Scottish Government
Riaghaltas na h-Alba

Evaluation of the Suicide Bereavement Support Service: Year 2 Evaluation Report

HEALTH AND SOCIAL CARE

social research

Contents

Executive summary

In 2021, the number of people who died from suicide in Scotland fell to its lowest level since 2017, with 753 probable suicides registered. This follows a year-on-year decrease from 2019 (833 registered) and 2020 (805 registered).[1] 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.[2]

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'.[3] 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, a pilot support service for families bereaved by suicide - the Suicide Bereavement Support Service (SBSS) - was funded by the Scottish Government.

Following a competitive tendering exercise, Penumbra and Change Mental Health (formerly named Support in Mind Scotland), working in partnership, were commissioned to manage and deliver the pilot, with Change Mental Health delivering 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 pilot 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.

Overview of service activity

The SBSS received 155 referrals over 19 months of delivery, an average of eight referrals per month. This has been reducing over time, with an average of five referrals per month over the preceding six months of service delivery. Self-referral and referrals from Police Scotland account for just under two-thirds (61%) of all referrals received by the SBSS. However, over the previous six months, these referral pathways have been less active. The service has carried out activities to raise awareness and establish new pathways, which has resulted in a wider variety of referral sources, though not resulting in an overall increase in referral rate.

At the end of February 2023, a total of 90 people were receiving support from the service. A total of 1,950 support sessions, and 1,452 hours of support, have been provided, which equates to an average of 12.5 sessions per person being supported, each lasting an average of 44 minutes. The service has supported a higher proportion of females (72%) than males (28%), with an average age of 44 across the

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

[2] Pitman, A. et al., 2014. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry 1(1), pp. 86-94

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

people being supported. Most people accessing the service for support are direct family members of the deceased.

The consistency and completeness of monitoring and activity data collected by the service has improved over time as processes have become embedded. There are still some slight inconsistencies in how some data is categorised and recorded, but service leads and managers are aware and working to address this.

Service structure and delivery model

The service is structured around a hub and spoke model, where the hub is responsible for centralised functions that support and influence local delivery. This includes aspects such as quality assurance, receiving and allocating referrals, and staff training and development. Local delivery is carried out collaboratively across the two partner organisations, with each area representing a spoke in the hub and spoke model. Service leads are confident that this model would enable easy expansion of the service into other areas.

The delivery model in both areas is underpinned by a person-centred approach that is compassionate and responsive to people's needs and circumstances. The service provides practical and emotional support for as long as people want and need it. The following components underpin the delivery model:

- Rapid response to referrals/self-referrals received (24hr target).
- Provision of person-centred emotional and practical support aligned with needs.
- Format, frequency, and duration of support sessions are led by the person being supported.

Overall, the service delivery model has been implemented and embedded as planned, and the evidence gathered during the evaluation period to date enables us to conclude that the service is providing a rapid response and liaison service for bereaved families.

Delivering support

The service launched in August 2020 when COVID-19 restrictions were still in place, meaning support could only be provided via telephone or video calls. Face-to-face support sessions have since been introduced though most people still opt for telephone or video calls. Some practical and logistical challenges have emerged, with the additional travel time for support workers being highlighted. Service staff acknowledged potential difficulties if more people start choosing face-to-face support.

While service staff provide practical and emotional support, practical support needs were found to be less common, with most support focussed on meeting emotional needs. When the service is supporting more than one person from a family unit or connected through the same bereavement, most people choose to have one-to-one

support sessions rather than shared support sessions. Learning gained by staff about people's needs and providing effective support to meet those needs include:

- The immediate emotional needs of those who have been recently bereaved relate to the impact of the trauma they have experienced.
- It can be more difficult to engage people in support when they have been referred to the service in the days immediately after their bereavement. Engagement is more effective with those who are referred a few weeks or months after their bereavement.
- Everyone is at a different point in their bereavement journey and has their own specific needs, which are influenced by circumstances and wider life events.
- There may be fluctuations in the intensity, frequency, and types of support that people need at any given time, and it is essential that people being supported understand that they can increase the frequency of support again if they have previously chosen to reduce it.
- Over time support can be focussed more on helping people to identify and take the steps towards their new routine, returning to work, starting to socialise more and resuming other day-to-day activities.
- SBSS staff must be vigilant to pick up cues that signal that someone has a practical support need, as fewer people tend to proactively seek practical support.
- It is important to help people see how far they have come and reflect on the progress they have made.

Some people disengage from support through non-attendance of support sessions and ceasing to return contact from the service, which service staff can find unsettling. There is a robust protocol that staff follow in these instances that gives people the opportunity to re-engage while not being overly intrusive. Others end their involvement through a managed exit, which is agreed following a discussion between service staff and the person being supported. This typically follows a period where the frequency and intensity of support have reduced, and there are conversational cues, such as the topics, that signal the support is becoming less necessary.

The core components of the service delivery model were reported to be working well, though whether the degree of flexibility and responsiveness can be maintained when the service is operating closer to capacity remains to be seen.

Supporting service staff

Throughout this evaluation, practitioners have consistently reported that mechanisms are in place to ensure they have all the support they need. There are several formal support structures in place for practitioners, which includes regular supervision, de-briefs, daily check-ins, and reflective practice sessions.

Over and above the more formalised support mechanisms, peer support within and across the service areas is highly valued by staff and seen as essential. Service staff also described working in an environment that encouraged and supported ongoing learning and development, which is essential in ensuring they are equipped to respond to the many new situations and different support needs of the people they support.

Experience and outcomes for people supported by the service

People are either referred to the service by another organisation or service or self-refer by contacting the service directly. Visibility and awareness of the service were highlighted as an area for improvement among those that had self-referred, with a few also describing a hesitancy or difficulty in taking the first step to establishing contact. The right time for accessing support is different for different people. However, several did feel that they would have benefitted from earlier engagement with the service. Following a referral/self-referral being made, people supported by the service reported that they received a rapid response.

People supported by the service explained that they led decisions about the frequency, duration, and scheduling of support sessions. They also described the importance of quickly establishing a relationship with the staff member supporting them, which made them feel comfortable opening up and sharing their thoughts, feelings and emotions.

The emotional support provided by the service was described as invaluable, helping people to explore, understand, process and cope with a wide range of emotions, including sadness, anger, blame, guilt, and shame. While practical support needs are not as common as emotional support needs, people valued this support as they often did not have the capacity to act for themselves or invest the energy that was needed.

People reported that being able to talk openly, share, explore and understand their feelings and emotions with someone who listens and responds in a compassionate and non-judgemental way was critical to the improvements they experienced in their mental and emotional wellbeing. Feedback also suggests that the service is having a positive impact on people’s ability to cope with daily life and get back to doing day-to-day activities.

Overall, people have a positive experience and receive responsive person-centred support that is delivered with sensitivity and compassion. They are receiving support that is led by them and provides the flexibility required to respond to their changing needs. The support has a positive impact on the emotional and mental well-being of the people they support, as well as the extent to which they feel they can cope and return to day-to-day life and activities.

1. Introduction

Background to the Suicide Bereavement Support Service (SBSS)

In 2021, the number of people who died from suicide in Scotland fell to its lowest level since 2017, with 753 probable suicides registered. This follows a year-on-year decrease from 2019 (833 registered) and 2020 (805 registered).[4]

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.[5] The findings of a 2018 research study suggest that up to 135 people are affected to some degree by a death by suicide.[6] Bereavement by suicide can have a severely detrimental effect on emotional and mental wellbeing and increases the risk of serious mental health issues. Many practical and emotional barriers prevent people who have been bereaved by suicide from accessing or seeking support until they reach a crisis point, if they seek it at all. These barriers include not knowing what support is available, where to look, or 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'.[7] This Action Plan contains ten actions for suicide prevention, including Action Four: *'with the NSPLG, the Scottish Government will ensure that timely and effective support for those affected by suicide is available across Scotland by working to develop a Scottish Crisis Care Agreement'.* 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 model builds on relevant research and other evidence/good practice models. Following a competitive tendering exercise, Penumbra and Change Mental Health (formerly named Support in Mind Scotland), working in partnership, were commissioned to manage and deliver the pilot, with Change Mental Health delivering the service in NHS Highland and Penumbra in NHS Ayrshire and Arran.

The pilot SBSS launched in August 2021 and was scheduled to end in April 2023. An extension to March 2024 has recently been granted to enable further learning to be generated and captured, informing any future service rollout.

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

[5] Pitman, A. et al., 2014. Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry 1(1), pp. 86-94

[6] Cerel, J., Brown, M., Maple, M., Singleton, M., van deVenne, J., Moore, M., & Flaherty, C. (2018). How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior.

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

‘Creating Hope Together’, Scotland’s Suicide Prevention Strategy (2022-2032) was launched in late 2022. It continues the commitment in the previous suicide prevention strategy to ensure that people bereaved by suicide can access timely, effective and compassionate support. The strategy document explains:

Our aim is for any child, young person or adult who has thoughts of taking their own life, or are affected by suicide, to get the help they need and feel a sense of hope.

Purpose of the SBSS evaluation

The Scottish Government commissioned The Lines Between to deliver an independent evaluation to run alongside the SBSS pilot. The evaluation aims, objectives and research questions are described below.

The evaluation aims were to:

- Understand whether the pilot has been implemented as intended and the elements of service provision that are working well or less well.
- Assess whether the service provides flexible support and makes the required connections with specialist services.
- Review whether participants considered the service to be supportive and beneficial.
- Analyse available data and review and advise on using baseline and outcome measures for service monitoring and evaluation.
- Make recommendations for any service improvements that can be implemented during the pilot period.
- Provide recommendations for further national roll-out, considering questions of scale and sustainability.

The specific evaluation objectives were to:

- Review the operational delivery model, including referrals into and onwards from the support service and the use of centralised coordination and support in combination with local staff and services.
- Review and analyse routine monitoring data, and track service design, implementation and delivery.
- Explore peoples’ experiences and perceptions of the support they have received from the SBSS, including an assessment of the whole family-based approach.
- Assess any change in outcomes for people supported by the service (with reference to the draft logic model provided separately), considering the limited duration of the pilots.

- Understand the views of the staff in central and local functions on service delivery and sustainability and barriers and enablers to service delivery.

The Research Questions for the evaluation were:

- To what extent have the pilots delivered on their intended aim to provide a rapid response and liaison service for bereaved families?
- What contextual factors have influenced the implementation and delivery of the pilots?
- What has been the experience and short-term outcomes for those using the service?
- To what extent can the impact and benefits for families be evaluated, and are there improvements that can be made to routine monitoring data?
- What are the key lessons for further roll-out, scale-up, and service sustainability?

Report structure

This report is the second annual report, drawing and building on the findings collected over the 2 years of the evaluation to date while also providing additional learning and evidence on experiences and outcomes. A summary of the first annual evaluation report was published in Autumn 2022[8]. A further report will be published in early 2024 following the end of the 3rd and final year of the evaluation. The Year 2 evaluation report is structured as follows:

- Chapter 2 covers the evaluation activity delivered throughout the evaluation.
- Chapter 3 provides an overview of service delivery activity and the profile of people that accessed the service.
- Chapter 4 explores the experience of service staff in managing and delivering the service and the learning generated from it.
- Chapter 5 presents findings on the experiences of people supported by the service and the impact of the support they have received.
- Chapter 6 presents our reflections on the draft service logic model.
- Chapter 7 provides conclusions and our recommendations for the future.
- Appendix 1 presents detailed Alt-text descriptions for infographics and charts.

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

2. Evaluation methodology

The table below illustrates the fieldwork and data collection activity undertaken during this evaluation. Four phases of fieldwork took place over the duration of the evaluation. The fieldwork largely comprised one-to-one interviews by telephone or video call. During the final phase of fieldwork, service leads and service managers participated in a face-to-face group discussion. Table 1 provides a breakdown of SBSS staff participating in the evaluation during each fieldwork phase.

Table 1: Details of fieldwork activity with SBSS staff

	Number of interviews Ayrshire & Arran	Number of interviews Highland
Service leads	1	1
Service managers and assistant manager	2	1
Frontline practitioners (during each fieldwork phase)	3	5

Table 2 provides a breakdown of interviews carried out over the duration of the evaluation with people supported by the service. It also details the interviews conducted with representatives of organisations that have made referrals to the service and those that have received referrals from the service.

Table 2: People supported and referral organisations

	Number of interviews Ayrshire & Arran	Number of interviews Highland
People supported by the service participating in an initial interview (roughly three months after engaging with the service)	19	23
People supported by the service participating in a second interview (four months after their initial interview)	7	10
People supported by the service participating in a third interview (four months after their second interview)	1	5
Representatives of organisations referring to the service	7	3
Representatives of organisations that have received referrals from the service	2	1

All interviews were recorded and transcribed. The data was analysed thematically. Quantitative data was also collected by the service and shared with the evaluation

team before each reporting phase. This included service monitoring and activity data (e.g. referral sources and support sessions delivered), which was organised and analysed using Microsoft Excel.

