

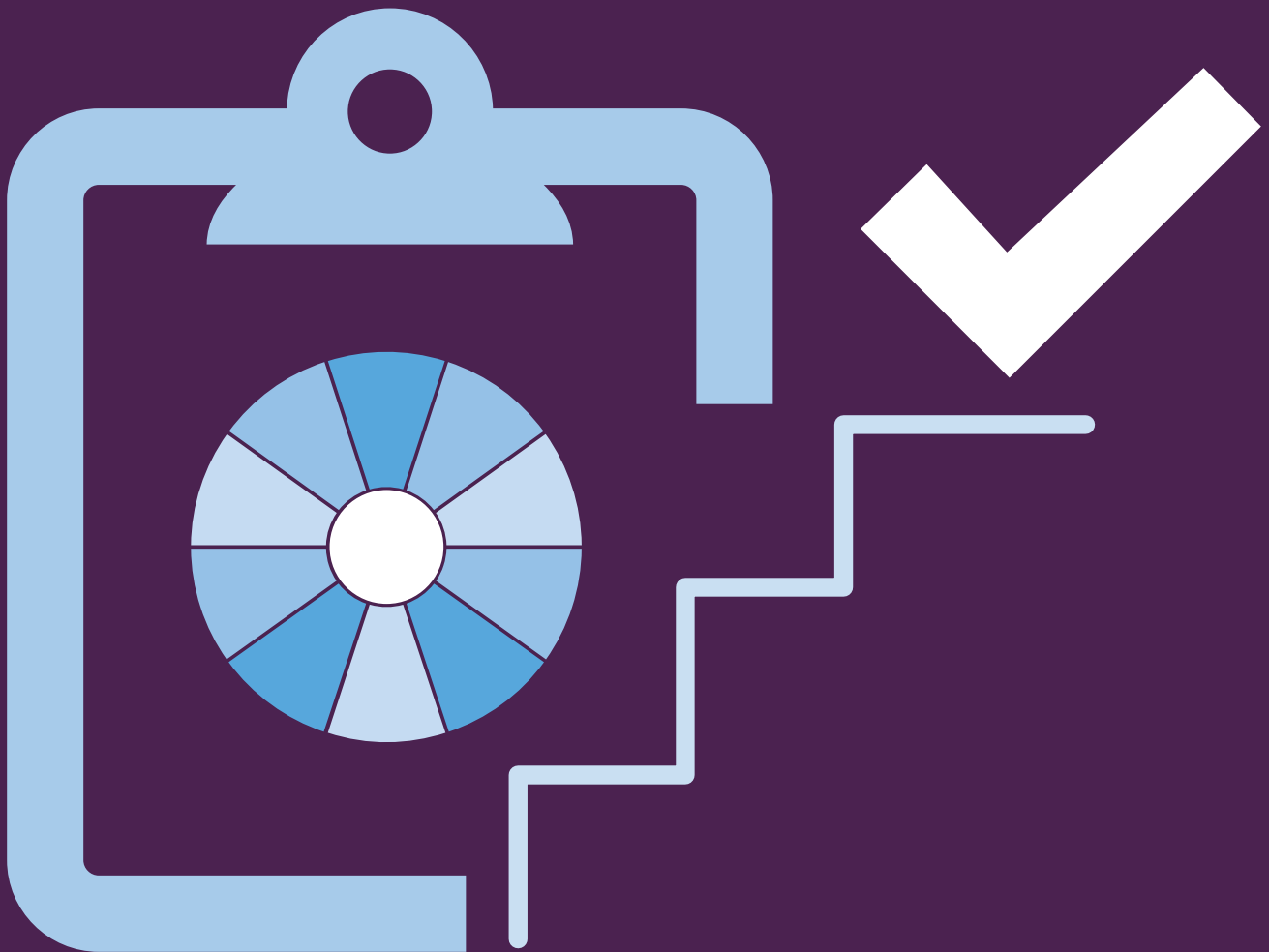


National  
Suicide Prevention  
Alliance

**Support  
after suicide**

Support after a suicide:

# Evaluating local bereavement support services



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The McPin Foundation is a mental health research charity that champions experts by experience at the heart of research methods and the research agenda.

