. They observed that people receiving support do not often express their practical needs, and staff must be vigilant to pick up indications that someone has a practical support need, then discuss it further and explore how to address it.

Through the support they have provided, service staff have generated extensive learning about the emotional support needs of those bereaved by suicide and the various factors that can influence this. This includes:

- Immediate emotional needs following a bereavement by suicide relate to the impact of the trauma people have experienced.
- Everyone is at a different point in their bereavement journey and has specific needs, which are influenced by circumstances and wider life events.

- There will often be fluctuations in the intensity, frequency and types of support people need at any given time, and it is important that people understand that these variations can be accommodated.
- Service staff need to have a range of tools, approaches, and models at their disposal to meet the emotional needs of the people they support.
- Beyond the early stages of support, there is often a shift to focusing on supporting people to identify and take steps towards their new routine, returning to work, starting to socialise more, and resuming other day-to-day activities.
- It is important to help people recognise and acknowledge how far they have come and the progress they have made.

Reflecting this learning in their approach, service staff provide a range of emotional support at different points in each person's journey, and which is responsive and tailored to their changing needs.

## 4.4 Caseload and capacity

At the last reporting point in March 2023, 90 people were receiving support from the service. This has increased by almost 50%, with a current caseload of 132 people being supported across both areas.

Individual caseloads vary, with most service staff reporting that they are approaching capacity. Reflective of findings in previous evaluation reports, a staff member's capacity is not defined by a specific number in a caseload but rather by the mix of different frequencies in support sessions, differing lengths of support sessions and the varied needs of the people being supported that make up any individual staff member's caseload. The number of people accessing face-to-face support and the additional time commitment this requires differs across practitioner staff, and this is also considered when assessing capacity.

All practitioner staff reported having a mix of people in their caseload that require weekly, fortnightly, monthly or even six-weekly support sessions. However, that mix is different for each member of staff. Furthermore, there are instances where the frequency of support staff provide can increase following a period where it has decreased.

While service staff reported being close to capacity, they also felt that there was an emerging pattern of flow through the service that enables new referrals to be accommodated. For example, changes in session frequency, service exits or planning for exits provides capacity for new referrals. Referral rates have been unpredictable throughout the pilot, so it is unclear whether this flow pattern through the service will continue to accommodate the current higher levels of referral.

In Highland, a staff member has left post, and capacity was maintained by increasing the working hours of the remaining staff. Had that not been possible, it

would likely have impacted the extent to which the needs and preferences of those receiving support could have been met.

While telephone-based support remains the preferred option for most people engaging with the service, staff in both service areas reported an increase in people opting for face-to-face support sessions during the evaluation extension period. Potential options for face-to-face sessions are explored during the initial conversation a staff member has with a new referral to the service, including logistics, locations and potential meeting places. The preferences for how each person accessing the service would like to receive support will also influence which practitioner is allocated to provide support.

Feedback from service staff suggests that people understand the need to ensure face-to-face sessions are feasible and logistically practical, and to date there have not been any situations where a request for face-to-face support has not been accommodated. In some instances, a combination of face-to-face and telephone formats has been agreed to reduce the frequency of travel required for in-person sessions, with one example given of a supported person who travels three hours by public transport to meet face-to-face.

Changing personal circumstances, such as returning to work, has also influenced the preferred format of support, with face-to-face no longer being convenient for a few people being supported, and moves to telephone-based sessions were arranged to accommodate this. Aligned to this, one service staff member explained that several of the people they were supporting had returned to work, which led them to require support sessions from the service at the end of their working day and into early evening. A shift in frequency to fortnightly calls for those people made this change in timing and format easier to accommodate.

### Setting boundaries for face-to-face support sessions

One staff member described a challenging situation with a person they support through face-to-face sessions. The supported person demonstrated aggression and anger with the circumstances surrounding their bereavement, and made accusations while mentioning names, which is not appropriate for a public space. While the staff member understands they are distressed, they have had to explain to the person that their behaviour is unacceptable.

### Supporting young people

One staff member shared their experience of supporting a young person who was 12-years old. The staff member supported the child’s mother, who had referred her daughter and consented to the support. This has been provided through home visits by the member of staff, who has taken a play-based approach to exploring emotions, thoughts and feelings to support the child in navigating their grief. The staff member feels that this has been an effective approach and explained that they also have a role outside of the SBSS, providing support to young people in a local school. Furthermore, they have participated in training focussed on supporting young people with grief using creative approaches. The staff member explained

that supporting young people required a different approach to supporting adults and that additional training and experience were essential.

## 4.4 Exiting the service

The Year 2 evaluation report described two ways in which service staff experienced people exiting the service:

- The supported person stops attending sessions and does not respond to contact from the service. In these instances, an exit protocol is implemented, which involves a series of weekly and monthly contacts followed by a final written letter explaining that they can re-access the service if needed.
- A managed exit whereby exiting the service is agreed upon following discussion with the person receiving support. This discussion is generally broached following a period where the frequency and intensity of support have reduced, and there are conversational cues which signal that a person's support needs have also reduced.

Service staff told us that these two routes to exiting the service are still evident. A small number of staff described how they had become more responsive to cues and opportunities to have discussions with people about exiting the service. The regular caseload review sessions in the service were also seen by staff as helpful in identifying cases where exploratory discussions about possible changes to support frequency and transitions towards exiting the service could take place.

During discussions with people who had been receiving support from the service for over 12 months, we explored the frequency of support sessions and their thoughts about what would indicate to them that they would no longer need the service.