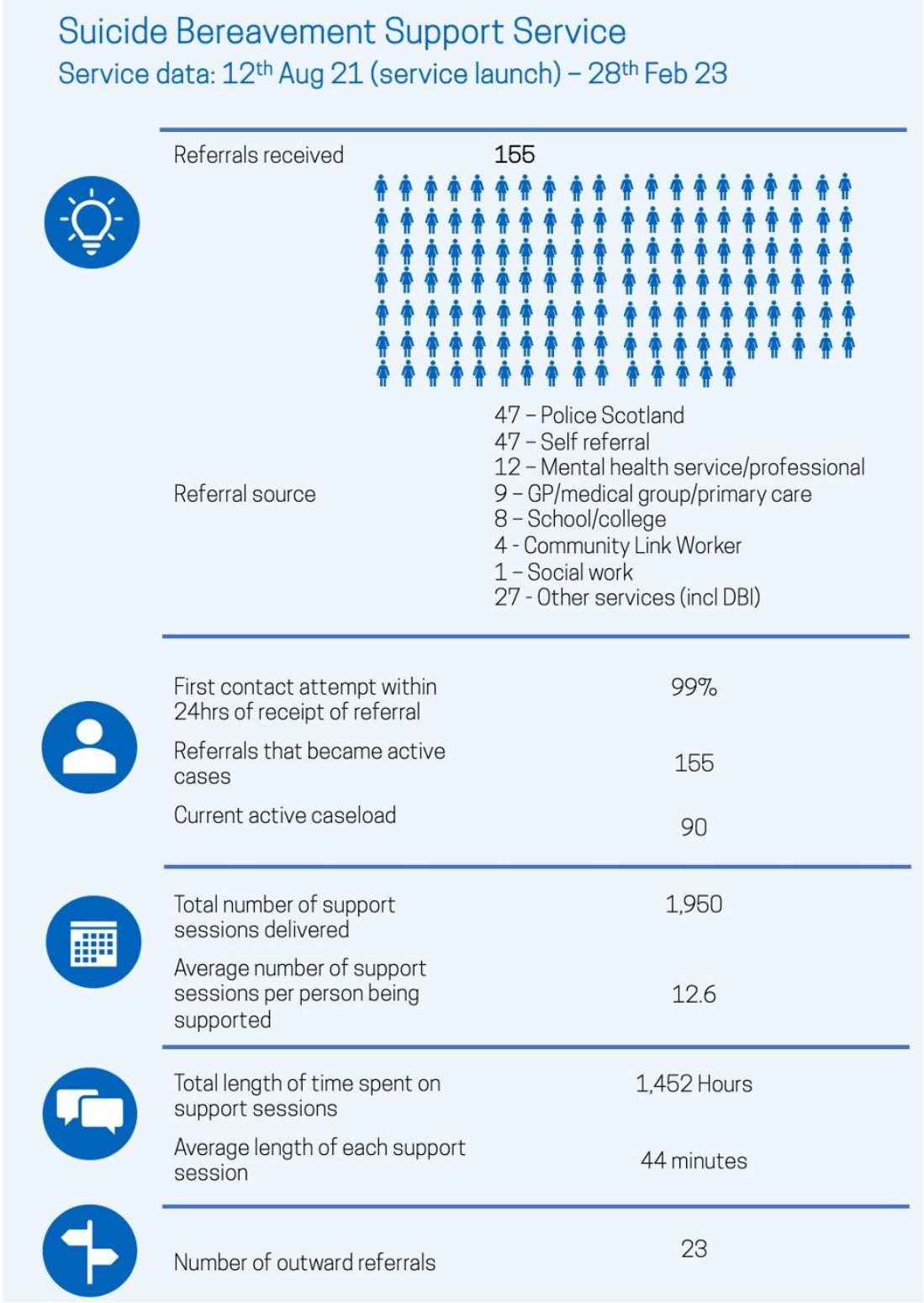
The service also administered the Short Warwick Edinburgh Mental Wellbeing Scale (SWEMWBS), which is administered three times (baseline, three months, and six months) by service staff with each person they are supporting who provides consent to complete it. There were 45 people whose SWEMWBS scores were measured at the start of the programme (baseline) and again at three months, and their scores 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 February 2023.



Number of people supported, and support sessions delivered

The SBSS received 155 referrals over 19 months of delivery, an average of eight referrals per month. This represents a decrease from previous reporting points where the monthly average was ten (as of April 2022, after eight months of delivery or nine (as of August 2022, after 13 months of delivery). Since September 2022, SBSS has received 33 referrals (25 Ayrshire and Arran, eight Highland), an average of only five per month, indicating a slowdown in referral activity, particularly in Highland.

At the end of February 2023, 90 people were receiving support from the service, with 53 in Ayrshire and Arran and 37 in Highland. Active cases increased at each reporting point across the evaluation (64 in March 2022 and 78 in August 2022).

A total of 1,950 support sessions, and 1,452 hours of support, have been provided using a mix of telephone, video call, text message and face-to-face delivery, with most support sessions being delivered over telephone or video call. This equates to an average of 12.5 sessions per person being supported, each lasting an average of 44 minutes. Across the two areas, Ayrshire and Arran delivered more support sessions, reflecting their larger caseload. The average number of sessions per person being supported and the average length of support sessions are broadly similar across both areas.

Inward referrals

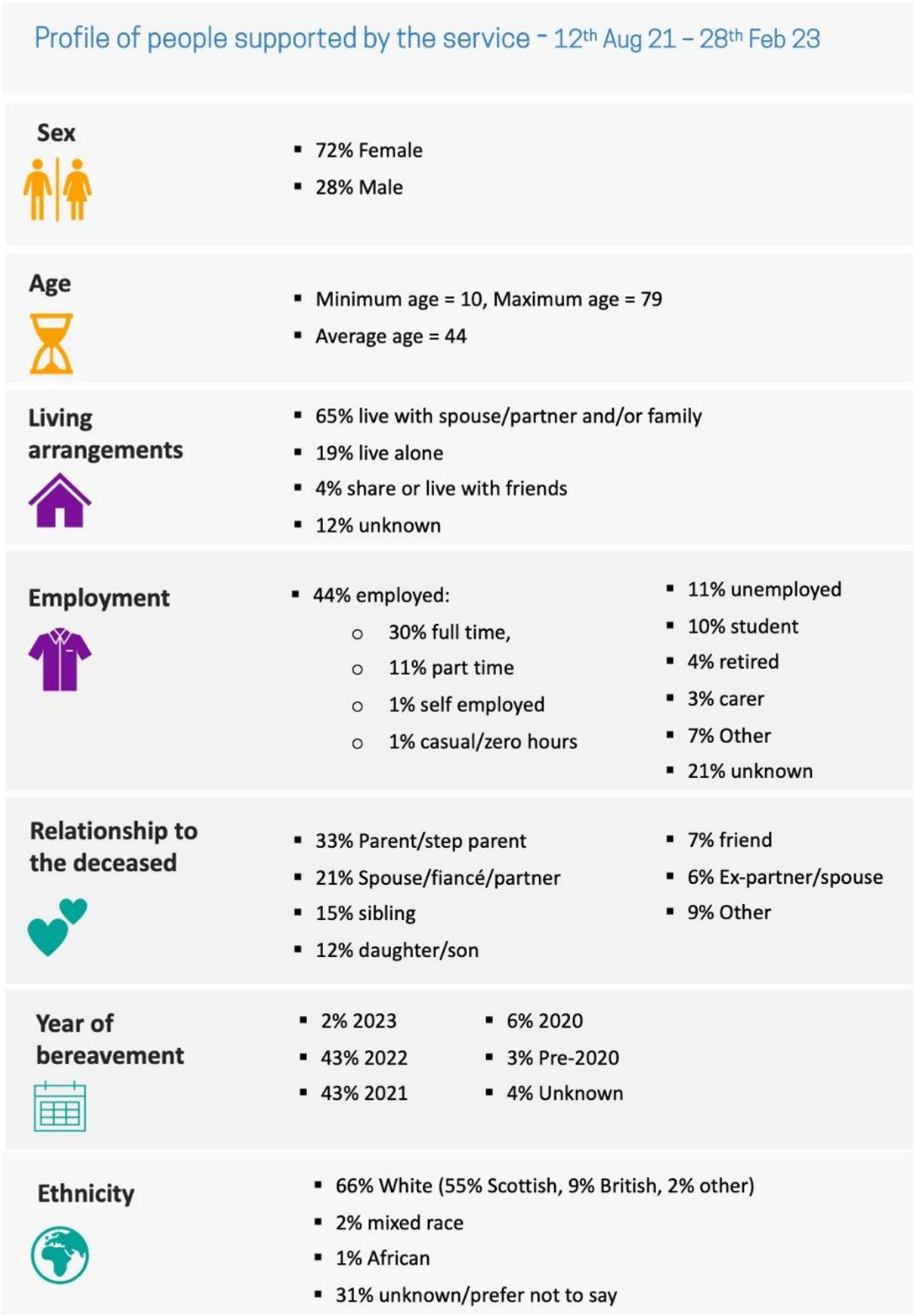
Self-referral and referrals from Police Scotland account for just under two-thirds (61%) of all referrals received by the SBSS. This differs across each service area, with those referral pathways accounting for 45% of total referrals received in Ayrshire and Arran and 77% in Highland. However, since the last reporting point in September 2022, these referral pathways have been less active in both areas. In the six months between September 2022 to February 2023, the service in Ayrshire and Arran received four referrals from Police Scotland and three self-referrals; during the same period, Highland received only one referral from Police Scotland and two self-referrals. In the past 12 months, the service carried out activities to raise awareness and establish new pathways, resulting in a wider variety of referral sources.

Outward referrals

The data demonstrates that there has been a low level of outward referral activity, with nine in Ayrshire and Arran and 14 in Highland. This is not surprising given the feedback we have received from people supported by the SBSS who feel their practical and emotional needs are being met by the service. However, signposting to resources and sources of information relevant to people’s needs does happen more frequently.

3.2 People supported

The infographic below sets out a profile of people supported by the SBSS.



Link to detailed description of infographic content

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

While the following information is presented for each pilot area, it is important to note that this is not to draw comparisons. It is being presented in this way to demonstrate the differences and similarities in the profile of people accessing the service in each area:

- **Sex** – in Ayrshire and Arran, the split has remained consistent (roughly 25% men, 75% women), while the proportion of women in Highland has increased. More men have accessed the service in Highland (32%).
- **Age** – the average age of supported people is lower in Ayrshire and Arran (41) than in Highland (46).
- **Living arrangements** –very little difference across the two areas, with most people receiving support living with a spouse, partner or family.
- **Employment** – the high proportion of 'unknown' in Ayrshire and Arran and a similar proportion of 'unknown' or 'other' in Highland does not allow for an accurate observation of any differences across the two areas.
- **Relationship to the deceased** – Highland supported a higher proportion of parents and children. Ayrshire and Arran have higher proportions of spouses/fiancé/partners and siblings that have accessed the service.
- **Year of bereavement** – the breakdown is broadly similar across the two areas, with most bereavements occurring in 2021 and 2022 (84% in Ayrshire and Arran and 88% in Highland). In Highland, a slightly higher proportion of supported people were bereaved by suicide before 2020, whereas in Ayrshire and Arran, a slightly higher proportion experienced a bereavement in 2020.
- **Ethnicity** – the high proportion of 'unknown/prefer not to say' in the service data from Ayrshire and Arran does not allow for any differences to be observed.

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

Some changes over time are evident when this year's profile data is compared with the profile data as of March 2022:

- **Sex** – the male/female split has remained consistent in Ayrshire and Arran (roughly 25% male, 75% female), while in Highland, the proportion of females accessing the service has increased from 60% to 68%.
- **Age** – the average age of supported people has lowered slightly from 44 to 41, while in Highland, it increased from 40 to 47. This likely reflects the higher proportion of parents/stepparents accessing support in Highland and the higher proportion of siblings supported in Ayrshire and Arran.
- **Relationship to the deceased** – most supported people are immediate family members of the deceased. While this has remained consistent during the pilot,

there has been some variation in relationship type. The proportion of parents/step-parents in Ayrshire and Arran has increased from 6% to 27%, and there has also been an increase in spouses/partners, from 16% to 22%. There has been a 10% decrease in the proportion of children of the deceased, from 16% to 6%. In Highland, the profile regarding the relationship with the deceased has not changed significantly.

- **Year of bereavement** – unsurprisingly, the proportion of supported people that experienced a bereavement in 2022 increased across both service areas. There has been no change in the number of supported people who experienced a bereavement before 2020, suggesting those accessing the service are doing so following a more recent bereavement.

3.3 Reflections on the data collected by the service

The completeness and consistency of data have steadily improved across the evaluation duration as data collection processes have become embedded. There remain a small number of inconsistencies in how some demographic data is categorised, specifically information about employment status and the supported person's relationship to the deceased. Data on service activity and demographics are recorded in each delivery area but not yet routinely compiled at an overall service level.