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The National Suicide Prevention Alliance (NSPA) brings together public, private and voluntary organisations in England to take action to reduce suicide and support those bereaved or affected by suicide.

Support After Suicide Partnership  
[www.supportaftersuicide.org.uk](http://www.supportaftersuicide.org.uk)

The Support After Suicide Partnership (SASP) is a hub for organisations and individuals working across the UK to support people who have been bereaved or affected by suicide. SASP is part of the National Suicide Prevention Alliance.

**With support from:** Public Health England

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# Introduction

This is a toolkit to help suicide bereavement services plan an evaluation using a 12 step approach. It has been developed by the McPin Foundation in consultation with people working in suicide and other bereavement support services, evaluation experts and service users. The case studies and quotes are all taken from the consultation.

## Why is evaluation important for suicide bereavement services?

A carefully planned evaluation enables services to reflect on what works, what doesn't work, and how things can be improved. It provides services with the evidence they need to demonstrate to those interested in using the service, funders and other stakeholders what the service is doing and who it is helping. It is also important to show the service is doing no harm, such as widening the health inequalities gap. Through collectively developing a strong evidence base, it will help new and existing suicide bereavement projects to demonstrate the value of their work, raise standards in service delivery and drive further developments and innovations.



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You need to provide evidence that what you do actually works...nobody's going to give you public money if you can't prove it.

Suicide bereavement support provider



## What is evaluation?

In brief, an evaluation is a series of activities where information – or data – is systematically collected and analysed in order to gain insights into how a service operates and its impact. It is a methodological assessment which looks at questions such as: Is the service delivering its stated aims and objectives? How is it achieving these aims and objectives? What should we change to improve the experience of people using the service or staff working within the service? These questions are important for services new and established.

Evaluation is different to research. In some cases a suicide bereavement service may choose to undertake a research study rather than an evaluation. Key differences include research producing generalizable knowledge rather than producing information for decision making, and being hypothesis driven.



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Staff sometimes see it as, well, delivering the service is more important [than evaluation]. And you think, I understand where you're coming from on that one, but please trust me, they're both important.

Suicide bereavement support provider





It took me a long time to seek support following my father's suicide, nearly 16 years in fact. I had been quite young when he took his own life - only 10 years old. Friends and family had offered well-meaning support, but they too were shocked and bewildered. Over the years I found myself feeling increasingly 'stuck'. How should I feel about my father? Why did other people never talk about what had happened? I had done individual therapy, but this was for other issues – it never seemed to get to the root of what it was I was feeling. I knew I needed to understand suicide more, and how it affected the people left behind.

I had searched the internet several times for organisations offering support to those bereaved by suicide, but could never bring myself to make contact. So much time has passed – surely I should not still need help to process it all? I finally took the step when a friend from work sent me the details of a local support group taking place in London. Before the group started, a volunteer contacted me to chat about what it would involve and what I hoped to get from it. Some of the questions were hard – things were still raw – but they didn't feel intrusive.

Attending the group over a 6-week period opened my eyes to the significance of the trauma we had all experienced. When the group ended the volunteer with whom I had initial contact sent me an email – he wanted to make sure the group had ended well for me. It was tailored, personal – I knew they had really listened to my individual story from the first point of contact. Looking back, I would have loved the opportunity to feedback on how attending the group had helped me to move forward, to recognise the next steps. I would encourage services to gain detailed feedback from people accessing support, helping them learn and improve. Ensuring staff and volunteers understand the impact they are having and giving funders evidence of outcomes being achieved.