Among those we spoke with, the frequency of support sessions included weekly, fortnightly, monthly and every six weeks. Those receiving monthly or six weekly support sessions generally recognised that their needs had reduced and felt a lower reliance on the service to cope and get by day to day. They had re-engaged with activities they participated in prior to their bereavement and, in some instances, started new hobbies and social activities. However, they still valued the safety net and reassurance of having support sessions available to them while at the same time recognising the reduced frequency was a way of testing how they managed between each session.

In a few instances, people receiving support from the service commented that they had a specific event they were looking to get past before considering ceasing support. This included anniversaries and the conclusion of reviews into the death of their loved one, such as those carried out by statutory services when someone is known to have been in contact with mental health services prior to their death. They recognised that these could be difficult times and gauging how they managed during those periods would give them a strong indication of how ready they were to exit support.

People supported by the service reflected on the strategies and techniques that have helped them move forward and cope day to day, but a few also commented that things could happen in their lives that took them by surprise. Family get-togethers, a glance at a photo, a question asked by a friend – were all given as examples of instances that had triggered an emotional response that the person had not expected. This and other similar instances had made them realise that they were not quite ready to stop receiving support. Two people also explained that they supported others in their family who were unwilling or did not feel ready to engage with outside support. This was an additional emotional pressure on them, but they felt that their support from the service enabled them to support their loved ones.

People receiving weekly and fortnightly support sessions were the least certain about when or what would indicate to them that they were ready to exit support. However, they did acknowledge that the next step for them was to begin reducing the frequency of their support sessions, and in most cases, this was starting to be explored with the member of service staff providing their support.

## 4.5 Referral pathways and the wider ecosystem of support

Self-referral and Police Scotland referrals were the two official pathways into the service when it was launched in August 2021. This was a deliberate strategy to enable the service to manage and understand potential demand for the service, while allowing the delivery model to be tested and become embedded. The Police Scotland referral pathway was chosen due to the role of police where there has been a suspected suicide, and the contact Police Scotland then has with those that could potentially benefit from the service.

Work to increase awareness of the service and expand referral routes commenced after the initial few months of the service launching, and when a full staffing complement was in place. The creation of new referral pathways was focused on the various touch points that someone bereaved by suicide was likely to have with different organisations and services. This area of service development was an ongoing aspect and involved various activities requiring the input of all service staff to both create new pathways, and also to maintain and embed those that had already been established.

### The most common referral pathways

Throughout the pilot, levels of self-referral have fluctuated, though it has been one of the most common routes into the service in both pilot areas. The most recent service referral data shows that 30% of all referrals in Ayrshire and Arran and 34% in Highland have come via self-referral.

In Highland, referrals from Police Scotland have also fluctuated during the pilot while remaining one of the most common routes into the service, accounting for 38% of all referrals received. This contrasts with Ayrshire and Arran, where the level of referrals from Police Scotland has constantly declined throughout the pilot and now accounts for only 13% of the total referrals received.

Recent discussions with representatives of Police Scotland in each of the service areas confirmed that they are aware of the referral levels into the service, with one Police Scotland representative in Ayrshire and Arran explaining that they were disappointed with the level of referrals that had been made. In both areas, good relationships and communication between service staff and the police were reported, and discussions about increasing referral rates regularly took place. Both divisions of Police Scotland also described internal processes to monitor referrals being made to the service by officers that had attended a suicide, and how follow-up procedures were in place where a referral had not been immediately discussed and offered. Why referral rates differ across the two service areas is unknown. However, the Police Scotland divisions in both areas are equally committed to working with the service to maximise the effectiveness of this route into the service.

While there has been a drop off in referral rates from Police Scotland in Ayrshire and Arran, there has been a steady increase in the level of referrals being received from health services (e.g. GP, Medical practice, community mental health), which now account for roughly a third of all referrals that have been received.

**Perceptions of referral organisations**

Throughout this evaluation, the feedback from those who have referred people to the SBSS has been positive, both in terms of the referral process and their perceptions of the service. The key themes in feedback are summarised below:

- The referral process is seen as straightforward, and communication from the service was reported to be effective. Referrers appreciated being updated that referrals had been received and that action had been taken to contact the person they referred. This is not always the case with other services they refer people to for various support needs.

- Most of those who have referred people to the service have made only a few referrals throughout the pilot period. However, they value having the service as an option to discuss with those whose needs related to a bereavement by suicide. A small number of referrers working in community mental health reported that presentation of these needs was more common (e.g. at least weekly occurrence), though often not as the highest priority need. In these instances, other mental health or substance abuse support was a priority before considering something like the SBSS.

- Several referrers spoke about the unique needs of those bereaved by suicide and some recognised and understood that tailored support is needed rather than generalised bereavement support or emotional and mental wellbeing support.

- There was mixed awareness of other support and services available for people bereaved by suicide in the pilot areas. This included more general bereavement support or support for emotional and mental wellbeing, as well as support specifically for those affected by suicide. However, differences in accessibility, availability, type and nature of support were identified as setting

the SBSS apart from other services and was the preferred support option for those making referrals.

- Change Mental Health and Penumbra have good reputations locally and are known for other services they provide, which increased the credibility of the SBSS among referrers.

- A few referrers explained that they have had follow-up contact with the person or people they have referred to the service and received positive feedback. This is reassuring for referrers and adds to their confidence in the service.

**Local priorities and the wider support landscape**

The evaluation engaged with service stakeholders with a role in local suicide prevention planning and activity in each pilot area. During these discussions we explored the perceived importance of the SBSS in terms of its contribution to local suicide prevention priorities and where the service sat in the wider provision and support landscape.

Stakeholders in both pilot areas reported that the SBSS had filled a significant gap in the support available for people affected by bereavement by suicide. While there was acknowledgement of various support and services already in place, it was also reported that these did not or could not provide the same accessibility, availability, responsiveness, type or intensity of support offered by the SBSS. Feedback suggests that the SBSS has been able to meet the needs of people bereaved by suicide that other types of provision would not be equipped to meet.