4. Management and delivery of the SBSS service

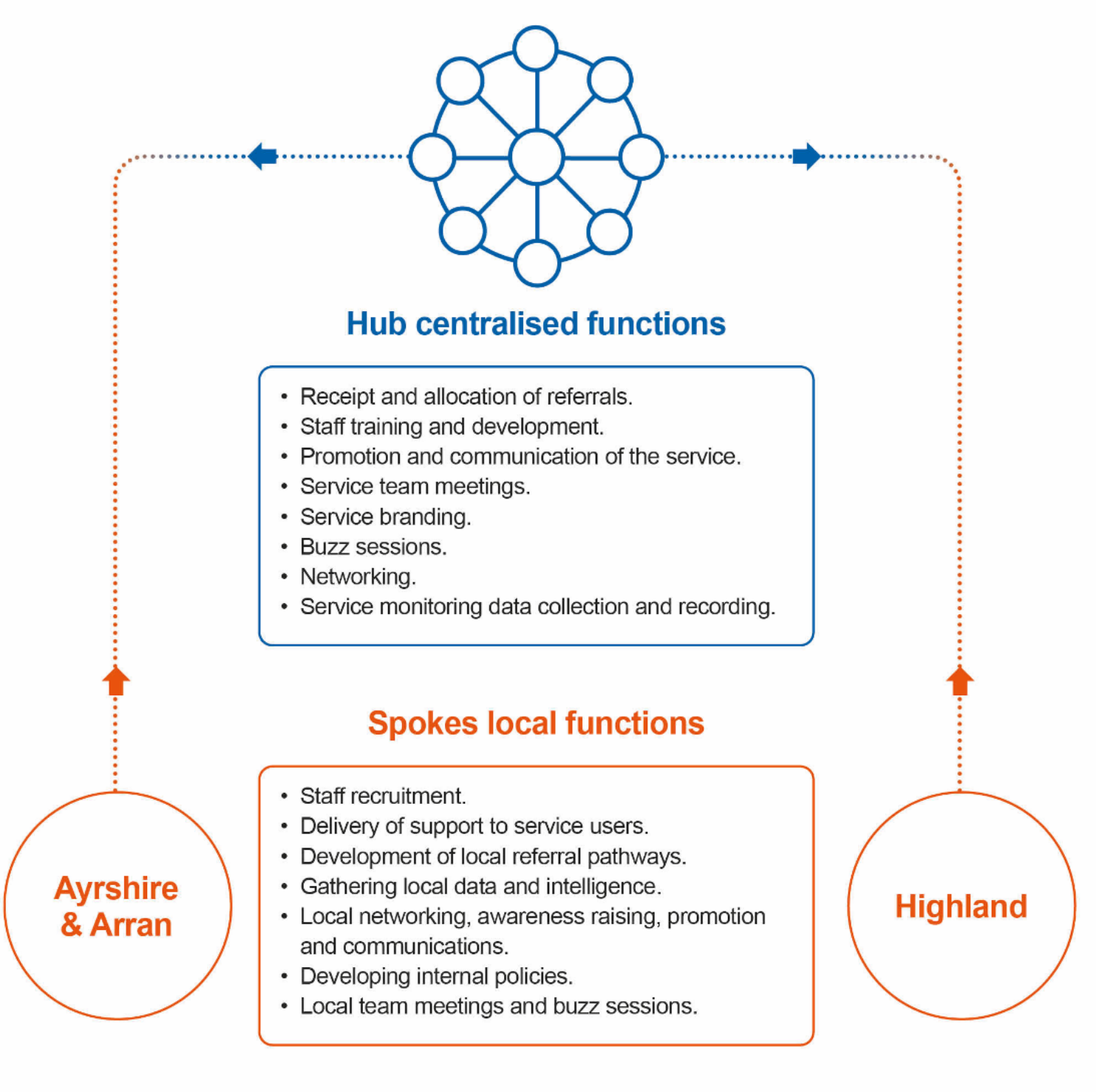
This chapter explores experiences of managing and delivering the service and the learning generated. The findings are drawn from interviews with SBSS staff with oversight and management responsibility and practitioner staff who support people. Feedback from those who referred people to or received referrals from the service has informed the section on referral pathways and the wider support landscape.

The chapter is organised under the following headings:

- 4.1 Overarching service structure
- 4.2 Service delivery model
- 4.3 Delivering support
- 4.4 Learning about the needs of people the service supports
- 4.5 Staffing, training and support
- 4.6 Referral pathways and the wider support landscape

4.1 Overarching service structure

The service is structured around a hub and spoke model, where the hub is responsible for centralised functions that support and influence local delivery, carried out collaboratively across the two partner organisations. The spokes represent the two delivery areas, with defined local functions and responsibilities.



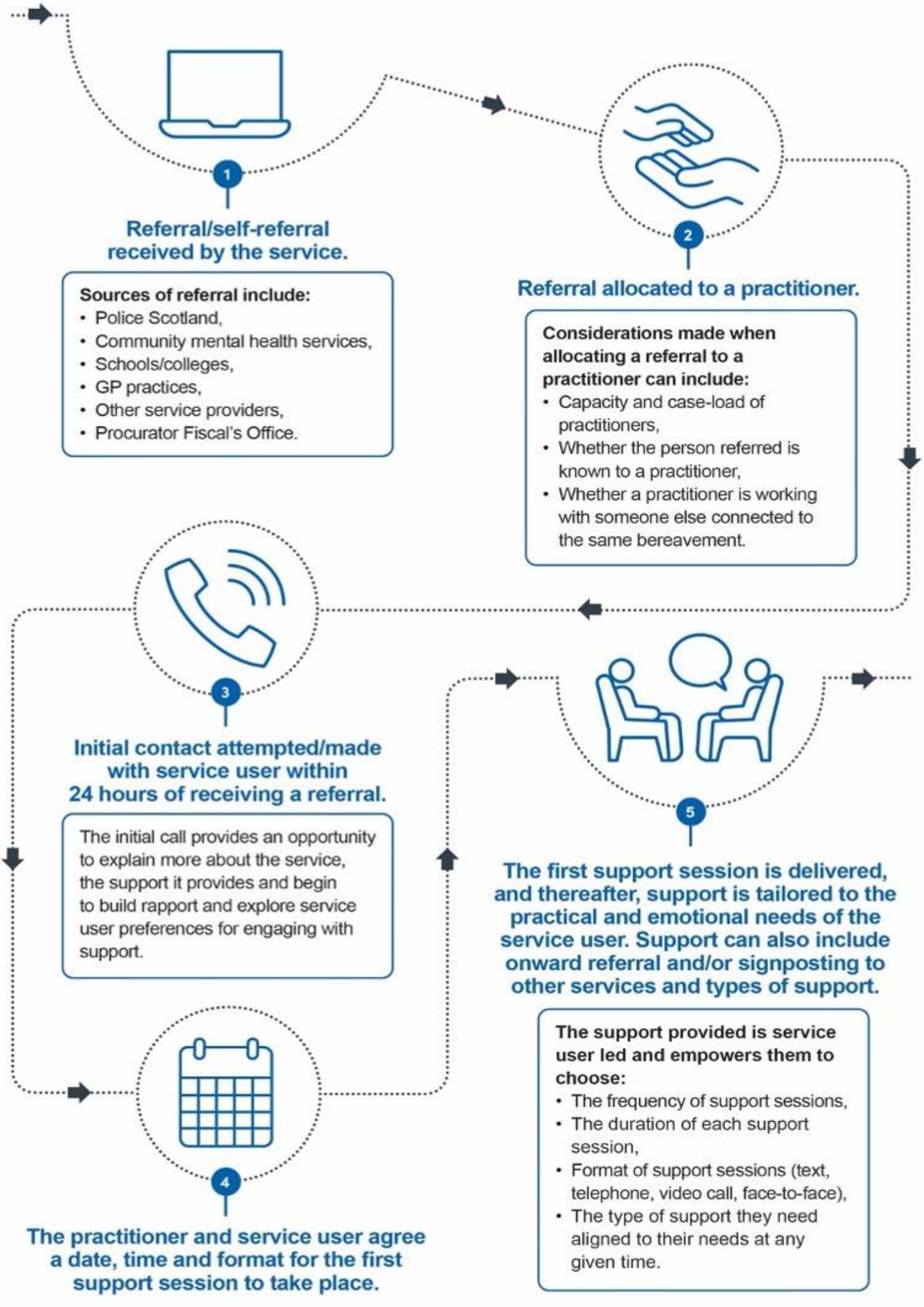
Link to detailed description of infographic content

4.2 Service delivery model

Several core components of the delivery model were consistent throughout the pilot:

- Rapid response to referrals/self-referrals received (24hr target).
- Provision of person-centred emotional and practical support aligned with needs.
- For delivery features such as the format, frequency and duration of support sessions to be led by the person being supported.

An overview of the service delivery model if provided in the infographic on the following page.



link to detailed description of infographic content

4.3 Delivering support

This section explores the different components of service delivery.

Mode, frequency and duration of support

The service launched in August 2020 when COVID-19 restrictions were still in place. Support could only be provided via telephone or video calls. As restrictions were lifted, the service began offering face-to-face support sessions.

During the recent fieldwork phase, service staff reported that most people receiving support still opt for telephone or video calls, though several have taken up the offer of face-to-face or accessed a mixture of both. One practitioner reported that most of the people they support now receive face-to-face sessions but did not know why that was the case. Face-to-face sessions can include 'walk and talk', home visits or meetings in other public spaces. This presents some practical and logistical challenges, particularly in winter when the weather makes it difficult to meet outdoors. Suitable indoor public spaces that provide enough privacy and a suitable environment are also difficult to identify. The additional travel time for support workers was also highlighted, and service staff acknowledged that it could become difficult to manage if many people being supported start taking up the face-to-face offering.

"Covering such a wide area as well can be really difficult because, for example, if I was going on a home visit to the lady I was talking about, or even further afield, it takes me over two hours to get there and then the same back, so then it cuts down the amount of people that I could see in that day."

While staff see the option of face-to-face support sessions as a positive development, one practitioner highlighted a need to be careful when offering this to existing people receiving support. In one instance, they made a person aware of the option to meet up face-to-face and found that this offer unsettled them as they had valued and took comfort in the anonymity of receiving support by phone.

People receiving support from the SBSS control the frequency and duration of support sessions and the length of their engagement with the service. Staff explained that they highlight this during early sessions and remind people that they are in control at later stages. Staff further reported that the frequency and duration of support sessions tend to reduce over time. However, the timeframe can vary significantly depending on the needs of each person being supported.

"There's just no rhyme nor reason to it, it's just, obviously, everybody's individual, and you know, their journey is very personal."

Linked to a person's needs around the timing of pivotal events, anniversaries, or incidents, Session frequency may reduce and then increase. Service staff highlighted that when people receiving support reduce the frequency of their sessions, it was important to reiterate that support can be increased again should people feel they need it. This prevents anyone from potentially needing support and not accessing it.

Practical support needs

Service staff observed that providing practical support was less common than delivering emotional support to meet people's needs. While staff make efforts to explain the different types of support they can provide, people receiving support are less likely to explicitly express their practical needs. Instead, practitioners use their skills to pick up on and identify opportunities where practical support can be offered to meet a particular challenge, issue or need.

"Not once has somebody said to me, can you do this for me? But then, you know, you'll hear it, you kind of just have to work instinctively. You know, somebody just said to me earlier on, I really want to access the police records, but I just don't know how to do it. And I said, listen, you don't have to, but if it's something that you want me to look at and see what the protocol would be, I'm absolutely happy to do that. And they were absolutely happy for that to be offloaded."

Feedback from service staff suggests that there is little commonality in practical support needs across the people they support, with these needs specific to each person's circumstances. Throughout the pilot, examples of practical support have included:

- Liaison with a local authority housing department.
- Help to access police records.
- Help to access their loved one's phone.
- Contacting a GP on the person's behalf.
- Support with locating a solicitor that had developed a will.
- Finding information and resources.
- Accompanying people to appointments.
- Supporting arrangements for scattering ashes.
- Looking into benefits.

While providing practical support is less common, service staff see it as valuable and necessary. They reported that people greatly appreciate the practical support they receive, giving them one less thing to think about and lessening the load.

Emotional support needs

While the service is not intended to replace or provide formal counselling or other talking therapies, a common feature of the support provided by the SBSS relates to emotional support needs. Service staff described the main features of emotional support as follows:

- Providing a safe space for people to share their thoughts, feelings and emotions.

- Helping people to explore and understand their feelings and emotions using different models and approaches.
- Reassuring people that their emotions and feelings are normal.
- Offering reflections from previous conversations and sessions.
- Providing constructive challenge, positive encouragement, guidance and advice.
- Sharing strategies and techniques that support emotional wellbeing.
- Sharing information and resources.
- Setting goals/actions/plans that support people to re-engage with day-to-day activities or hobbies.
- Helping people to recognise their progress.

Staff may deliver a range of emotional support at different points in each person's journey and within each support session, depending on their needs and what is being discussed or explored at any given time.

"It's just about knowing what is needed at that time. It might just be about listening and giving them that space to get it out, other times, it might be taking them back to something that you discussed in another call. It's responding to what they need."

4.4 Learning about the needs of people the service supports

Service staff have gained significant learning about the support needs of people that access the service, the factors that influence this, and the approaches and tools effective in meeting those needs. The main points of learning are detailed below:

- For most people who have been recently bereaved, immediate emotional needs relate to the impact of the trauma they have experienced. For those who enter the service later, the extent of this can be less acute.
- Those referred to the service in the days immediately after their bereavement can sometimes be more difficult to engage in support. In contrast, there is more effective engagement from those referred after a few weeks or months have passed. Some staff questioned whether a referral in the immediate aftermath of a bereavement is the most effective approach.
- Everyone is at a different point in their bereavement journey and has specific needs, which are influenced by circumstances and wider life events. Examples of factors that affect the extent of emotional support people require include existing personal support structures, other challenges they are facing (e.g. financial), returning to work following the bereavement, tensions in family relationships, birthdays and other anniversaries.

- There may be fluctuations in the intensity, frequency and types of support people need at any given time.

- It is important to ensure that people being supported understand that they can increase the support frequency again if they have previously chosen to reduce it. Furthermore, the service must have the capacity and flexibility to respond to these changes.

- 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. Service staff reported that the models and tools they gained through trauma informed practice training have proven to be useful and effective. Models that help people to understand the grief process, and the emotions they are experiencing have also been utilised to good effect.

- Beyond the early stages of support, there is often a shift to focusing on supporting people to identify and take the steps towards their new routine, returning to work, starting to socialise more, and resuming other day-to-day activities. People receiving support also become more open and ready to consider other forms of support, such as group-based peer support, employment support or assistance with issues not directly related to their bereavement.

- While people supported by the service often have practical support needs, they rarely proactively seek help for those needs. To identify and meet someone's practical needs, SBSS staff must be vigilant to pick up cues that signal someone has a practical support need, then discuss it further and explore how to address it.

- A key role for staff is to help people see how far they have come. Staff take time to reflect on the activities that people previously could not picture themselves coping with and were now managing. This highlights the importance of listening, as they could identify small changes and progress that the person receiving support might not have recognised.

In the most recent fieldwork stage, service staff shared examples of cases where people had pressing support needs potentially related to or exacerbated by their bereavement, which fell outside the remit and expertise of the service. These examples related to mental health needs and problem alcohol and/or substance use. Staff explained that there are instances where these needs can be met by other services and provision alongside the suicide bereavement support provided by the SBSS.