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### **Bereaved daughter**

# What we know about suicide bereavement support

Research shows that bereavement by suicide is linked to a number of negative health and social outcomes. This includes depression and an increased risk of suicide and suicide attempts.<sup>1,2</sup> Friends, as well as family members, may be affected.<sup>2</sup> The current national suicide prevention strategy published in 2012 identifies those bereaved by suicide as a vulnerable group and recognises how weak and limited the evidence base is in this area.<sup>3</sup>

A recent research study using an online survey method with respondents mostly from the USA and Australia found that people were generally positive about their experience of individual therapy following bereavement by suicide.<sup>4</sup> However, this is just one small study, and thus needs to be built upon to understand more about what type of therapy, for how many sessions and over what period. Previous studies have had substantial methodological limitations, such as issues with sample representativeness and the outcome measures used, and often took place outside of the UK.<sup>5</sup> There remain many unanswered questions about what types of support are effective, and for whom – as well as precisely which components of a support service are bringing about positive outcomes for adults and children, and how.<sup>6,7</sup> These are the kinds of questions an evaluation can help to answer. This is why it is recommended that all suicide bereavement services evaluate their work and share findings.

Some of the challenges in evaluating and building an evidence base around support for people who have been bereaved by suicide apply to bereavement support as a whole. One issue is that there is such a wide range of types of support on offer that it can be hard to identify a systematic approach to evaluating them.<sup>4</sup> Another is the unpredictability of the grieving process, which makes standardised measurement of outcomes difficult.<sup>6,7</sup> Nevertheless, collecting information about service outcomes and client experiences, can help build an understanding of the needs of those who have been bereaved by suicide and the impact that services can have on people's lives. Evaluation can help improve service delivery and show value for money to funders, and importantly, it can also push the development of suicide bereavement services higher up the national agenda. The UK will know a lot more over the next 10 years, if all suicide bereavement services in the UK evaluate their work and make their findings public.

# Planning an evaluation

Whatever you do locally, evaluation should be an essential component, not an optional thing. And you think about it right at the planning stage as opposed to half way through or at the end.

NHS clinician

This toolkit approaches the process of planning an evaluation by breaking down the overall task into a number of steps. These are not all essential and sequential but they are organised in this toolkit as 12 individual steps.

- Steps 1 to 7: Planning
- Steps 8 to 10: Deciding on what data to collect
- Steps 11 and 12: Write up and dissemination

The toolkit provides pointers to help services plan an approach that will work for them and gives case study examples drawing on current practices in the UK. There are also lots of guides and resources for evaluation online; links are provided to some of these in Appendix 2.

**The 12 step approach is outlined in detail on pages 9 to 31. In summary it covers:**

<b>Step 1</b>	Aims and objectives: Identifying what the service aims to achieve and how.
<b>Step 2</b>	Who to involve in the planning process: Which stakeholders, including external advisors, does the service need to help plan the evaluation?
<b>Step 3</b>	Data collection: What data could be collected?
<b>Step 4</b>	Available resources: Which, and how many, resources does the service have available to commit to the evaluation?
<b>Step 5</b>	Who does the evaluation: Will the evaluation take place in house or be commissioned externally?
<b>Step 6</b>	Aligning service delivery and evaluation. Planning how to efficiently integrate evaluation activities alongside the workings of service delivery
<b>Step 7</b>	Ethical considerations: Thoroughly reviewing all aspects of the evaluation plan to ensure good governance
<b>Step 8</b>	Monitoring and client feedback: Components of a basic evaluation
<b>Step 9</b>	Measuring outcomes: The outcome tools used by current suicide bereavement services
<b>Step 10</b>	Theory of Change: Developing a model to explain service inputs, outputs and outcomes.
<b>Step 11</b>	Understanding findings and write up: Making sense of the information collected and drawing conclusions based upon this data.
<b>Step 12</b>	Making the most of what you have learnt: Creating a dissemination plan for both internal and external audiences.