The value attributed to SBSS was not framed in a way that dismissed or devalued the support provided by other services and provision, with stakeholders acknowledging that different people needed different types of support and services to meet their needs, and therefore a range of different support and services were required. In both pilot areas, stakeholders identified a need to better understand and map the different pathways into, through and across the different support and services that could help to meet the needs of people affected by suicide, to help develop an understanding of what, if any, gaps remained.

There is a strong desire among stakeholders to see the SBSS continue in the pilot areas. The service was viewed as a key component in achieving local aims and aspirations in relation to suicide prevention and without the service there would be significant gaps in being able to meet the varied needs of people bereaved by suicide. Some stakeholders also reflected on the knowledge, learning and intelligence that the SBSS has developed as having great potential to inform and contribute to wider suicide prevention planning and activity.

The contribution of the service beyond the support it provides to people bereaved by suicide was also highlighted by stakeholders. SBSS leads and managers attend various working and sub-groups involved in local suicide prevention planning and activity, and their contribution to these groups is highly valued.

Some stakeholders also reported that the level of demand and need for the service was still to be fully understood. They argued that the need for the service is evidenced by those who have been referred or sought out and accessed the service. However, stakeholders also reflected the need for greater awareness about the service across the pilot areas. In these discussions, stakeholders explained that their comments on service visibility was not a criticism and acknowledged the breadth of activity undertaken by service staff to raise awareness and develop referral routes. Stakeholders also recognised that it can take a long time to achieve awareness and understanding of a new service across an existing service landscape and among the public more widely, and the period the pilot has been operating is relatively short.

Related to the above, one stakeholder highlighted the time it can take to achieve an awareness and an understanding of who a service is for. They shared an example of a local service that has been in operation for many years which is perceived by the public as a service for younger people, but is in fact, open to all ages.

## 4.6 Critical elements of the service delivery model

We explored with service staff and people supported by the service which elements of service delivery were critical for providing a positive experience and generating outcomes. Several features were consistently cited:

- **Independence of staff and a compassionate person-centred approach:** Having someone outside the immediate circle of friends and family to talk openly with, and for that person to demonstrate empathy, sensitivity and compassion while being responsive to the emotional and practical needs of the supported person.

- **Flexible and person-led support:** Session frequency, format and duration is led by the supported person. Furthermore, being able to test longer gaps between support sessions was highly valued by people, especially because they were confident that if they needed to increase the frequency again, the service would be accommodating and responsive to that need.

- **Consistency in support:** The opportunity to develop a trust-based relationship, rapport, and understanding is important for the person being supported as well as the member of service staff and is seen to be one of the most important aspects of providing effective and responsive support. However, it is also important to acknowledge that staff changes in the service have resulted in instances where there have been changes in the person providing support for some people, and this is perceived to have been managed well with minimal impact on the effectiveness of support provided.

- **Initial response and access:** A rapid response following initial referral and commencement of support sessions at the earliest opportunity helps ensure people receive support when needed.

- **No time limit on the support provided:** There is no set maximum duration that a person can receive support, and this is perceived by staff and supported people to acknowledge the complexity and impact of bereavement by suicide. It removes any pressure or concerns for the person being supported that they will not lose support they still feel they need.

- **Support for service staff:** Service staff have continually praised the level, different formats and effectiveness of support they receive in their role and see it as critical in enabling them to carry out their role effectively.

- **Encouraging and enabling continuous development:** An environment that encourages and enables staff to prioritise their development and access opportunities that allow them to continually build on their skills, knowledge and competence was highly valued and seen as essential for frontline practitioners.

# 5. Experiences and outcomes of people receiving longer-term support

Prior to the pilot extension into a third year, the evaluation had engaged with people who had been receiving support from the service for periods ranging from three months to nine months to explore their experiences and the outcomes that had been generated. The findings and evidence from this have been detailed in the previous evaluation reports. In summary, the evaluation up to the end of Year 2 found that:

- People have a positive experience and receive responsive person-centred support from the service, that is delivered with sensitivity and compassion.
- People receive support that is led by them and provides the flexibility required to respond to changing needs.
- The service has a positive impact on the emotional and mental well-being of the people it supports,
- as well as the extent to which they feel they can cope with and return to day-to-day life and activities. For some people, the impact is profound, with feedback suggesting that it has been the difference between living and dying.
- Wider support and service options aligned to their needs are explored with people, and support required to access them is provided as required and appropriate.

During this extension period, the evaluation was tasked with understanding the needs, experiences and outcomes of people receiving support over a longer duration. This was explored with 13 people who have been receiving support from the service for over 12 months. The findings are presented in the following sections.

## 5.1 Format of support

All but two of the 13 people supported by the service that we engaged with during this phase of the evaluation reported that all their support sessions had been carried out by phone. They stated that this had been their preference at the outset, and they had continued with this format because it had worked so well for them, even when the option to have face to face sessions was introduced.

“I’ve kept going with the phone calls, and well, it's really worked for me. In the early days it’s all I felt I could manage, but now, as I say, it’s worked really well and it’s just really convenient, easy.”

“It's all been over the phone because that's my preference. The first, I suppose, nearly first year, I didn't really want to meet up with anybody, I didn't want to look at anybody, if that makes sense. Even now that I’m back to, well closer to my old self,

I don’t feel the need to change it. I know I could meet up with [practitioner] but this gives me what I need.”