However, there have also been instances where the severity of needs related to mental health and/or problem alcohol or substance use are identified by the person being supported as needing to be addressed before they can effectively engage with support for their bereavement. SBSS staff will assist them to access the required support if people are not currently engaged with services that can meet those wider needs.

Ending support

Feedback from staff suggests that people disengage from the service in one of two ways. Firstly, someone may simply stop attending sessions and stop responding to contact from the service. This has tended to follow a period of short, low-frequency sessions. While staff believed this reflected progress on the part of a person receiving support and the extent to which their needs had been met, it was still unsettling for staff. The lack of contact, and the support ending that way, is unexpected given the positive relationships that staff feel they have established with the people they support.

“I've had people that just stop engaging. You send them a text, or you phone and you just don't get anything back. Which can be worrying because you don't know what's happened. Like, have you got the support and you don't want to engage anymore? You've moved on and me texting or calling is triggering you and you don't want to think about that time? You just don’t know.”

In these instances, there is a protocol for staff to follow:

- Step 1 - attempt contact weekly for four weeks.
- Step 2 - attempt contact monthly for three months.
- Step 3 - send a final written letter explaining that they can re-access the service in the future if they need to.

Service staff feel that the protocol provides an approach that allows people to re-engage while not being overly intrusive. The second type of ending was described by service staff as a managed exit, agreed following discussion with the person and following a final session. Again, this typically follows a period where the frequency and intensity of support have reduced, and there are conversational cues, such as the topics that signal the support is becoming less necessary, for example, people talking less about their bereavement and the impact of it, and more about daily life and plans for the future. People who leave the service following a managed exit are informed that they can re-access support if needed.

“He didn't feel that the grief was the most important thing in his life anymore. He was kind of actively trying to move through that. And we had a discussion of, well, if you feel like that then that's great, you've got to a point where possibly our service is no longer needed. We agreed that I'd text him in the new year and if he wanted to engage, that's fine.”

Service staff explained that these types of concluding conversations need a lot of consideration and care. One described a situation where someone they were supporting had made significant progress and presented as coping well and returning to daily life. They prepared to have an exit conversation with them at their next support session. However, the staff member subsequently discovered that the person had been re-traumatised and needed the support to continue.

Supporting children and young people

During the pilot, the service worked with a small number of young people under 18. There were mixed experiences of successfully engaging young people in support. Sometimes, practitioners faced challenges scheduling appointments and having the young person attend those arranged. It was less of a problem for others as the young person readily engaged in support sessions.

Practitioners observed that it can take longer for a young person to begin talking about the impact of the bereavement than adults. As well as providing support through the service, practitioners will often signpost and refer young people to youth-specific grief and bereavement services, such as Winston's Wish. The service also supports several parents/carers of young people who do not wish to engage with the service, or the parent/carer feel either the young person is not ready to engage with the service or they are receiving support from other organisations. In these instances, the parents/carers can also seek advice and guidance from the service on supporting their young person or may need reassurance that they are getting things right.

In the first annual report, we highlighted a practitioner's suggestion that a live web chat function might be an effective way to engage with young people. More recently, this has also been requested by a young person receiving support from the service.

Supporting families

When the service supports more than one person from a family unit, this is rarely provided as whole-family support sessions. Most people opt for one-to-one support. Given what people receiving support from the SBSS have told us about the importance of being able to speak to someone outside of their network of family and friends, this is not surprising.

However, a few instances of group support were described by staff. One couple received a blend of one-to-one and joint sessions. The practitioner observed different dynamics across the two formats, where the people receiving support seemed less open in discussions during joint sessions. Another couple initially received support sessions together but moved to one-to-one sessions due to each person engaging at a different pace and needing different types and intensities of support. Each wanted space to focus on their own needs and journey. The final example involved parents and a child who initially accessed group-based support though only had a single session in this format before opting to move to one-to-one sessions.

When the service has received referrals for more than one person in a family unit or connected through the same bereavement, efforts are made to ensure that each person works with a different practitioner. This stems from early learning in the pilot, where a practitioner supporting more than one person from a family identified risks in maintaining confidentiality and the need to navigate the dynamics and relationships of the family members. There is one example however, where a parent/carer and their child are receiving support from the service, and a single practitioner supports each of them with one-to-one sessions.

Service capacity

As has been consistent throughout the pilot, service staff reported that their caseloads were manageable and that they could take on additional people requiring support to varying extents. For some, this fluctuated as they responded to the changing needs of the people they were supporting during periods when an increase in frequency was required.

As caseloads have grown, service staff commented that it can be more challenging to always accommodate people's preferences around the day and time of support sessions. This has not created any issues; however, staff are conscious that it will become more challenging with a larger caseload. Should referrals come at a faster rate than people are disengaging, then this is a challenge that the service will need to address in the future. To mitigate capacity challenges and support planning, local service teams have caseload review sessions, supplemented with regular discussions about team capacity.

Service staff were clear that an assessment of caseload capacity could not be based solely on the number of people they were supporting due to the often-changing needs and frequency of support. Instead, they felt capacity was better determined by the number of support sessions a practitioner could manage on any given day. This was suggested to be three to four support sessions. However, this was seen by staff as a guide rather than an absolute, given that this could differ from day to day, and people may need longer support sessions (e.g. those lasting over an hour). For support sessions that were particularly emotionally challenging, practitioners need more time to write notes or might need a debrief after a difficult session. Furthermore, other components to practitioners' roles influence capacity, such as training, research, attending events and other activities to raise awareness of the service and develop referral pathways.

4.5 Staffing, training, and support

The staffing structure in each delivery area is slightly different. In Ayrshire and Arran, the service comprises a service lead, a service manager, an assistant manager and three full-time practitioners who support those accessing the service. The assistant manager also has a caseload of people that they support. In Highland, the service is staffed by a service lead, a manager and five part-time practitioners.

Throughout the pilot, the service has experienced staff turnover at practitioner level in both areas and at manager level in Ayrshire and Arran. Service staff in Ayrshire and Arran acknowledged that their original service manager's departure came at a time when data collection processes were not yet fully embedded, which, in turn, led to a lack of consistency in approach. Changes in practitioner staff led to some pinch points in capacity, but staff reported these were manageable in the short term.

Changes in practitioner staff also meant that people being supported had to be reallocated to another practitioner. Service staff reported this was managed well, with most affected responding positively and remaining engaged with the service. This was echoed in feedback from people supported by the service who reported that they had quickly developed a positive relationship with their new practitioner.

Service staff reported that a small number of those re-allocated to a new practitioner did disengage from the service but felt they were ready to do that anyway.

Initial training and ongoing development

Practitioner staff undertake initial training of four to eight weeks when they enter the post. Staff have consistently described it as comprehensive and that it equips them for their role. Some staff members that have previously worked in other related or similar roles reported that the training content was similar to previous roles, but they still appreciated the refresher it provided.

Staff commonly reported that while the initial training equipped them with the needed skills, they were still nervous and apprehensive before delivering their first support session. Staff that joined the service following staff changes reported that they benefitted from drawing on their colleagues' experiences, which made it less daunting as they had a good idea of what they could expect. Service leads and managers explained, however, that it can be challenging to access and organise the full suite of initial training for individual staff members timeously. Some aspects of training require a minimum number of attendees before it can be delivered, and there can be delays in accessing it for new staff. Service managers and leads also acknowledged the need to define the minimum training required before a practitioner could start the role, informed through the learning they have gained.

Service staff described an environment that encouraged and supported ongoing learning and development and said they value this, as they often face new situations requiring further knowledge, awareness or skills.

Ayrshire and Arran is a pilot site for the Significant Adverse Event Review (SAER). SAERs take place following events that have resulted in unexpected death or harm and it focuses on analysing factors that have contributed to the circumstances of the event. The service has identified this as an area where they would like to develop practitioner knowledge. Staff have been supporting people involved in these reviews following their bereavement and having a better understanding of the process and what is involved will enhance the support they can provide during that time.

Supporting practitioner staff

Throughout this evaluation, practitioners have consistently reported that there are mechanisms in place to ensure they have the support they need when it is required.

"What I've found with this organisation, if I'm comparing it to any previous organisations, roles, is this organisation has given me time to process my thoughts and process my work and reflect on that in between clients. With this project it's exceeded my expectations, and the level of support that I've had has been phenomenal."

There are several formal support structures in place for practitioners, including:

- Supervision sessions (every four to six weeks with a manager).
- Morning meetings.

- De-briefs (with managers, service leads, or another practitioner).
- Daily check-ins (peer-to-peer and across areas if necessary).
- Reflective practice sessions.

Over and above the more formalised support mechanisms, peer support within and across the service areas is highly valued by staff and seen as essential. Service staff recognise and acknowledge the emotionally demanding nature of their job and the importance of having these different support structures in place.

“I don't think we could do the role that we are doing if there wasn't a kind of open-door policy. You know, if you've had a really bad call, phone me, talk to me, you know, and it's just being able to offload that information. And I think we're quite a small team, but with the Highland team as well, you know, we could phone them, and that wouldn't be a problem, you know. We try once or twice a week to meet in the morning or an afternoon and kind of talk over our cases and things, but I really think being able to talk about what our day has looked like is so important. And because there are really horrific things that we have to hear about, and quite graphic detail, and not, being able to talk that through and leave it at work, it’s so important.”

Although staff reported feeling well supported in their roles, during the most recent fieldwork, two practitioners reported being reluctant to take annual leave, particularly when working with someone requiring more intensive support. Mechanisms are in place to ensure that other practitioners can provide support when someone’s usual practitioner is off during periods of leave or absence. However, if it is felt inadequate in specific circumstances, ways of supplementing this should be explored.

4.6 Referral pathways and awareness of the service

When the service launched in August 2021, self-referral and referrals through Police Scotland were the only official pathways into the service. Towards the end of that year, work to increase awareness of the service and expand referral routes commenced. This involved identifying the likely touch points that someone bereaved by suicide is likely to have with different organisations and services (e.g. GPs, mental health teams, funeral directors, and third-sector organisations). Work to expand referral pathways has remained a consistent and growing activity of all staff in the service since then, involving:

- Distributing information.
- Email contact.
- Discussions with other organisations.
- Attending other organisations' team meetings.
- Attending stakeholder meetings (e.g. local Suicide Prevention Steering Groups, Choose Life groups).

- Working with other stakeholders involved in suicide prevention activity (e.g. Choose Life co-ordinators).
- Attending networking events and open days.
- Visiting organisations to leave leaflets and talk about the service.

The work by services to raise awareness and expand the referral pathways resulted in an increased variety of referral sources but did not change the average number of people entering the service from month to month. At the same time as the service expanded the diversity of referral sources, there was also a noticeable reduction in referrals from Police Scotland. Of the total referrals made into the service by Police Scotland to date, 71% were received in the first eight months in Ayrshire and Arran (10 out of 14) and 79% over the same period in Highland (26 out of 33). Against the backdrop of staff changes in Police Scotland, service managers and leads have been working with their contacts to understand why and what is required to rectify the situation.

“One thing we're exploring at the moment is our relationship with police because that was one of our main referral routes in prior to August last year. And we haven't had any referrals in from them since then. They're currently doing a review, a suicide review, in terms of the number of suicides that they've had in the area and they're feeding back to me on that… we'll try and get some clarity as to why that's tailed off, and what we can do, and then we can work on how to build it up again.”

Some service staff reported a spike in referrals following awareness-raising activity but saw it reduce again. They highlighted the importance of continually building awareness of the service, so it becomes embedded in referrer’s minds.

Experience and perspectives of referral organisations

Feedback from organisations that have referred people to the service has been wholly positive. The service is perceived to fill an important gap. While most of the organisations were aware of other services that could provide people with emotional support, they reported that the SBSS was the only one specifically designed to meet the needs of people affected by suicide. Organisations appreciated being able to offer a referral to the service as an option to the people they are supporting.

“It's been very worthwhile for us … in our job being able to signpost people and refer people on to something like this, it’s just massive, so important.”

From the perspective of referring organisations, the following strengths of the model were highlighted:

- No waiting list and fast access (e.g. simple and quick referral process).
- Excellent communication from service staff with referrers, letting them know that a referral has been received and when contact has been made with the person they referred.

- The service can provide longer-term support and provides emotional and practical support.

A few organisations described a need to raise awareness of the service. They commented that after finding out about the service, they had seen no other materials, literature or presence. One GP explained that before their discussion with the evaluation team, they had asked their colleagues about their own experiences of referring to the service so that they could share some wider views. However, most of their colleagues were unaware of the service even though they would have received the same materials. This further highlights the need to continually revisit and maintain momentum around awareness-raising activity and connections with other services.

Only one organisation reported experiencing challenges in offering a referral to someone bereaved by suicide. Police Scotland staff in the evaluation highlighted that due to their very early engagement with the bereaved, it was often not appropriate or possible to discuss a referral. In these instances, the officers attending leave an information pack that contains details about the service and how to contact them. We know from some people that they revisit this information, but it can be many weeks later.

A small number of referral organisations also explained that they had experiences of people declining the offer of a referral, even where they had expressed needs related to bereavement by suicide. In those instances, the individuals did not think the service was what they needed or wanted.

“One of them was a person that had quite a chaotic lifestyle and she was involved with the community mental health team and the addictions team. I'd mentioned that and she just said that it wasn't the right time she was wasn't in the headspace to engage in anything like that.”

A few organisations reported ongoing contact with the person they had referred to the service. In all instances, they had received positive feedback and reported that they would not hesitate to make future referrals.

“I have spoken with a few of the people [we referred], that kind of came back at a later point. And they have mentioned what a good service it is and how well supported they felt. So it's not just one or two, it seems to be kind of across the board. Anybody that's kind of accessed it, it's favourable, and said good things about the service. So that's important.”