There are different ways of approaching an evaluation but shared principles are always followed:

- **Systematic inquiry:** Carefully planned, with robust systems in place for data collection, storage and analysis
- **Carried out with integrity and honesty:** People carrying out the evaluation must be competent and trained
- **Respectful to people:** The safety and security of clients is critical, including respecting their right to privacy and protecting them from harm

Public Health England's resource *Local suicide prevention planning* (2016) gives the following advice on evaluation based on the World Health Organization guidance.

- **Don't reinvent the wheel. Be consistent and use established approaches where they exist. For example, use standard questionnaires to measure wellbeing, if one of the service's aims/objectives is to improve wellbeing.**
- **Don't be afraid of finding that an aspect of your service has no or low impact, as lessons can still be learned, especially if the evaluation is carried out well.**
- **Don't feel you need to work alone. Approach your local university to explore setting up an evaluation partnership. Universities may be able to provide guidance on developing a high quality evaluation, involving clinical academics who bridge the gap between practice and research.**

As recommended by Dr Ellen Townsend,  
Associate Professor and Director of the Self-Harm  
Research Group, University of Nottingham

If you are a publically funded service you will have a duty to address the health inequalities gap and evaluation is one mechanism for evidencing you are doing that.

*The Health and Social Care Act 2012 introduced the first specific legal duties on health inequalities, including duties on the Secretary of State for Health. All staff undertaking NHS and public health functions on behalf of the Secretary of State are responsible for ensuring compliance with these duties.*

This toolkit has organised the stages of an evaluation into 12 steps however they do not have to all be covered, nor approached sequentially. Instead new or established services need to consider which steps, and their ordering, will best meet their needs.

Three evaluation stages are also used to structure the toolkit:

- Level 1 – evaluation – the basics
- Level 2 – measuring outcomes
- Level 3 – building a Theory of change

It is recommended that all services start with Level 1.



**Step 1:**

# Setting the service aims and objectives

“We want to be able to prove how effective and efficient we are in delivering the service.”



Suicide bereavement support provider

The first step for a successful evaluation of a new service is to set out the aims and objectives, or in an existing service, to clarify the stated aims and objectives.

A suicide bereavement service's aims are often separated into one overall aim and several specific sub-aims.

The **overall aim** describes in broad terms what the service wants to achieve, in terms of benefits or changes for the clients accessing support.

The **specific** aims tend to be more detailed but will link to the overall aim.

The **objectives** are the planned activities designed to bring about the benefits or changes.

An example is provided below:

### Overall aim:

To enable people who have been bereaved by suicide to improve their resilience, functioning and wellbeing

### Specific aims:

To enable people who have been bereaved by suicide to:

- Understand their grief
- Develop coping strategies
- Feel safe to explore their thoughts and feelings

### Objectives:

To offer telephone support and signposting

To offer one-to-one support in the person's home

To offer grief education through closed groups

The aims and objectives for a service might be specified by the funder as part of the commissioning process, or they might be developed by trustees of a charity or senior management in an NHS Trust. The process of developing these might involve a wide stakeholder group (see also Step 2). What is important is making sure the aims and objectives are developed and communicated appropriately. It is important that staff and volunteers know what they are trying to achieve and that clients know how a service might benefit them.

It is also important to recognise that an organisation can have aims and objectives, as well as individual projects. For example an organisation might be concerned with health inequalities among the local population and responses to those bereaved by suicide. This is where it is important to outline whether an evaluation is covering all activities delivered by an organisation, or a set of defined activities within one or a number of projects or services.



“We want to know how well we've supported people, that's always a question.”



Suicide prevention charity

**Step 2:**

## The people to involve in the planning process

“ If our service is user-led, that’s great, but if our evaluation isn’t...it’s really making sure that the people who have been bereaved by suicide are at the heart of the planning of the evaluation... it’s really right that people who’ve been touched by this are shaping up the evaluation. ”

Suicide prevention charity

In developing an evaluation plan, services are encouraged to think about which stakeholders to involve in the process. The more involved people feel, the more successful the process is likely to be. This is particularly important for those whose will be impacted by an evaluation such as frontline staff or volunteers and people using services.