One person reported that they had moved to a mix of face to face and telephone support. They explained that as the brighter months of the year came around, the option of meeting for a walk and receiving support appealed to them, while telephone sessions still provided convenience when their work made it difficult to meet up. Another person explained that they had met up for a face-to-face support session once, and another reported that they wanted to have an in-person session before they finished their support completely. In both instances this was borne from a desire to meet the person that had been supporting them and express their gratitude

“I've often thought to myself, you know, do you know I'd like to meet [name, anonymised] before the session's totally finished, you know, just to let them know how much they have helped me. It’s something I’m going to mention in the next session.”

## 5.2 Changing frequency of support and influencing factors

People supported by the service commonly reported that support sessions were weekly when they first accessed the service. All of those we spoke with struggled to recall the early periods of engagement with the service in detail, describing it as a blur and as a time in their bereavement journey where they struggled to understand and process what had happened. The higher frequency of support during those early stages had been essential in helping them get through that period.

“At the beginning it was just getting through a day, getting through a couple of hours in a day. I can’t really explain how important it was to have [practitioner] there whenever I needed them.”

Most of the supported people explained that there had been periods when they had started reducing the frequency of the support they received from the service, which coincided with a feeling of being better equipped to cope, better able to get by day to day and feeling less reliant on the support.

“I won't use the expression 'moved on' because you'll never move on, especially losing a daughter, losing a child. But I suppose I could see progress, I wasn’t feeling the same way between calls and felt that I didn’t need to be having them so often.”

“I was back to work, I had a routine again, and just managing better in myself.”

However, people also described how circumstances in their lives and different events had set them back and heightened their need for support again.

“I’ve recently had some really bad news that I’m finding it hard to deal with. She would be my, yeah, the person I would always turn to for support I suppose, and I can’t. So I'm just very much feeling the loss I suppose at the moment, finding stuff a

bit harder and yeah, needing a bit more support than I thought I would at this moment in time, but I'm sure with time that will get better."

There was a wide variety of circumstances and factors that had influenced people's increased need for support, with examples including:

- Ongoing reviews by statutory agencies of the bereavement with certain points in the review process creating heightened feelings of distress and bringing back painful thoughts and memories.
- Isolation and lack of a wider support network.
- Re-engaging with activities that the person would have done with the loved one they had lost.
- Strained relationships and traumatic events with other family members, partners or ex-partners.
- Moving house and leaving memories behind, or selling the home of their loved one.
- Returning to work, where roles mean that people face situations that can trigger memories and be re-traumatising (e.g. healthcare workers).
- Death or serious illness of a family member or friend.
- Trying to support other people affected by the bereavement who are not yet ready to access support for themselves.

"I'm in the middle of trying to sell the house, and you know, that's the house that we had together, and when I do move there will be stuff I need to get rid of. But everything is memories and it's hard because it's part of bad memories but also so many good ones. I'm just finding it really really hard just now."

The reassurance that the frequency of support can be increased again was reported to be highly valued. Having this option gave people the confidence to test how they would manage with less support. Several people reported that they would have been more hesitant about reducing the level of support they received without the reassurance that they could increase it again if needed. Related to this, that there is no time limit placed on support was also seen to be critical by those who have accessed support.

"So at the moment I check in with [practitioner] sort of once a month, but I also know that I can, if I want to, you know, between that sort of once a month, that I can get in touch if I need to. I could even go back fortnightly or even weekly sessions, that was always made clear. And that's like, a sort of safety, that lets you go OK let's try monthly or whatever and you know you can go back if you're not ready."

"Yeah I think it's very important to not feel that you're rushed or you've got a time limit because as I said you can think you're doing okay yourself maybe after six months, but then sometimes after that you know, you find yourself in a bad place

again, something can trigger it off or a memory or just how you're feeling yourself, so I think it's very important not to have a time limit, if I'm honest."

## 5.3 Changing needs

People supported by the service described the period after their bereavement as a time of confusion, when they experienced a wide mix of intense feelings and emotions, usually combined with questions they did not have answers to. Several explained how bereavement by suicide is different from other bereavements they had experienced in terms of the nature and intensity of the thoughts and emotions they were experiencing.

"It was a feeling of guilt that I've never known before, guilt that I wasn't there for him, that I wasn't there to help him. You don't think it's ever going to go away."

In those early stages following their bereavement, people supported by the service spoke about the importance and value of having someone to speak to and who would listen to them with empathy and compassion. Those supported by the service reflected on the support they had received and how it helped them understand and accept that their feelings were normal and to come to terms with the questions they would never have answers to.

"At the very very start it was just someone who listens without telling you what everyone was telling you at the time. You know, "everything will be okay, blah blah blah blah blah." Someone who just listens and don't provide those ready-made phrases that you get tired of hearing and someone you can just cry in front of, which I did a few times. Someone you can be very honest with, that was really important at the very start. At that time, it was a phase where actually I wasn't right at all mentally, and I had very dark thoughts."

"Sometimes you just need to know, you just need that reassurance that what you are feeling is normal. There's so much your feeling, and thoughts your having, and you wonder if it will ever stop. [Practitioner] just helps you work through it, it's OK to feel those things, it's OK to be thinking that way."

"All the why's and the what if's that go round and round. I'm not saying that I don't still think those things, but there's an acceptance that I'll never know and that is sort of OK."

Supported people described how over time and with the support of the service the intensity of the emotions and feelings related to the bereavement reduced, and the impact of those emotions and feelings subsided. The support helped them to understand and process their emotions and feelings but also gave them strategies that helped them to cope better day to day. Some supported people spoke about support sessions becoming more future and solutions-focused rather than predominantly being related directly to their bereavement. However, the ongoing need for support was acknowledged, the need to still have that person they can speak to openly without judgement or expectations about how they should be feeling by now remains. Supported people explained that they can be caught off guard by something that can set them back and catch them unprepared.