Onward referral pathways

SBSS staff report that, as appropriate and necessary, they speak to the people they support about different, additional support and external services available to meet their needs. They reported that there was a strong collective awareness and understanding of the different support and services available to meet a range of different needs across the team. There were no specific gaps in external service provision highlighted by SBSS staff. However, waiting times to access some services – such as counselling, CBT and similar therapies – did create barriers to access.

Feedback from SBSS staff suggests that people often prefer to receive details about different external support options and then decide if and when they might seek 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 include the bereavement charity CRUSE, the Distress Brief Intervention Service and The Lennox Partnerships, a social enterprise which supports people to access employment.

The evaluation has engaged with three organisations that received referrals from the SBSS. Two offer group-based peer support to people bereaved by suicide, one of which also provides other social activities such as arts and crafts. The third organisation provides employment support. All three organisations reported that the referrals they had received from the service were appropriate in terms of the support they provide, and the needs of the person being referred. The two organisations that provided peer support to people bereaved by suicide welcomed the addition of the SBSS in their areas, feeling that there was no duplication of service and that each service offered something different. They acknowledged that different forms of support were required by people bereaved by suicide. Neither had any concerns that referrals from the service would impact their service delivery or capacity.

5. Experience and outcomes for people supported by the service

In this chapter, we discuss the experiences of the support people have received from the SBSS and the difference it has made.

The findings are drawn from interviews with 42 people supported by the service over the evaluation period. Just under half (19) have engaged in a single interview, 17 engaged in two separate interviews, and six participated in three interviews, each taking place between four and six months apart. This has provided insight into short and longer-term experiences and outcomes.

The chapter is organised under the following headings:

- 5.1 Accessing the service.
- 5.2 Reasons for accessing the service.
- 5.3 Experience of support.
- 5.4 Impact.
- 5.5 Strengths and areas for improvement.

5.1 Accessing the service

In this section, we discuss how people accessed the service, their first contact with the service, and whether access came at the right time for them.

Pathways into the service

People were referred to the service through a formal referral process by an organisation or service, with various examples provided, or self-referred by contacting the service directly. Those referred to the service confirmed they were given enough information to decide about a referral. Some recalled that the service had been described to them as specifically for people who had been bereaved by suicide. Others could not recall what had been explained to them about the service.

A few people also described referrals to other organisations, which led to them accessing the SBSS. For example, one person who is a carer for their partner said her GP had referred her to an organisation that supports carers, and that organisation made them aware of the SBSS. Several of those who self-referred explained that they had learned about the service in different ways, either through conversations with friends, family or colleagues. Others came across it in the local press or online, doing their own searches or through social media. A few people found out about it when they revisited leaflets left with them by Police Scotland. In these instances, none could recall discussing the opportunity to be referred to the service.

“Well, it was actually from leaflets that had been lying for a while, and there were actually quite a lot of leaflets that the police gave us right afterwards, and I was just looking through them one day and came across some numbers to phone.”

For those who self-referred, the most reported area for improvement with the service was its visibility and awareness, particularly among the general public.

“So the only thing that I'd say needs improved is I didn't know about the service. It was the lady from Petal [another support organisation] that told me.”

A few people described hesitancy or difficulty in taking that first step to contact the service. At that time, they explained that they did not know what they wanted to say or what they were looking for. One person described having the contact details for over a week before being able to make contact.

“I had the details, and I still remember going to make the call, and I just couldn’t. Even when I finally managed to, I had spent the morning staring at the phone and thinking about what I was going to say. It would have been easier if I hadn’t been the one having to do that … And because I was sort of in crisis at that point, trying to leave an answer phone message when you're crying. It's actually really quite hard.”

Feedback was mixed about the timeliness of accessing the service. Some people reported feeling that it would have benefitted them to have been able to access the service earlier than they had. This was particularly apparent for those referred to the service after accessing health services at a point of crisis.

“I took a complete breakdown [following the suicide]. I spoke to the manager at the [GP] surgery. And they, in turn, spoke to the mental health nurse who phoned me and arranged for the referral to the service.”

However, feedback from those who reported accessing the service at the right time suggests that what constitutes the ‘right time’ is different for every person. Some accessed the service within days of their bereavement, which was right for them. They reported recognising at that very early stage that they needed some form of support to help them with what they were experiencing. Some accessed the service weeks and months after their bereavement, which felt like the right time for them. For some of these people, this was because they were also dealing with other issues they felt they needed to address first, sometimes involving accessing and receiving support from other services and organisations. Others spoke about the need for support only becoming a consideration for them after a passage of time since the bereavement. Two people recalled being offered a referral by Police Scotland but declining it at that early stage.

“A bit of time had passed. I think I just wanted the funeral and everything out of the way before I thought about any of that. Yeah, that was obviously down to me though, that was like my timeframe.

And then, after several weeks, I felt I wasn't moving forward, and I needed to talk to somebody.”

First contact from the service

Following a referral/self-referral, people supported by the service reported that they received a rapid response from the service. While not everyone could recall the exact timeline, most reported being contacted within 48 hours. Several people reported that this had exceeded their expectations, and none had any concerns about the timeliness of the response. Some people also spoke about the initial call from the service, providing reassurance and comfort from how the member of staff spoke with them and how the service was described.

“[Service staff] really put my mind to rest, right from the very beginning from the minute I spoke to them.”

5.2 Reasons for accessing the service

Many of the people supported by the service that we spoke with explained that at the point of accessing the service, they did not specifically know what support they were looking for or what support would help. They just recognised and realised that they needed something. As two people described:

“I didn't go in with any expectations. I was just in a really bad place. I was just like, I know I need help.”

“At that point, no, you're absolutely in a traumatic state. A state of shock, you're not thinking, you obviously, you're busy trying to just take in the information of what's happened, and you're really not going to say I need this or that. You just don’t know what you need.”

Several people articulated how they felt when they first accessed the service and what they felt they needed support with, or access to. This included:

- Feeling isolated.
- Needing someone to talk to.
- Being able to better understand their experience.
- Having someone that would listen to them.
- To explore what they were feeling and why.
- Reassurance about what and how they are feeling.
- Advice and guidance.

5.3 Experience of support from the service

This section explores people's experiences of how support is provided and the types of support they have received.

Format and frequency of support

Most of the people we spoke with received support from the service over the telephone or via video call. A small number were also having some sessions face-to-face. Most of those that received support over the phone or via video call reported that they had discussed the option of face-to-face support sessions but, for the time being, were happy with the current format. All understood and appreciated that it was their choice and received support based on their preferences. As two people described.

"We did start the walking and talking quite quick. We met up I think it was Monday, and then we were supposed to meet up again on Friday. But I wasn't doing too good, so we just had a phone call instead. It's usually a phone call or just go for a wee walk for an hour once a week."

"I was given the opportunity to do Zoom calls, but we've just continued with the phone, I prefer the telephone contact. It is just a bit simpler and easier to have a telephone conversation. It's just a little bit less formal. It's more private, I suppose, a phone call. It sounds strange, but you might not kind of feel up to seeing someone in person on a Zoom call."

People supported by the service explained that they led decisions about the frequency, duration and scheduling of support sessions. The frequency of support sessions varied among those we spoke to, with some engaging weekly, some fortnightly and others monthly or every six weeks.

"It was very much self-directed, what my needs were, and that was the right thing. It wasn't being led for me; it was being led by me. They just went with what I said, and, you know, sometimes just through conversation, we would be able to plan out whether I needed it in a few days or at the end of the week, and it kind of led its own path naturally."

Some people who have been engaged with the service over a longer period also described how the frequency of their support sessions had reduced over time. Within this were examples of support frequency reducing but increasing again due to an incident, event or anniversary that had impacted the person negatively and increased their support needs. Often after a period of increased frequency, this would then reduce again. Having the flexibility to adjust the regularity of when people received support was highly valued.

"At the beginning, it was weekly, and then it was fortnightly and then it went to monthly but then it had to go back to fortnightly again because of the time, of what was happening in my life. It was quite bad over the Christmas period. And so it was every fortnight, and then it went back to four weeks."

Relationships and the approach of service staff

People supported by the service spoke about the importance of quickly establishing a relationship with the staff member supporting them, which made them feel comfortable opening up and sharing their thoughts, feelings and emotions. As two people described.

“That was something that I was worried about because you don't always, kind of click with somebody, and that's true for everybody. And you have to feel kind of reassured. But I must say, we established a very good relationship very soon.”

“I'm not one to open up easily, but very quickly I did. But it came down to the skills of [the practitioner] because normally I would not be able to do that.”

People reported that the ease and speed with which they were able to establish a positive and productive relationship with service staff was due to their approach and the following skills and qualities:

- Being a good listener.
- Having patience and letting the person move at their own pace.
- Being responsive and proactive.
- Showing compassion and having a caring nature.
- Calming.
- Non-judgemental.

Aligned with this, consistency in the staff member providing support is highly valued by those receiving support, providing them with much-needed continuity, comfort, and familiarity. The relationship between staff and the people they support is a core aspect of the service. When we spoke to people who had experienced a change in practitioner due to staffing changes in the service, their feedback their transition to working with a different staff member suggests that it was well-managed. However, several people did explain that they felt a sense of loss for a short period thereafter. People supported by the SBSS reported that they felt able to develop an equally positive and productive relationship with the new member of staff they are working with.

Practical support needs

As well as emotional support, the service also provides practical support to meet people’s needs. The supported people we interviewed provided various examples of the practical support that the service has provided, which aligned with the examples cited by service staff detailed in an earlier section.

“Sometimes she'll send me links by email or just follow up anything I request because early on, sometimes it's hard to take in information. I was so traumatised. And in the early days, you sometimes maybe don't want to follow up, or look for yourself and [practitioner] was able to pass me on information about anything that I wanted to find out about.”

People supported by the service explained that they valued this practical support as they often could not take those actions for themselves or invest the needed energy. Even though people described this as practical support, they often explained that it benefited their emotional wellbeing.

“I didn't really know where to go...the place my head was in, I couldn't even tie my own shoelaces. I needed someone that could just take that pressure off.”

A few also spoke about practical needs they planned on raising with the service, explaining that it had not previously been an immediate priority, but they were now in a place where they could turn their attention to it.

Emotional support

The emotional support provided by the service was described as invaluable and was the aspect of support that people spoke about and described most often during interviews.

“So you still remember things, and the silliest of things can bring back a memory, which can be painful. But [practitioner] has always been there whenever I've needed something. And that's been invaluable … it's a bit like a tsunami, when something like this happens, you feel that you're drowning, everything just swamps over you, and the waves coming are too high to swim. And time just means that the waves start getting a bit smaller and smaller, but they're still there. And occasionally, you'll get a wave that comes out of nowhere.”

Some people supported by the service spoke about previous experiences of grief and loss but described how the feelings and emotions are different when bereaved by suicide. People recounted experiencing various emotions, including sadness, anger, blame, guilt and shame.

“I can certainly, particularly the blame, the guilt, the anger. It has been helpful for me, particularly to stop and think, well, it's not my fault he's gone. And I can feel angry that he's not here. So it's been really helpful, I feel like I can understand why I feel or think like this, but I am not quite managing the processing my way through it on my own. And that's where [practitioner] kind of been able to say, let's talk about that.”

People reported that emotional support provides them with a safe space to explore, understand, process or cope with their emotions and speak openly and honestly about their feelings. When exploring how that support is provided and the nature of the support they had received, the following were commonly cited:

- Being able to talk openly and be listened to without judgement.
- Offering advice and guidance when needed.

- Helping to understand and reassuring them that their feelings are normal and allowed.
- Strategies to help manage feelings.
- Reflecting thoughts and feelings back to explore and process them.
- Highlighting and celebrating the little successes and providing encouragement.

People who had been engaged with the service for longer reflected on how their emotional needs changed over time. This was commonly articulated as feeling better able to cope with their emotions, having more good days than bad and feeling less need for support. However, it was also highlighted that this could fluctuate, and periods of improved emotional well-being could be followed by periods of increased emotional need.

“And it kind of caught me off guard because I wasn't expecting to be upset about that. And then it wasn't till I sort of got my birthday card from Mum, just saying from mum, it was like, oh my god, and that was my first ever birthday without him. And it was like, this whole can of worms just exploded. And if I didn't have the service to have fallen back on at that point, being perfectly honest, I would be quite scared about where I would be now.”

Accessing other services

While people recalled discussions about additional support and available services, most who engaged in the evaluation felt that the service was meeting all their current needs. Even so, they acknowledged that they may need additional or different support in the future and appreciate being more aware of what is available. Examples of additional support taken up by people who accessed other services related to their bereavement include formal counselling services and group peer support.

> “Yeah, I've started, so I have gone to a group in Perth. And then I've also gone too, I think it's facing the future by the Samaritans. So [practitioner] recommended both of those. And those are things I would never have known about or attempted because it would have been too daunting.”

While most people who accessed other support reported that it had benefited them or a loved one, a few found the peer support groups difficult. They explained this was because of people's different stages in their grief and some of the subject matter discussed.

> “I've actually went, three or four times to the group session. I've now just withdrawn from that again because it's not suitable for me.”

People also appreciated that the service helped them identify organisations to support them with issues unrelated to their bereavement. Examples include help to access employment support, arts and crafts activities and Advocacy support. They

also reported that the service had shared links and signposted them to a variety of different websites and resources that they could access.

5.4 Impact

When talking with people about the difference that support had made to them, the vast majority described improvements in their mental and emotional wellbeing and being better able to cope with and return to day-to-day life and activities. We discuss each of these in the following sections.

Improved emotional and mental wellbeing

People reported that being able to talk openly, share, explore and understand their feelings and emotions with someone who listens and responds in a compassionate and non-judgemental way was critical to the improvements they experienced in their mental and emotional wellbeing.