If an organisation lacks evaluation expertise, bringing in people who can help to plan and provide advice is recommended. Look for people to volunteer their expertise or specifically recruit and resource them to support evaluation activities such as through local universities or colleges. Ask other suicide bereavement services if they can lend you expertise.

For suicide bereavement services, stakeholders may include people using services (also known as clients), relatives and carers, funders, staff and volunteers, committee members and trustees, managers and advisors. They could be involved at all stages in the process, for example:

- Deciding what data could be collected, and how - data collection tools should be piloted with clients or potential users of a service before deciding which tools to use
- Developing materials to explain the purpose of the evaluation to help clients understand why they are being asked to take part
- Planning when to ask clients for feedback and how to preserve confidentiality

By co-producing an evaluation plan, stakeholders will be better prepared for its introduction, will understand the purpose and can help shape how it is delivered. Their skills and resources will add value to the process.

**Step 3:**

## The data to be collected

“ The quantitative data is often what funders are interested in and it’s easier to make comparisons from that point of view as well, to compare what we do in the different areas. The qualitative data gives more of a richness and puts it into context. ”

Suicide bereavement support provider

An evaluation will usually collect two main types of data – numbers (for example the number of sessions held per year) and words (for example service clients' opinions on how helpful they found the service). Numerical data are referred to as ‘quantitative data’ and data in the form of words are referred to as ‘qualitative data’. The box below outlines the different domains of data that are relevant to suicide bereavement services.

### What information is of most interest to suicide bereavement services?

Data domain	Examples
<b>Service level operational data: overall</b>	Number of calls to a helpline, number of people attending a group session, number of visits to a service's website
<b>Service level operational data: individual</b>	For each client: Types of support received from the service, length of contact with the service, source of referral, support also received from other services
<b>Demographic data</b>	Age, gender, ethnicity, place of residence, relationship to the person who has died, length of time since the death
<b>Client experience</b>	Feedback on how useful the service has been: What was good about the service, what could be improved? Would they recommend the service to others?
<b>Outcome measurement</b>	Using a standardised assessment tool or tools to measure whether there have been any changes for people using the service

Most evaluation designs use questionnaires as the basis of data collection, asking people to provide self-report responses or answer questions from the evaluator. This toolkit focuses on this approach; however, it is important to note that data can be collected in many different ways. Other study designs may include longer interviews, or the use of creative methods like photography, film, drama, personal artefacts, drawing and art work to help people express how they feel. Creative methods can be especially helpful when working with children and young people, people with low literacy, people whose first language is not English, or anyone who might prefer to express themselves in ways other than spoken or written word.

In the planning process, thinking about how much data to collect and how is important. This toolkit explores three approaches to data collection in Steps 9, 10 and 11. These are summarised below.

All suicide bereavement services should develop a framework for 'Level 1' evaluation which focuses on collecting monitoring information and client feedback. The decision to carry out more extensive evaluation 'Level 2' by collecting outcomes data or 'Level 3' by building a theory of change will depend in part on the available resources and expertise, which are covered in Steps 4 and 5. Underlying the decision-making regarding what data to collect services usually have three fundamental questions:

- Is what I am delivering helpful and useful?
- Are we reaching everyone who needs our services?
- Are there health inequalities in access and provision to address?

Deciding what questions to ask is a vital step in any evaluation. Sometimes there are a great many questions of interest, but these must be reduced in number by prioritising and piloting.

### Three approaches to data collection

<b>Level 1:</b> Evaluation – the basics	<b>Level 2:</b> Measuring outcomes	<b>Level 3:</b> Building a Theory of Change
What every service must do to understand progress being made: Monitoring information and client feedback.	What every service would benefit from doing: Collecting data on individual outcomes	What every service could produce with evaluation data: Describing inputs, outputs and outcomes

**Step 4:**

## The resources available

“ First you need to be quite clear about what you want to look at, what you want to measure, and why. And then you need to get the balance between what you might want and what is feasible within that service. ”

Suicide bereavement support provider

What data is collected, and by whom, will depend in part upon available resources. All evaluation requires adequate resource. Poorly executed, under resourced evaluation projects can negatively impact on staff morale, impact on how clients may benefit from the service, and fail to produce the evidence they intended to.