“It just started me questioning what were all these years about, you know? And, yeah, it really got me down. So, yeah, that's where I find that checking in with [practitioner], I think just talking to her, I sort of figure it out myself, you know? She doesn't give me any answers, but she does help me figure it out for myself.”

“I mean, my feelings maybe aren’t quite so acute now. I don't know, I just get general troughs and crests of life. And it's depending on how I'm feeling about the other things, will then also be how well I'm able to deal with things.”

“There's days when I think, when I'm having a really good time and I think, do I really need this? And then there's just something will happen that trips me up and I think, no, do you know what, I still do need this. It’s the things that just come up and bite you in the bum. That’s the only way that I can describe it.”

“And usually by the end of the conversation I think, right, okay, I've come up with that solution. That's what I'm going to do.”

## 5.4 The difference that support has made

The support that people have received from the service was consistently reported to have positively impacted on their mental and emotional wellbeing, which was attributed to a reduction in the intensity and frequency of emotions that had a negative impact.

“I do feel a bit stronger now, I do, I definitely do. I don't think my mental health would be as good as it is now.”

“I definitely feel that [practitioner] helped me get the power back.”

“In fact, some people say to me, my boss said to me, she says you're happier now than, she's known me for 14 years, through that was my marriage and my son, and she says this is the happiest I've ever seen you in 14 years, it's unbelievable. So she says you’ve got a bit of your spark back.”

“It was really important for the emotional side initially and then it's sort of support with you as you sort of change slightly or are able to adapt more than that support sort of goes with you. So it's made a massive difference emotionally. Mentally, yes, the support was there.”

“I think I'm making some really good progress and I'm beginning to be more happier in my life, but [support worker] being there definitely helps me.”

The service was also reported to have supported people to feel better equipped to cope with day-to-day life and finding a new normal. A variety of different examples were given by people supported by the service to demonstrate the progress they had made, which included getting back to participating in social activities and hobbies, going back to and remaining in work, and generally having a more positive outlook and hope for the future.

“When I first went back to work, the first day was not so great as we had a child protection workshop. But they switched the format and they just launched into it, and it was suicide and things like that. And I just stood up and ran out the room, and I thought I was gonna pass out. And I just felt as if I was right back there in the moment, and had it not been for [practitioner] that night I don’t think I would have ever gone back.”

“I've got nothing but praise for it because it's changed my life completely, completely changed my life and I've got a life now, whereas before I'd be like, I didn't want to continue, you know what I mean?”

“Well I don't think I'd be working, I wouldn't be back at my work, I wouldn't be out and about and socialising, I would just be like hiding.”

“I couldn't speak any higher of the service in terms of, I genuinely don't know if I would have functioned in work and stuff without the support that I've had so yeah it's pretty huge.”

“So I suppose I've gone out more and I've certainly gone for coffee and lunches by myself. So I find that that's a big step forward.”

“I’ve started doing mindfulness stuff, I've gone along to a pilates group and I also go along to a relaxation yoga class.”

For a few, the difference the support of the service has made was reported as potentially having been the difference between life and death.

“And [support worker] was very very supportive and very, oh god he doesn’t even know sometimes I did get upset about it but no, I probably wouldn’t have carried on if it wasn’t for [support worker] to be honest.”

“I think I could honestly say that that if I hadn't had the service there's a chance I might not be here today.”

“I wouldn't have known what I needed at that point. I was just in abject gut wrenching pain and loss and feeling suicidal and my world was upside down. So I don't know that I knew what I needed, but what I now know, looking back, was how much it really helped me.”

# 6. Considerations and options beyond the pilot period

Areas of consideration and options for the provision of suicide bereavement support beyond the pilot period are presented below. These were developed through a workshop with the service leads and managers of the SBSS service, discussions with stakeholders and consideration of the findings from previous evaluation phases.

The following is not intended to represent an options appraisal, and further work would be required to fully consider the funding implications, viability, strengths, weaknesses, opportunities, and threats associated with the different options presented in this chapter.

## 6.1 A local gap if SBSS is not continued

Local stakeholders held a strong view that the SBSS had filled an existing gap in the support available to people bereaved by suicide in the service area.

“It’s definitely filled a gap, and that’s not to say there wasn’t anything before, we just didn’t have anything that offers quite what the bereavement service has and the way that it does it. So I think it would be devastating for us to lose it to be honest.”

While there was acknowledgement that local support services were available for people bereaved by suicide in the pilot areas before the service launched, these were not perceived to offer the same level of rapid response, one-to-one, person-led practical and emotional support as the SBSS. Referral organisations also highly valued the SBSS as a referral option that they can offer when needs relating to a bereavement by suicide are expressed or identified. The SBSS is perceived to provide support that is specific to the needs of people bereaved by suicide which is seen as a particular strength among stakeholders.

## 6.2 The need for planned and managed exits if the service ends

The evaluation findings have demonstrated that people receiving support from the service can remain engaged and have an ongoing need for support over a sustained period. This reflects the bereavement journey supported people can go through, in which progress and setbacks are experienced. The SBSS continues to take referrals, and it is reasonable to assume that there will be those who still need support when the current funding for the service pilot ends. Service staff and stakeholders highlighted the critical need for a closure of the service to be carefully planned and managed to minimise the potential impact on those receiving support if the service does not continue.

## 6.3 Gaps in learning and understanding

Delivery of the SBSS pilot has generated extensive learning about the enablers and challenges for people bereaved by suicide in accessing support and learning what

has made the support effective for those who have accessed the service. However, service staff and stakeholders identified further issues to consider, for example:

- Has general awareness-raising activity been effective in reaching all parts of local communities in the pilot areas?
- Do current referral pathways facilitate and support access for all the different communities in these areas?
- Would the current model of support provided through the SBSS meet the needs of different communities?
- What are the additional considerations, if any, that need to be made to ensure that the support provided through the SBSS is accessible and appropriate for different communities?