Many people described the difference in terms of how they were feeling. Commonly this related to a more positive outlook, increased confidence about the future, feeling mentally strong enough to get on with daily life, and doing things they hadn't thought they would do again. It was, however, highlighted by people that while they had experienced improvements, and these could be maintained most of the time, there are things that can re-trigger/traumatise them and possibly lead to a period of feeling less emotionally and mentally well.

As with coping and re-engaging with their day-to-day lives, the extent of improvements in mental and emotional wellbeing varied among people. People supported by the service commonly described these improvements in one of three ways firstly, that they were experiencing the emotions associated with their bereavement less frequently.

"The feelings are still there; I think they always will be. But I suppose it's not experiencing them as often as I was. And when I do, I can be present with them, I accept I'm feeling them, but they don't affect me as much."

A second improvement related to people being able to better manage their emotions and reduce the negative impact that they were having. Lastly, a small number spoke about the support having helped them to overcome feelings of self-blame and guilt.

"So I suppose I don't feel guilty now, obviously, I miss him dreadfully, but I don't feel guilty about it. Whereas at the very beginning, I felt so guilty about it. I didn't think I could laugh. I didn't think I could have a life."

Other examples of improved emotional and mental wellbeing and the mechanisms that lead to these improvements included:

- Having the reassurance that someone is there for you.
- Reducing feelings of isolation and being alone.

- Being able to get things off their chest and having an outlet when they needed to vent.
- Being in a place where they could accept and understand what had happened.
- Feeling stronger and more mentally resilient.

For some people, the difference was more profound. It was not uncommon for people to explain that they feared suffering drastic consequences because of their bereavement had it not been for the support of the service. As two people described.

“I'm not saying this lightly, but I would either be in hospital, jail, or in the ground basically.”

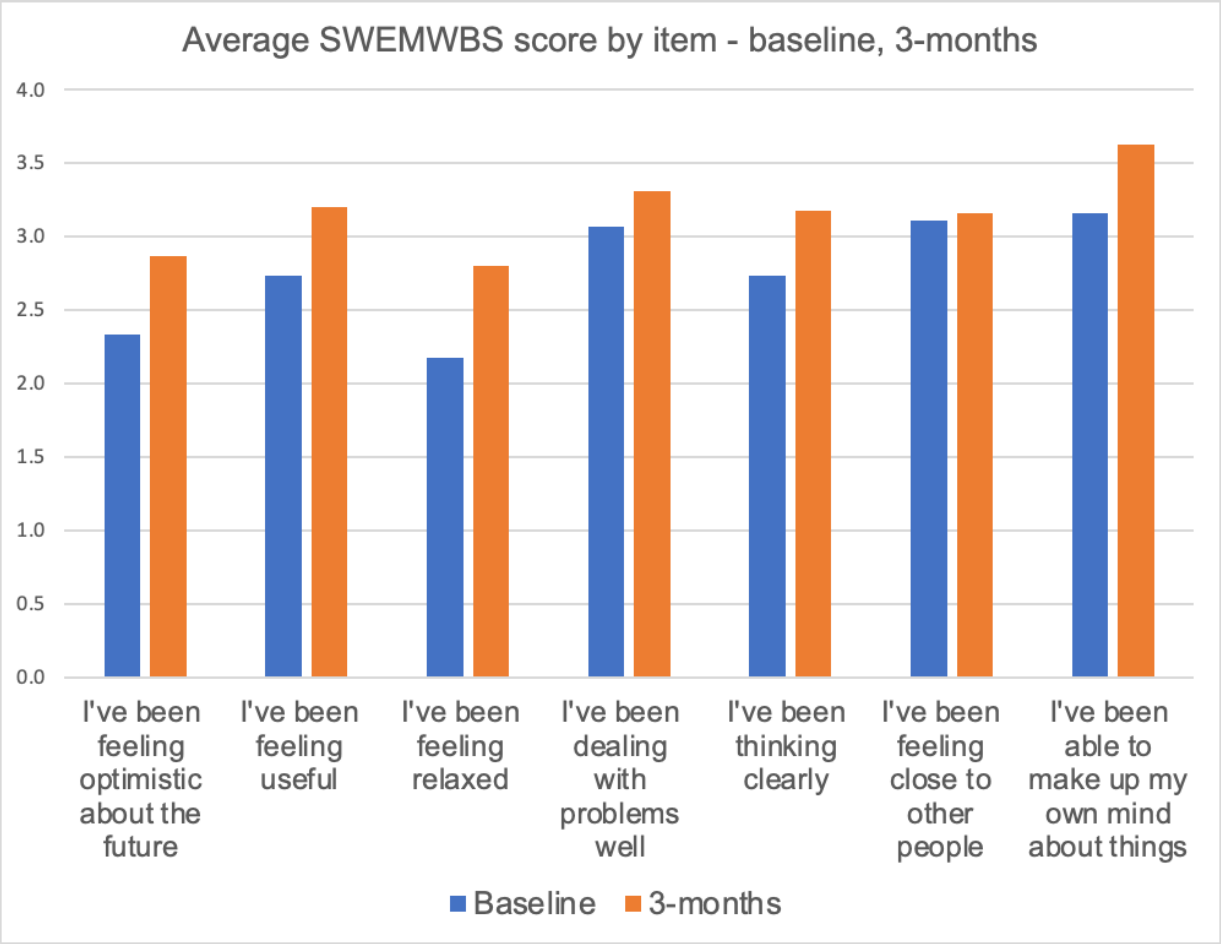
“Absolutely massive. I just wanted to die. I didn't want to be alive anymore. I don't feel like I actually want to die now. Without that service, I maybe wouldn't be here, to be honest.”

Measuring improvements in mental wellbeing

To further understand the service’s impact on the mental and emotional wellbeing of the people they support, service staff administer the Shortened Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). This is done at three different time points in a person’s support journey to measure the change in levels of mental wellbeing over time.

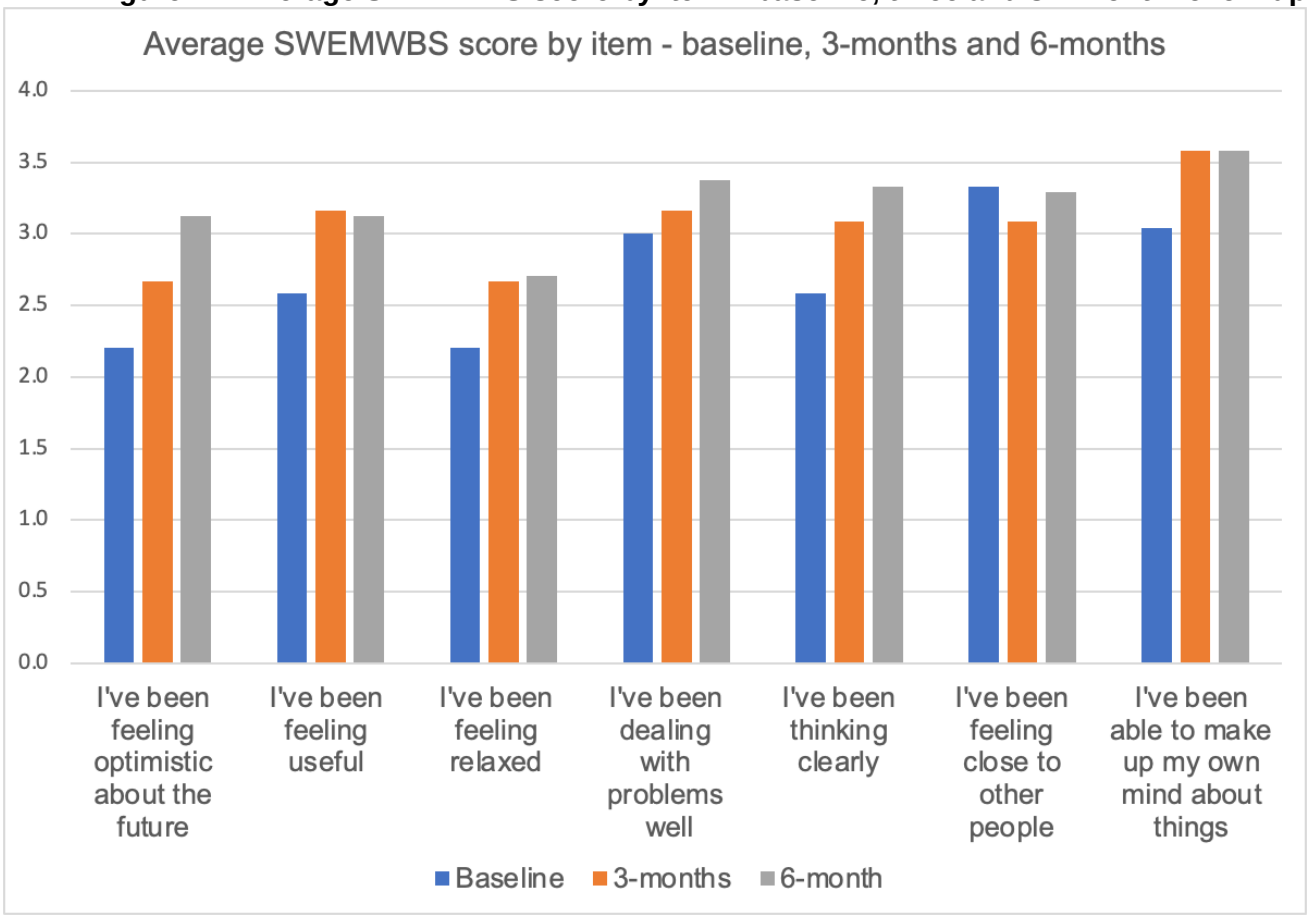
SWEMWBS data gathered by the service demonstrates an overall increase in wellbeing at the three-month follow-up compared to the baseline. The chart below provides the average score across each item of SWEMWBS based on 45 people (30 Highland, 15 Ayrshire and Arran) who completed SWEMWBS at baseline and three months later.

Figure 1 – Average SWEMWBS score by item – baseline and three-month follow up



Twenty-four people (18 Highland, six Ayrshire and Arran) have completed SWEMWBS at baseline, then three and six months later. The results are shown in the chart on the following page.

Figure 2 – Average SWEMWBS score by item – baseline, three and six-month follow-up



After three months 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.

The average score across all but one item ("I've been feeling close to other people", which returned to baseline levels following a dip at the three-month point) increased from baseline compared with the six-month follow-up. There is a very slight drop in score in one item ("I've been feeling useful",) and another item has remained the same ("I've been able to make up my own mind about things) when comparing the 6-month follow-up with the three-month follow-up.

Better able to cope and return to day-to-day life

A recurring theme throughout the evaluation has been the positive impact the service has had on supporting people to cope better with their day-to-day lives. People supported by the service highlighted the interlinked nature of improved emotional and mental wellbeing as an enabler to coping and returning to everyday activities, further helping their mental and emotional well-being.

The extent to which people feel better able to cope with daily life and have returned to activities they had participated in before their bereavement varied. Generally, those at an earlier stage in their support journey described small steps and improvements, whereas more significant changes tended to be reported by those who have engaged with support for longer.

Those that described small changes and steps provided examples which included:

- A shift from not wanting to get out of bed to managing to get up and do some household chores.
- Being reliant on home deliveries for groceries, but now going to the supermarket for essentials.
- A reluctance to be outside of their home to now going out for a coffee.

Those who were further along their support journey described how, over time, they had been able to get back to doing much of the things they did before their bereavement. Examples of this included:

- Going on holiday again
- Being able to remain at work, return to work or apply for new roles.
- Re-engaging with hobbies, interests and social activities.
- Some of these experiences are recounted in more detail by supported people below:

“I think going [on holiday] gave me a bit more confidence that I can do things myself. And a lot of that has to do with the work that [practitioner] has done with me, I think, just sort of saying [to myself], I can do it, that I am strong, that I am going to get through this. And that it's absolutely fine to have wee blips. It did give me that sort of confidence, that I could go off and do things.”

“One of the things that I really kind of struggled with was sort of that going out, and maybe not even having a meal, but like going for a coffee. And I've actually managed to be able to do that by myself.”

In terms of coping better, some people tended to articulate this as being able to get on with their day-to-day lives, having more good days than bad, and the bad days not being as difficult as they had been. Others spoke about being able to get on with life more easily, and as mentioned previously, people tended to link this to experiencing improved mental and emotional wellbeing. Aligned with this, some people highlighted that although they generally felt better able to cope, there could still be days that set them back, where they felt less able to manage again.

A small number of supported people spoke about how engaging with the service had helped them rebuild their confidence, which again was an enabler to better coping with life and returning to daily activities. A few people explained how they now felt more comfortable and better able to talk about their experience of bereavement and use their loved one’s name in conversation again. This was attributed to having been able to explore their experiences in a safe space with the service, which gave them the language, confidence and comfort to do so with others. As two people described.

“Before I started doing this, you know, I found it impossible to say my son's name. But for example, last weekend, there was a community event, and I went to this event, and I could actually reference him. Now for me, that was a huge step.”

“I've always thought of myself as being quite a strong, maybe not independent, but a strong person. And I think all that happened with [loved one]. It just pulled the rug out from under me, and I think I am getting back to that person that I was.”

People valued that they could move forward at their own pace and did not feel any pressure from the service. They reflected that while there could be periods where they didn’t feel like they were moving forwards and sometimes moving back, the service was always there alongside them.

> “They [the service] help me reflect and helped me move forward at a pace that I can cope with, and `they've been really excellent at helping me take the next step forward and whether I want to take the step forward. Some days I've not felt like taking that step forward. And I just have to stand in the same place many, many times. And I think the biggest thing I want to say is that they stand there with me… you're not alone.”

5.5 Strengths and areas for improvement

The following provides a summary of the identified strengths of the delivery model and areas that people supported by the service suggested could be further developed or improved.