An evaluation *will* need:

- Staff or volunteer time to manage the process

An evaluation *may* need:

- To cover printing and postage costs if materials are sent out
- A licence for a survey hosting website if on-line forms are used
- To cover training costs for staff
- To cover consultancy fees for expert advisors if recruited
- To cover clients' participation vouchers, travel costs and refreshments
- To update IT facilities
- To produce printed reports or website updates for dissemination
- Budget to pay external evaluators if the evaluation is outsourced

If a service is putting together a tender for a new contract or is making the case to a trustee board or management group to cover evaluation costs, the desirable budget allocation is 5-10% of service delivery costs. Thus, if the service costs are budgeted at £30,000, £1,500 to £3,000 should be set aside for evaluation.

**Step 5:**

## Who does the evaluation

“ The key is, getting the right person... it has to be someone who can work with this group with a sensitivity and an understanding of vulnerability and needs. ”

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Researcher

Evaluation needs to be delivered by skilled and specifically trained evaluators. There are three main options available to suicide bereavement services:

- Internal or in-house delivery
- External delivery by a commissioned evaluation team or individual
- A combination of internal data collection and external oversight

Both internal and external models have advantages and disadvantages, which are summarised below. One key resource issue is cost, and achieving value for money from the evaluation.

### The benefits and limitations of external and internal evaluation

**Benefits of internal delivery:**

- Manage in-house, keeping control over decision making
- Can be cheaper, integrate evaluation into an existing role
- Relationship with clients established, so might be easier for people to take part
- Sensitive to needs of client group, have high level of understanding of issues faced

**Limitations of internal delivery:**

- Lack of capacity to undertake evaluation
- Lack appropriate skills in staff team
- Negative impact on relationship with client
- Clients not feeling able to give full and frank feedback to members of staff
- Staff may lack objectivity as they are close to service delivery, maybe uncritical of model and approach

**Benefits of external delivery:**

- Quality independent review achieved, providing critical feedback and space to reflect on potential for change
- Gives credibility to your findings because it is an external body delivering the work
- Adds value to the organisation by introducing different methods, tools and approaches that had not previously been available or fully understood

**Limitations of external delivery:**

- Can be expensive unless in kind support is provided
- Must be well commissioned; poorly managed processes can lead to complaints from clients and do not provide the learning a service requires to understand change in outcomes
- Impact on staff time is not eliminated; type of data collection still needs to be decided on, and the evaluation partner needs to be managed and supported

**Delivering evaluation in-house**

When the evaluation is delivered in-house it is essential to ensure that the people responsible for delivering the evaluation have sufficient time allocated for these tasks. Having robust systems in place for data collection and storage will help to ensure that the evaluation is successful. Training staff to deliver the evaluation in-house might include training in using IT systems and data entry, as well as training in using data collection tools and analysis. Writing into job descriptions the specific requirements of a post covering evaluation activities is recommended.

Another important consideration is the requirement for research integrity. This is sometimes explained as objectivity and the removal of bias from an evaluation. In-house evaluations must work hard to ensure evaluation systems are transparent, so that an external person could come in and follow the data and understand how conclusions were reached. In-house evaluation teams should actively reflect on their role within the research process. Robust evaluations must report both positive and negative findings, and in-house teams may find it hard to deliver challenging recommendations to colleagues or governance bodies.

**Working with an external evaluator**

If suicide bereavement services proceed with an external commission, there are a few things to bear in mind to make sure you get what you need and that your staff and clients are fully supportive of the evaluation and how it is run. Services will need to provide some input into how the evaluation is undertaken. It can be helpful to start these conversations early and before the evaluation begins. Services will also need to discuss how the evaluation will be undertaken, and whether all or some of the data will be collected by service staff or the evaluators alone. Usually, it will be a combination of the two.