Examples of different communities and additional considerations mentioned by service staff and stakeholders included different faith groups, LGBTQ+ and Gypsy/Traveller communities, and those living in poverty and/or areas of multiple deprivation. A question was also asked about the presence of cross-sectional stigma and discrimination, the extent to which this could create additional barriers to accessing support, how these could be overcome, and the role of organisations already trusted and working with different communities.

## 6.4 Referral pathways and general awareness

In considering the future of the SBSS, it was suggested that should there be a national rollout of the service, this would create opportunities to supplement local referral pathways by creating one or more national referral routes. The Distress Brief Intervention (DBI) referral pathway through NHS 24 was cited as a successful model which could be considered. Furthermore, service staff and stakeholders suggested that a rollout of the service would also enable an effective national awareness-raising campaign, which could achieve greater reach and encourage self-referral across a wider range of those affected by a bereavement by suicide. This could be supported through a dedicated website for bereavement by suicide support, which included a simple online self-referral function.

## 6.5 Future role and remit of the service

Another consideration raised by service staff and stakeholders was the potential for future service development beyond the current role and remit of the SBSS. This included:

- The role of the service in helping to equip others to provide support to people bereaved by suicide, for example, workplaces, faith leaders, organisations that work with marginalised communities.

- Exploring whether and how peer volunteers and those with lived experience could support the service and potential service development, for example, with supplementary group-based support, where none is locally available. While it wasn't in the scope of this evaluation to explore service delivery models used by other services, models that use volunteer/peer support do exist, and there may be learning from these approaches that could inform future service development.

## 6.6 Outline options

There are several permutations for the SBSS beyond the pilot period. In the context of the considerations set out above, and in the absence of a full and rigorous options appraisal process, three skeleton options are presented below that have been drawn from discussions with service staff and stakeholders.

## Option 1 – Service rollout to all Health Board areas in Scotland

This option would see the SBSS delivery model replicated in each Health Board area. The service would have a physical presence in each area, developing local referral pathways, raising local awareness and participating and contributing to local suicide prevention planning and activity.

Delivery in each Health Board area would represent new spokes in the existing hub and spoke model, with the hub maintaining its current central functions (e.g. provision of core staff training, quality assurance, and service monitoring).

This option provides the potential for creating a national referral pathway and a centralised self-referral pathway to supplement local referral activity. This could be facilitated through the creation of a suicide prevention website for Scotland, which included functionality for referrals to be made by other services and organisations as well as for people to self-refer. The national referral pathway would be managed as one of the hub's central functions. A national campaign could be developed to increase and support awareness raising among the general public.

Given what is detailed in section 6.3 about the gaps in learning and understanding, there would be scope for local investment and development to address any local priority areas or needs which are not being met through the current SBSS delivery model. While this has the potential to create variation in the service across the country, it provides the flexibility to accommodate any needs and priorities specific to each Health Board area.

## Option 2 – Single national service linked with local delivery to meet local priorities

This option is similar to option 1, but instead of replicating the existing SBSS delivery model in each Health Board area, a national service team covers the whole

of Scotland. This would see the option of face-to-face support removed from delivery, with text, telephone, and video calls being the only available support formats.

A combination of local and national referral routes would be developed and implemented. As with option 1, this could be supported through a suicide prevention website, which included functionality for self-referral and for other services and organisations to make referrals on behalf of someone who has been bereaved by suicide.

At a local level, those with responsibility for suicide prevention would be expected to work with existing provision and services to equip and enable them to address any local priorities and needs that the national SBSS service model is not meeting. This will likely result in variation across each Health Board area, but any variation should reflect local needs and priorities.

## Option 3 – managed closure of the SBSS

In this option, SBSS enters a period of managed closure that would likely need to run beyond the end of the current pilot period to ensure those currently receiving support from the service experience as little negative impact as possible.

The learning that has been generated through the pilot, particularly the elements of the service delivery model that have generated a positive experience and a range of outcomes for those who have received support, is shared with local suicide prevention leads.

Based on discussions with local stakeholders involved in local suicide prevention activity in the pilot delivery areas, an implication of this option would mean that meeting the needs of those bereaved by suicide would be challenging and reliant on existing provision and services outside of the SBSS.

This option would likely see a continuation of the existing variation across Scotland in the availability, accessibility, and quality of support in terms of experience and outcomes for those bereaved by suicide.

# 7. Conclusions

This chapter sets out the conclusions, aligned with and responding to the evaluation questions set for the extension period.

## What are people's longer-term experiences of receiving support from the service, and what outcomes are achieved?

The overall experience of those who engage with the service over a longer period remains positive. They value the trust-based relationship which develops through the consistent support from the same staff member, and the sensitive and compassionate delivery. The flexibility and person-centred nature of the support means the service is responsive to their changing needs. It is also important to acknowledge that the person-centred and person-led delivery model was informed through the involvement of people with lived experience of bereavement by suicide. This emphasises the importance and value of ensuring the involvement of lived experience in any service design and development.

While a relatively small sample of supported people were engaged to explore longer-term outcomes, three common themes emerged. These centre on an overall improvement in mental and emotional wellbeing, feeling better able to cope day to day, and a reduction in the negative impact of the emotions they experienced. Other significant benefits of the support included being able to remain in employment and increased participation in social activities and events.

Most outcomes reported by those who have engaged with the service over a longer duration mirror those that have been identified in the shorter term among other supported people. While outcomes may be the same, the findings from the evaluation highlight and reflect the individual and unique nature of each person's experiences, needs and journey through trauma and grief.