Strengths of the service delivery model

Several features of service delivery were commonly identified as strengths by people supported by the service. Each of these is described below:

- **The service staff and their approach** – staff skills, qualities, and ways of delivering support was the most cited strength of the service. Their approach was described as non-judgemental, compassionate and sensitive, responsive to needs and demonstrating empathy.

- **Person-led and person-centred** – a highly valued feature of the service is that the person receiving support dictates the format, frequency and duration of their support sessions. Furthermore, knowing that they can bring whatever they want to discuss, and that each session is focussed on their needs was also important to people.

- **Flexibility and availability** – people are reassured that if they choose to reduce the frequency of support, it can be increased again should they need it. Furthermore, people appreciated the understanding shown by service staff if they were unable to make an agreed appointment and their flexibility in arranging another date at the earliest opportunity. Knowing that they can contact the service if they need support between their scheduled appointments also provides people with a great deal of reassurance and confidence that someone is there to help them when needed.

- **Someone outside their family and social network** – people consistently spoke about the value of being able to talk to someone who is not a friend or family member. This was for a range of different reasons, most commonly not wanting to burden friends and family, to be able to say things they would not be comfortable saying to friends and family and to avoid upsetting them.

- **Consistency in support** – people supported by the service value a consistent connection with a practitioner, believing this enables service staff to develop an in-depth understanding of them, their circumstances, and their needs. It means they do not have to cover the same ground with different members of staff. However, it is also important to highlight that those that have experienced a change in the member of staff supporting them reported the transition as smooth, despite finding it daunting. People reported that their new practitioner had a thorough understanding of their situation and circumstances, quickly put them at ease, made them feel comfortable, and were quickly able to develop a positive relationship with them.

- **Speed of access –** being able to start receiving support so soon after the initial contact and having no waiting lists was considered essential. People explained that they needed the support at the point they had been referred, and any delay would likely have had a negative impact.

- **No time limit** – having no limit on the length of time that a person can access the service was seen to remove any potential pressure to be progressing with how they were coping with their bereavement and allowed people being supported to go at a pace they were comfortable with.

The strengths of the model, as identified by people receiving support, were also viewed as essential components for any roll-out of the service beyond the pilot areas.

Suggested improvements

The area most suggested for improvement by people supported by the service related to awareness and accessibility, particularly amongst those that feel they would have benefitted from engaging with the service earlier. Several people described struggling to find support when they were looking for it. Furthermore, many of those that were referred to the service commented that they had not come across or seen anything about the service since that point.

There is a strong feeling among the people supported by the service that it needs to be more visible. Other than awareness of the service, there were no other commonly suggested areas for improvement. However, there were some further suggestions from individuals. These were:

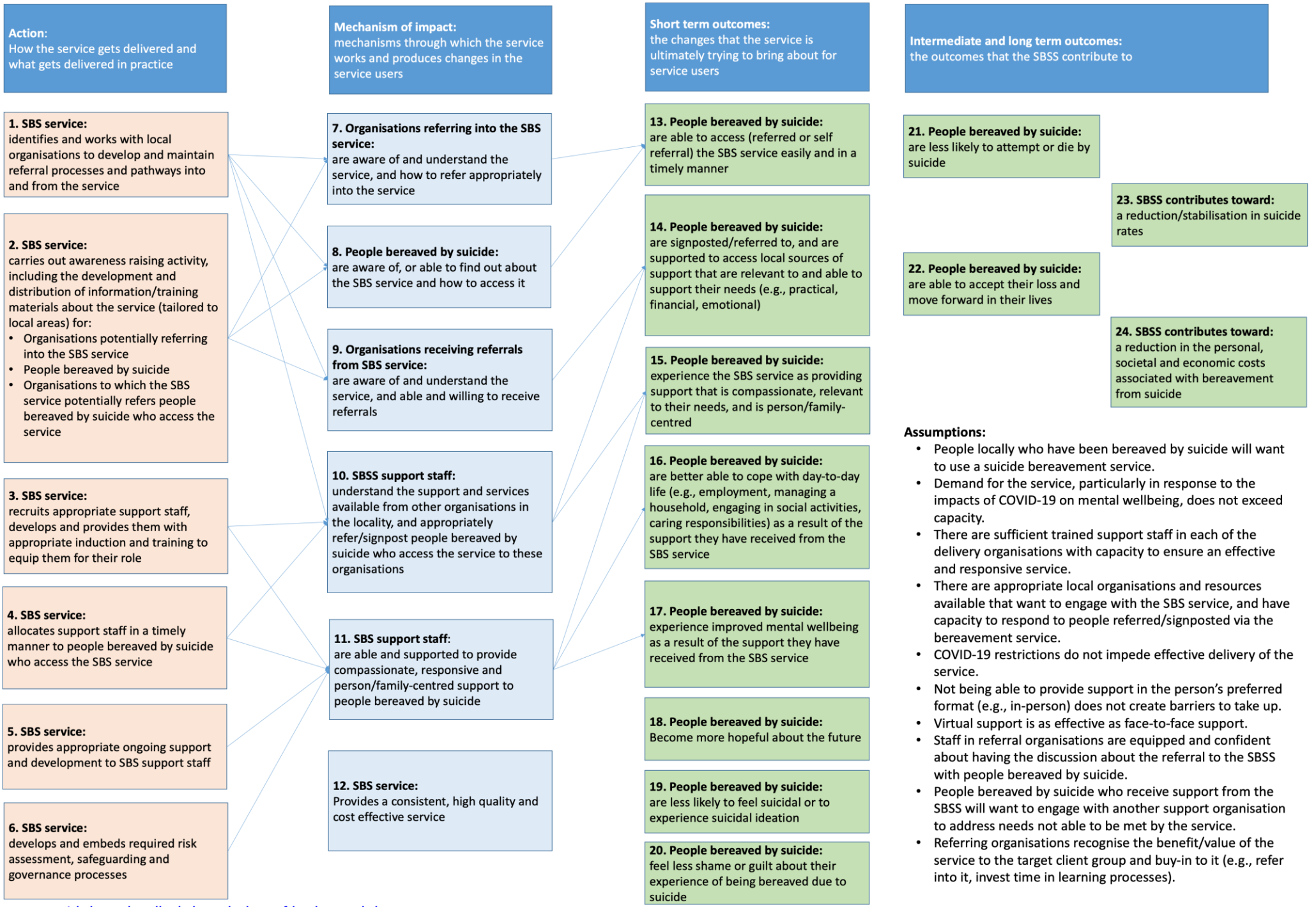
- Being sensitive to the value someone receiving support places on anonymity and considering this when offering face-to-face sessions.

- Offering people therapeutic interventions, such as CBT, in the context of not being able to easily access it elsewhere.

- Having an information pack available that includes links and resources that they commonly share with people, as well as containing information about the emotions people will likely experience, and details of other organisations.
- Creating short bios for service staff that can be shared with people accessing the service so that they know a little about the person supporting them.
- Forming peer support groups.
- An email address or online form as an alternative to phoning the service when making a self-referral.

6. Reflections on the service logic model

A service logic model was developed before this evaluation was commissioned. In this chapter, we discuss the extent to which the different components of the logic model reflect the service model and delivery approach, and the outcomes achieved. The logic model is shown on the following page.



Assumptions:

- People locally who have been bereaved by suicide will want to use a suicide bereavement service.
- Demand for the service, particularly in response to the impacts of COVID-19 on mental wellbeing, does not exceed capacity.
- There are sufficient trained support staff in each of the delivery organisations with capacity to ensure an effective and responsive service.
- There are appropriate local organisations and resources available that want to engage with the SBS service, and have capacity to respond to people referred/signposted via the bereavement service.
- COVID-19 restrictions do not impede effective delivery of the service.
- Not being able to provide support in the person's preferred format (e.g., in-person) does not create barriers to take up.
- Virtual support is as effective as face-to-face support.
- Staff in referral organisations are equipped and confident about having the discussion about the referral to the SBSS with people bereaved by suicide.
- People bereaved by suicide who receive support from the SBSS will want to engage with another support organisation to address needs not able to be met by the service.
- Referring organisations recognise the benefit/value of the service to the target client group and buy-in to it (e.g., refer into it, invest time in learning processes).

[Link to detailed description of logic model]

6.1 Scope of the evaluation

The following components of the logic model on the previous page are outside the scope of this evaluation:

- Intermediate and long-term outcomes could not be tested within the pilot and evaluation timeframe.
- An assessment of cost effectiveness of the service.
- Outcomes related to feeling suicidal or experiencing suicidal ideation, and feelings of hopefulness, shame or guilt have not been measured as no validated tools that could effectively measure this were used in the evaluation. However, it is important to acknowledge that the qualitative evidence gathered through interviews with people supported by the SBSS indicates that the support provided by the service contributes to these outcomes.

The initial logic model also included a mechanism of impact that referred to the service 'ensuring appropriate services are in place to support people who are signposted to them by the SBSS'. This has been removed as the SBSS is not able to ensure appropriate services are in place to meet the wider needs of the people they support.

6.2 Assessment of logic model components

In this section, we discuss each component of the logic model and assess the extent to which it has been achieved and/or accurately reflects the actions, processes and outcomes of the service.

Actions

Logic model component:	Assessment
The service identifies and works with local organisations to develop and maintain referral processes and pathways into and from the service.	A core area of activity for the service has been in working with stakeholders, partners, and other organisations to develop and maintain referral pathways. However, this is an area of work that requires continued focus and repeat activity, to ensure referral pathways are embedded and maintained.
The service carries out awareness-raising activities, including the development and distribution of materials about the service for referral organisations and people bereaved by suicide.	A wide variety of awareness-raising and relationship development activity has taken place to increase the profile of the service and establish a variety of referral pathways into the service.
The service recruits appropriate support staff and provides them with appropriate induction and ongoing training and development to equip them for their role.	People supported by the service have provided overwhelmingly positive feedback about the nature and approach of staff. Service staff report that their initial training, supplemented by ongoing training and development, ensures they feel equipped for their role.

The service allocates support staff in a timely manner to people bereaved by suicide who access the service.	Evidence suggests that most referrals are allocated to a practitioner within 24 hours of being received.
The service provides appropriate ongoing support and development to service support staff.	Service staff reported being provided with and having access to a range of formal and informal support, which they reported to be effective. This includes supervision, debriefs, reflective practice and peer support. Staff report being encouraged to identify and participate in further training and development opportunities.
The service develops and embeds required risk assessment, safeguarding and governance processes.	Service staff confirmed the relevant policies and processes are in place and are understood by staff

Mechanisms of impact

Logic model component:	Assessment
Organisations referring to the service are aware of and understand the service and how to refer appropriately to the service.	It stands to reason that if an organisation has made a referral, then they are aware of the service. Referral organisations that we have engaged with through the evaluation demonstrated a basic understanding of the service, knew how to refer people, and found the referral process simple and straightforward. People that were referred to the SBSS also confirmed that the information they received about the service in advance of the referral was accurate.
People bereaved by suicide are aware of or able to find out about the service and how to access it	Feedback from some people about the difficulty they had in finding out about and accessing the service suggests that further work is required to increase the visibility of the service and information about accessing it.
Organisations receiving referrals from the service are aware of and understand the service and are able and willing to receive referrals.	Only a very small number of organisations that have received referrals from the service engaged with the evaluation. Feedback from these organisations indicates that they welcome referrals from the service and confirmed that they understood the service, having had discussions with staff prior to referrals being made. However, the evidence base is too small to reliably comment on the extent to which this is consistent across all organisations that have received referrals from the service.
Service support staff understand the support and services available from other organisations in the locality and appropriately refer or signpost people to these organisations.	Staff reported having a good understanding of the service and support available locally. Feedback from staff and people supported by the service confirms that referral and signposting are discussed as appropriate to meet needs.
Service support staff are able and supported to provide compassionate,	Service staff reported feeling well supported in their role and see a compassionate, responsive

responsive, and person-centred support to people bereaved by suicide.	and person-centred approach to providing support as a fundamental and core aspect of their work. This was further evidenced by feedback from people about their experience of the support they received.

Outcomes

Logic model component:	Assessment
People bereaved by suicide are able to access (referred or self-referred) the service easily and in a timely manner.	Easy and timely access has not been the experience of all people. For many, their path to finding and accessing the service has been difficult and resulted in them receiving support later than they would have liked. Further work is required to meet this outcome.
People bereaved by suicide are signposted/referred to and are supported to access local sources of support that are relevant to and able to support their needs.	Feedback from service staff and people supported by the service confirms that different sources of support are explored and aligned to people's needs, and signposting/referral activity takes place as required.
People bereaved by suicide experience the service as providing support that is compassionate, relevant to their needs and is person/family centred.	Feedback from people supported by the service demonstrates that they have experienced and received person-centred and person-led support which focuses on their needs and preferences and has been provided in a compassionate manner.
People bereaved by suicide are better able to cope with day-to-day life because of the support they have received	Consistency of feedback and evidence gathered during discussions with people supported by the service provides a strong indication that this outcome is being achieved.
People bereaved by suicide experience improved mental well-being because of the support they have received.	Consistency of feedback and evidence gathered during discussions with people supported by the service and through SWEMWBS data collected provides strong evidence that this outcome is being achieved.

7. Conclusions and recommendations

This chapter sets out our conclusions and recommendations, aligned with and responding to the evaluation aims and key research questions.

Evaluation Aim:

- Understand whether the pilot has been implemented as intended and the elements of service provision that are working well and less well.

Research Questions:

- What contextual factors have influenced the implementation and delivery of the pilots?
- To what extent have the pilots delivered on their intended aim to provide a rapid response and liaison service for bereaved families?

The planned launch for the service was April 2021; however, it officially went live in August 2021. It was felt that the lead-in time for development and implementation was not sufficient, and this led to the launch of the service being delayed. A key factor was the recruitment challenges experienced during the implementation phase.