## To what extent has the following changed over time:

- Number of people being referred
- Sources of referral
- Frequency and length of support sessions
- Form of support re. telephone or face to face etc

Levels of referrals have not followed any consistent pattern across the pilot. There have been periods where the average number of referrals has increased, followed by periods when they have decreased. However, the most recent monitoring data for the period since the Year 2 evaluation report (Feb 2023 to end of Sept 2023) shows the highest level of referrals, with an average of 12 per month. This is a

potential indicator that referral pathways are becoming more embedded, and awareness of the service is increasing.

Referral sources have differed in the two pilot areas over time. In the initial stages of the pilot, the only two referral routes were through Police Scotland and self-referral and these pathways represented the highest proportion of referrals during the early reporting points for the evaluation. As other referral routes were introduced, a greater variety of sources were observed in the service monitoring data. While Police Scotland and self-referral continued to represent the two most common pathways into the Highland service, this has not been the case in Ayrshire and Arran. Self-referral has continued to represent a high proportion of referrals into the service in Ayrshire and Arran, but levels of referral from Police Scotland have continually reduced while referral pathways through health services have increased. The experiences of the service, and the fluctuations in referral activity across different services and organisations, has highlighted the sustained and varied activity that is required to initially establish, maintain, and embed effective referral pathways.

The average number of support sessions gradually increased over the first 18 months of the pilot, though this could be reasonably expected as the overall caseload grew and a 'steady state' of delivery was reached. At the last data collection point for the Year 2 evaluation report (Feb 2023), the average number of sessions per supported person was 12.6, and the latest monitoring data as of the end of September 2023 shows very little change, with the average number of support sessions being 12.4. There is also very little variation in the average length of support sessions, with the lowest average of 44 minutes and the highest and most recent average of 47 minutes per support session.

While the service introduced the option of face-to-face support sessions following the removal of COVID-19 restrictions, telephone-based support has continued to be the preferred method for receiving support among most people accessing the service. Feedback suggests that this is due to the sense of anonymity that speaking on the phone provides, while also enabling people to receive support in a space where they feel comfortable and safe. The strength of evidence that has been presented in previous evaluation reports relating to the positive experience and benefits reported by people supported through the service demonstrates how effective telephone-based support can be.

## What can the profile of those using the service tell us about who benefits most from the service and who may be missed within current approaches:

- How has the profile of people accessing the service changed over time?
- How recently have people experienced suicide bereavement before accessing the service and has this changed over time?

The consistent qualitative evidence from people supported would suggest that their varied needs are being met by the service through a person-centred approach. The evidence does not provide any insight into whether there are some people who benefit more from the support than anyone else.

Data collected by the service demonstrates that most people who access support through the service are immediate family members, with smaller proportions of extended family, and finally, a very small number of friends and colleagues of the deceased also accessing support. During the initial months of the service going live, a small number of people that had experienced a bereavement more than 18 months prior accessed the service for support. However, over the pilot period most people accessing the service had experienced a bereavement either in the same year they accessed support or in the year prior.

## What are the views, experiences and key learning amongst frontline practitioners, particularly on issues around training and supervision, and how can this inform wider service delivery beyond the pilot?

In exploring experiences and learning with frontline practitioners, feedback predominantly related to their learning about the needs of the people accessing the service, and which aspects of the delivery model and approach helped to ensure those needs were being met. This feedback is reflected in section 4.6, which sets out the critical elements of the service delivery model.

The support provided to frontline practitioners has been highly praised throughout this evaluation, with supervision a valued component. Likewise, the environment whereby all staff are encouraged and enabled to continually access opportunities to build their confidence, knowledge and skills is also valued. Both these components – effective support and opportunities to continually develop – were also highlighted as critical components of the service model and are seen as essential for any future rollout. The hub and spoke model has helped to facilitate and ensure a consistent approach to this across each of the pilot delivery areas.

## What are the barriers and opportunities associated with different referral pathways into the service, and what is the key learning for the development of new pathways for referrals?

Self-referral has remained a consistent pathway into the service, accounting for around a third of all referrals received in both pilot areas. The low visibility of the service among the public has been the most common criticism from supported people throughout this evaluation and is likely the one area that, if addressed, could enhance this pathway further. Should the service be rolled out across Scotland, the hub and spoke model would support the delivery of a national marketing campaign aligned to the single point of access that the centralised function for receiving and allocating referrals provides.

In each pilot area the referral pathway through Police Scotland has performed differently though it is unclear why given that in both areas, the service teams have a close working relationship with Police Scotland. Furthermore, Police Divisions in both areas have similar approaches to monitoring the level of referrals and follow-up processes in place to ensure a referral is offered if the initial opportunity has been missed.

The focus of establishing additional referral routes into the service has been with services that are likely to be touch points for someone who has been bereaved by suicide. Primary care services and other health services have featured strongly in this, particularly in Ayrshire and Arran, though a wide range of other community-based organisations and services have been active in both pilot areas.

Development of referral routes at different touch points that someone affected by suicide could engage with helps to provide vital safety nets that minimise the likelihood of someone slipping between the cracks and not being able to access the support they need when they need it.

## What are the opportunities and limitations of the current hub and spoke model for service delivery with respect to wider service rollout?

It is difficult to reliably identify the full range of opportunities and limitations of the hub and spoke model in terms of wider service rollout. This model has been piloted with only two spokes and combines a partnership approach to service delivery, which limits the extent to which the hub and spoke model has been tested during the pilot period.

However, when considering this in the context of the central functions that are carried out by the hub, the following areas reflect the potential strengths of the model in terms of a wider rollout:

1. A quality assurance function that can ensure consistency in the initial training, skills and competencies of staff, and the overall delivery model and its effectiveness.

2. Ensuring effective models of staff support and continuous development are embedded in local delivery.

3. A central point for managing and coordinating referrals into the service.

4. A centralised collection of local delivery and monitoring data that can be collated to provide a whole service picture of delivery activity across Scotland.

5. The local functions of the spokes in the model supports and enables development of local referral pathways and for the service to be active and contribute to local suicide prevention forums and activity.

## How does the service fit within the wider ecosystem for support and provision for suicide bereavement and suicide prevention?

Further work is required in both pilot areas to fully map and understand the different pathways into, through and across the various suicide-specific support services as well as the wider bereavement, mental and emotional wellbeing and other support services that have a role in suicide prevention.

However, the findings from this evaluation strongly suggest that the SBSS filled a significant gap in support for those bereaved by suicide, which will re-emerge if the SBSS ceases to operate.

# 8. Recommendations

Based on the evidence collected and the conclusions drawn over the full duration of the evaluation of the SBSS, this final report makes five recommendations. In summary these are:

1. The SBSS is made available to anyone in Scotland who has experienced a bereavement by suicide.

2. National and local suicide prevention activity should continue to gather insight and learning into the needs and preferences of different communities to inform any further service development that may be required.

3. Evaluation activity should be undertaken to capture learning and understand the effectiveness of any future service developments or new activity.

4. SWEMWBS is implemented in any new area that the service is launched.

5. The administration of SWEMWBS is included in the initial training and induction for new service staff as well as any continued support required to ensure staff are confident in its use.

These recommendations are discussed in further detail below.

The SBSS provides compassionate, sensitive, person-led and person-centred support that meets the preferences and needs of those bereaved by suicide. This has been critical to people having a positive experience of their engagement with the service.

Robust qualitative and quantitative evidence of the positive impact of the SBSS on people's mental and emotional wellbeing has been gathered in both pilot areas. Furthermore, the qualitative evidence collected strongly demonstrates a range of additional benefits being generated because of the support people have received.

Several critical components of the delivery model and approach were identified which ensure people's needs are met and that supported people have a positive experience of the support. These components should be considered essential in a service that supports people bereaved by suicide.

Based on the evidence and learning captured throughout this evaluation, it is the recommendation of this report that the SBSS is made available to anyone in Scotland who has experienced a bereavement by suicide. It is essential that in doing so, the elements of the service delivery model identified as critical to providing a positive experience and generating outcomes for people receiving support are maintained.

There are still gaps in understanding who is and who is not accessing the SBSS, and the reasons for this, and it is recommended that national and local suicide

prevention planning and activity should continue to gather insight and learning into the needs and preferences of different communities to better understand and inform any further service development that is required.

There is not sufficient need for or value in any further external process and outcome evaluation should the service be rolled out to other areas of Scotland, assuming the delivery model remains unchanged. This evaluation has gathered sufficient evidence of the effectiveness of the model in providing a positive experience, meeting needs and generating positive outcomes for those supported by the service. However, if any service developments, changes or new activity is implemented or undertaken it is recommended that evaluation activity is carried out to ensure learning is captured and potential effectiveness is assessed.

SWEMWBS has provided valuable quantitative evidence about the positive impact that the support provided by the service has on the mental and emotional wellbeing of people supported by the service. The data gathered through the administration of SWEMWBS demonstrated that after three months of support, and at six months, scores were significantly higher than baseline. The average SWEMWBS score at baseline for the three-month group was 19.3, which rose by 2.8 to 22.1 after three months. For the subset whose SWEMWBS scores were measured at six months, scores rose by 3.5 from 19.0 to 22.5. It would be expected that these results should be similar if the service model was replicated in other areas.

It is therefore recommended that the use of SWEMWBS is implemented should the service be launched in a new area, with the results monitored as one of the centralised functions of the hub. Should the SWEMWBS results differ significantly from those generated during this evaluation, this would indicate that further investigation is required to understand the reasons for this. Aligned to this, there were some early challenges when implementing SWEMWBS in the pilot and it took time to achieve consistency in its administration across the service. It is, therefore, recommended that the administration of SWEMWBS features in the initial training and induction for new service staff alongside any continued support that is required to ensure staff are confident in its use.

# 9. Appendix 1 – Detailed description of infographic presenting demographic data

The following sets out the demographic profile of those that have been supported by the SBSS across both pilot areas:

Sex

- 71% female
- 24% mal
- 0.5% non-binary
- 4.5% unknown

Age

- The youngest person supported by the service was 10 years old, and the oldest was 86
- Average age of supported people was 43.5

Living arrangements

- 57% live with a spouse, partner, or other family
- 17% live alone
- 3% share or live with friends
- 22% unknown

Employment status

- 11% unemplyed
- 8% student
- 2% carer
- 7% other
- 1% volunteer
- 25% unknown
- 43% employed, of which:
- 31% full time

- 10% part time
- 1% self employed
- 1 casual or zero-hour contract

Relationship to the deceased

- 28% parent or step parent
- 19% spouse, fiancé or partner
- 14% sibling
- 13% daughter or son
- 9% friend
- 6% ex-partner or ex-spouse
- 2% Grandparent
- 2% Uncle/Aunt
- 2% cousin
- 1% in-law
- 1% colleague
- 5% other

Year of bereavement

- 24% 2023
- 33% 2022
- 29% 2021
- 5% 2020
- 5% pre-2020
- 5% unknown

Ethnicity

- 67% white, made up of 55% Scottish, 10% British and 2% other
- 1% mixed race
- 0.5% African

- 31% unknown or prefer not to say

Link back to relevant section of the main report

social research



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