The service delivery model has been implemented and embedded as planned, and the evidence gathered during the evaluation period to date enables us to conclude that the service is providing a rapid response and liaison service for bereaved families.

Overall, most aspects of the service delivery are reported to be working well, with several aspects identified as strengths of the service. This includes:

- The approach, skills, and qualities of service staff.
- People receiving support dictating the frequency, duration and format of engagement, and support focussed and responsive to their needs.
- The flexibility and responsiveness of support.
- People having someone outside of their family and social network to speak openly and honestly with.
- Consistency in practitioners that people receive support from.
- Rapid entry to support from the point of a referral/self-referral being received by the service, and no waiting lists.
- No time limit on the support that a person can receive, reducing any pressure on the person and allowing them to move at their own pace.
- The robust and valued support mechanisms in place for staff and the encouragement and support to continually learn and develop.

A key component of the implementation has been a phased approach to developing and maintaining referral pathways into and out of the service. There has been much activity by the service to extend inward referral pathways and to raise awareness and visibility of it. While this has led to an increase in referral sources, it has not resulted in increased referrals to the service. In fact, over the duration of the pilot, overall levels of referrals have dropped, particularly through the Police Scotland pathway. This has been the biggest influencing factor on service delivery and the one area that could be working better.

The service experienced challenges during times of staff turnover. This delayed the extent to which data collection processes were embedded and created short-term capacity pressures in the service. However, service delivery was maintained despite these pressures, and there was no feedback to suggest that it led to any negative impact on people receiving support.

Evaluation Aim:

- Review whether the service is considered to be supportive and beneficial by participants.

Research Questions:

- Assess whether the service is providing flexible support and making the required connections with specialist services.
- What has been the experience and short-term outcomes for those using the service?

Over the duration of the evaluation, we have engaged with almost 30% of all of the people supported by the service at least once and a smaller proportion two or three times at different points on their support journey.

The consistency in the feedback we have received during the evaluation, supplemented by the SWEMWBS data gathered, gives us no hesitation in concluding 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 are explored with people aligned to their needs, and support required to access is provided as required and appropriate.

A small number of people receiving support from the service also shared ideas for improving or enhancing the service, as described in the previous chapter, and these should be considered during the extension period.

Evaluation aim:

- Analyse available data and review and advise on the use of baseline and outcome measures for service monitoring and evaluation.

Research question:

- To what extent can the impact and benefits for families be evaluated, and are there improvements that can be made to routine monitoring?

SWEMWBS was the only tool used by the service to capture baseline and outcome measures for the people they support. The staffing changes experienced in the service in Ayrshire and Arran impacted the extent to which the process for undertaking SWEMWBS with people was fully embedded. While this has improved over time, there remains a higher volume of SWEMWBS data gathered in Highland. However, subsequent feedback from service staff suggests that the process is now fully embedded in both areas. The use of SWEMWBS is also seen to support conversations with people that help them to reflect on the progress they have made and to explore future support needs. However, SWEMWBS was not designed or intended for this purpose, and we would recommend that the service develop a bespoke tool to support reflection with people being supported or identify an existing tool that has been developed for that purpose.

The combination of qualitative data gathered through interviews with people supported by the service and the quantitative data gathered through SWEMWBS enables us to say with confidence that the service does generate a positive impact on emotional and mental well-being. Therefore, there may be limited value in maintaining the use of this measurement tool going forward. However, if the service is rolled out in the future, being able to demonstrate that outcome achievement remains consistent across different areas may be worthwhile.

In terms of wider service activity data, the consistency and completeness of data have improved over time as processes have become embedded. This has also been the case with demographic data. There are still some slight inconsistencies in how some data is categorised and recorded, but service leads and managers are aware and working to address this. Furthermore, data is not routinely compiled centrally to provide a whole service perspective. We recommend this is resolved to ensure the required systems and processes are in place to support this function in any scaling up or rollout of the service.

Evaluation aim:

- Provide recommendations for further national roll-out taking into account questions of scale and sustainability.

Research question:

- What are the key lessons for further roll out and scale up and sustainability of the service?

Service leads are confident that the overarching hub and spoke model, with defined central and local functions, alongside the consistent delivery model that has been embedded in each area, would enable the expansion of the service into other areas.

Questions remain about whether the delivery model can maintain the degree of flexibility and responsiveness that is valued by people receiving support when operating closer to capacity. This can hopefully be explored during the pilot extension, though the potential to do so will be dictated by referral volumes into the service.
The following have been identified as areas for consideration in relation to a rollout of the service based on the learning generated to date:

- How can potential demand in a given area be best assessed and ensure service staffing is reflective of that?
- How can the service provide equitable access to face-to-face support for all people that request it?
- Does the provision of face-to-face support dictate that there will need to be practitioners based in each area the service is rolled out to?
- What is the best approach to developing and maintaining referral pathways into the service and wider awareness?
- Is there value in having regional staff that are focused on establishing and maintaining referral pathways and raising awareness and the profile of the service?
- As the service expands, how can the relationships and peer support across practitioner staff in different delivery areas be maintained, and what would be needed to facilitate this?
- What are the strengths, risks, opportunities, and challenges of service roll out involving the introduction of new delivery organisations versus roll out of delivery that involves only Penumbra and Change Mental Health?
- What additional resources might be required for a centralised hub function to support expanded service delivery?
- What model and approach would be required to ensure effective governance of an expanded service?

The pilot evaluation is being extended, and providing insight into the areas detailed above will be a core aim and focus.

Summary of recommendations

The following summarises the recommendations for the SBSS:

- Explore with service staff what mechanisms could be put in place to give them more confidence or increased comfort about taking leave during periods of greater needs among the people they are supporting.

- The strengths of the model identified by people receiving support were considered to be essential components to be included in any roll out of the service. We recommend that capacity levels in the service are managed to ensure that the strengths identified can continue to be maintained.

- The service continues to carry out awareness-raising activities and activities to develop new referral pathways. It will be important that this activity is maintained as well as remedying the drop off in referrals received from Police Scotland

- Service monitoring and activity data is still being provided to the evaluation team in different formats and categorised differently. It is essential that this issue is resolved, and data is collected, categorised, and reported consistently before any roll out.

- While SWEMWBS has been used by service staff to support reflection and help people see how far they have progressed, it was not developed or intended to be used in this way. It is recommended that the service develop a bespoke tool to support this activity with people being supported or identify an existing tool that has been developed for that specific purpose.

- Consider the areas for improvement suggested by people supported by the service, such as making first contact with the service for support via email rather than over the phone.

How to access background or source data

The data collected for this social research publication cannot be made available by Scottish Government for further analysis as Scottish Government is not the data controller.

8. Appendix 1 – Detailed Alt-text descriptions for infographics and charts

8.1 Demographic information infographic – detailed description

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

Sex

- 72% female
- 28% Male

Age

- The youngest person supported by the service was 10 years old, and the oldest was 79
- Average age of supported people was 44

Living arrangements

- 65% live with a spouse, partner, or other family
- 19% live alone
- 4% share or live with friends
- 12% unknown

Employment status

- 11% unemployed
- 10% student
- 4% retired
- 3% carer
- 7% other
- 21% unknown
- 44% employed, of which
    - 30% full time

    - 11% part time
    - 1% self employed
    - 1 casual or zero-hour contract

Relationship to the deceased

- 33% parent or step parent
- 21% spouse, fiancé or partner
- 15% sibling
- 12% daughter or son
- 7% friend
- 6% ex-partner or ex-spouse
- 9% other

Year of bereavement

- 2% 20 23
- 43% 20 22
- 43% 20 21
- 6% 20 20
- 3% pre 20 20
- 4% unknown

Ethnicity

- 66% white, made up of 55% Scottish, 9% British and 2% other
- 2% mixed race
- 1% African
- 31% unknown or prefer not to say

Link back to the relevant section of main report

8.2 Service structure hub and spoke infographic – detailed description

The centralised functions carried out by the hub include:

- Quality assurance
- Service model design and implementation
- Links with national networks and partnerships
- Receipt and allocation of referrals
- Core staff training and development
- Promotion and communication fo the service
- Service team meetings
- Service branding
- Buzz sessions
- Networking
- Service monitoring, data collection and recording
- Impact analysis

The functions carried out locally in each pilot area by the service management and delivery teams include:

- Staff recruitment, ongoing training and support
- Delivery of support to people that have accessed the service
- Development of local referral pathways
- Gathering local data and intelligence
- Local networking, awareness raising, promotion and communications
- Developing internal policies
- Local team meetings and buzz sessions

Link back to relevant section of the main report

8.3 Service delivery model infographic – detailed description

The five main components of the service delivery model are as follows:

- A referral or self referral is received by the service. Sources of referral has included Police Scotland, community mental health services, schools and colleges, GP practices, Procurator Fiscal's Office and other service providers
- The referral is then allocated to a practitioner in the service. Various considerations are made when allocating a referral to a practitioner which can include:
    - Capacity and caseload of practitioners
    - Whether the person referred is known to a practitioner
    - Whether a practitioner is already working with someone else connected to the same bereavement
- Initial contact with the person referred to the service is attempted within 24 hours of receiving the referral. The initial contact provides an opportunity to explain more about the service and the support it provides. The practitioner begins to build rapport with the person referred to the service and explores their preferences for engaging with support
- The practitioner and person receiving support agree a date, time and format for the first support session to take place
- The first support session is then delivered, and thereafter, support is tailored to the practical and emotional needs of the service users. Support can also include onward referral and signposting to other services and types of support. The support provided is led by the person receiving support and empowers them to choose the frequency of support sessions, the duration of each sessions and the format of the session which can be carried out by text, telephone, video call or face to face. The type of support the person receives is aligned to their needs at all times.

Link back to relevant section of the main report

8.4 Logic Model – detailed description

The breakdown of the logic model categories, and the components within each of those categories is as follows.

The first category is actions, which detail the components that relate to how the service is set up and gets delivered. These are:

- Component 1 - The service identifies and works with local organisations to develop and maintain referral processes and pathways into and from the service.

- Component 2 - The service carries out awareness-raising activities, including the development and distribution of materials about the service for referral organisations and people bereaved by suicide.

- Component 3 - The service recruits appropriate support staff and provides them with appropriate induction and ongoing training and development to equip them for their role.

- Component 4 - The service allocates support staff in a timely manner to people bereaved by suicide who access the service.

- Component 5 - The service provides appropriate ongoing support and development to service support staff.

- Component 6 - The service develops and embeds required risk assessment, safeguarding and governance processes.

The second category is mechanism of impact, which details the mechanisms through which the service works and generates outcomes for those being supported by the service. These include:

- Component 7 - Organisations referring to the service are aware of and understand the service and how to refer appropriately to the service.

- Component 8 - People bereaved by suicide are aware of or able to find out about the service and how to access it.

- Component 9 - Organisations receiving referrals from the service are aware of and understand the service and are able and willing to receive referrals.

- Component 10 - Service support staff understand the support and services available from other organisations in the locality and appropriately refer or signpost people to these organisations.

- Component 11 - Service support staff are able and supported to provide compassionate, responsive, and person-centred support to people bereaved by suicide.

- Component 12 – The service provides a consistent, high quality and cost effective service.

The third category is short term outcomes, which details the positive change that the service is trying to achieve with those receiving support from the service. The intended short term outcomes include:

- Component 13 - People bereaved by suicide are able to access (referred or self-referred) the service easily and in a timely manner.

- Component 14 - People bereaved by suicide are signposted/referred to and are supported to access local sources of support that are relevant to and able to support their needs.

- Component 15 - People bereaved by suicide experience the service as providing support that is compassionate, relevant to their needs and is person/family centred.
- Component 16 - People bereaved by suicide are better able to cope with day-to-day life because of the support they have received.
- Component 17 - People bereaved by suicide experience improved mental well-being because of the support they have received.
- Component 18 - People bereaved by suicide become more hopeful about the future.
- Component 19 - People bereaved by suicide are less likely to feel suicidal or to experience suicidal ideation.
- Component 20 - People bereaved by suicide feel less shame or guilt about their experience of being bereaved by suicide.

The fourth category is intermediate and long term outcomes, which details the outcomes that the service is intended to contribute to through its work. The intended intermediate and long term outcomes are:

- Component 21 - People bereaved by suicide are less likely to attempt or die by suicide.
- Component 22 - People bereaved by suicide are able to accept their loss and move forward in their lives.
- Component 23 – The service contributes towards a reduction or stabilisation in suicide rates.
- Component 24 – The service contributes towards a reduction in the personal, societal and economic costs associated with bereavement from suicide.

The final category details the assumptions that underpin the theory of the logic model. These assumptions describe the conditions that are necessary for service activities to deliver the intended outcomes. These assumptions are:

- Assumption 1 – That people locally who have been bereaved by suicide will want to use a suicide bereavement service.
- Assumption 2 – That demand for the service, particularly in response to the impacts of COVID-19 on mental wellbeing, does not exceed capacity.
- Assumption 3 - There are sufficient trained support staff in each of the delivery organisations with capacity to ensure an effective and responsive service.

- Assumption 4 - That there are appropriate local resources available with capacity to respond to people referred or signposted via the bereavement service.
- Assumption 5 - That COVID-19 restrictions do not impede effective delivery of the service.
- Assumption 6 - Not being able to provide support in the service users' preferred format does not create barriers to take up.
- Assumption 7 - That other local support organisations want to engage with the suicide bereavement support service.
- Assumption 8 - Staff in referral organisations are equipped and confident about having the discussion about the referral with potential service users.
- Assumption 9 - That suicide bereavement support service users will want to engage with another support organisation to address needs not able to be met by the service.
- Assumption 10 - Referring organisations recognise the benefit and value of the service to the target client group and buy in to it (e.g. refer into it, invest time in learning processes).

Link back to relevant section of the main report

social research

The views expressed in this report are those of the researcher and do not necessarily represent those of the Scottish Government or Scottish Ministers.

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