There tend to be three routes to commissioning evaluation expertise. Some of these options are limited by cost and usually this process is reserved for evaluations with a budget of £10,000 or more.

- Universities can offer help with evaluations, particularly where budgets are larger
- A number of charities, social firms and small businesses offer evaluation services
- There are many independent consultants operating in this sector



**Step 6:**

## How to integrate evaluation within service delivery

“ I think a lot of it does come from the way that managers kind of introduce evaluation, the way they help practitioners to understand that this isn't just something that's been imposed by funders but is something that can help them to reflect on their practice and improve it. ”

Suicide bereavement support provider

Services must think carefully about how the evaluation will be carried out alongside the service's day-to-day activities. This is so that staff and volunteers can get fully behind evaluation activities, promoting them and/or being part of the team delivering them.

It is important that data collection is not too heavy on people using services, and does not detract from the actual support they are receiving. A key aspect is to ensure that the data collection process is not onerous or time consuming for staff or clients. A few things to consider include:

- How much data will be collected? Depending on the service aims, basic monitoring information might be enough
- What training do staff and volunteers require in data collection and data storage to ensure high quality information is captured and processed? Making data collection activities part of job descriptions helps to integrate evaluation into routine service delivery
- When will clients and/or staff be asked for information? Deciding on the timing for collecting data is important, ensuring that it is sensitive to people's needs and distress, yet is still systematic
- How long will it take for clients to complete a questionnaire or interview? Piloting data collection tools helps services estimate how long their processes will take so people are informed, and processes can be modified as required

- How will feedback be provided? It is important to consider how information will be shared with the clients who have participated, to staff and volunteers, and to funders and other relevant partners as part of strategy and service development planning conversations. The feedback loop is a central element of the evaluation cycle

Integrating data collection within service delivery is crucial; it can and should form part of the core business of providing support. In this way evaluation should be fully integrated into tasks and responsibilities with appropriate resources allocated. In addition, evaluation processes should be reviewed regularly and changes made based upon the feedback gathered from clients, staff, advisors or funders.



**Step 7:**

## The ethical considerations

“ It has to be done at the right time and it can't be too complicated, because people's concentration isn't there. If you have a form with loads of tick boxes or loads of things someone's got to answer, it's actually ineffective with someone who's been bereaved because your head can be all over the place. ”

Suicide bereavement support provider

One of the fundamental principles of evaluation is that it is respectful of the people involved. In particular, evaluation must be carried out in accordance with the ethical principles of informed consent, confidentiality and minimisation of the risk of harm.

Suicide bereavement services work with vulnerable people, and should therefore already have safeguarding and data protection procedures in place, as well as information sharing protocols or agreements where data is shared between agencies. Further guidance on information sharing protocols are available in the PHE guidance: *Local suicide prevention planning*. These should be integral to the evaluation as well as the service model.

Before carrying out an evaluation, an internal body within the organisation may need to scrutinise the evaluation plans. Occasionally, it may also be necessary to apply for ethics approval from an external body. To find out more about when you might need to apply for NHS ethics approval, please see the Health Research Authority website: [www.hra.nhs.uk](http://www.hra.nhs.uk)

### Informed consent

All clients in an evaluation should be fully informed about:

- What they will be asked to do
- How the information they give will be used
- How confidentiality and anonymity will be protected
- Any limits to confidentiality

They should also be informed that participation is voluntary, that they do not have to take part and if they do consent, can withdraw that consent at any time without having to give a reason. They should also understand that refusal to take part in evaluation activities will not affect their access to services and support in any way. It should also be explained that they are free to give negative as well as positive feedback, and that finding out what has not worked is as important as finding out what has worked well.

It is particularly important to ensure that children and young people, or other vulnerable groups, understand what they are being asked to do and that they are giving their informed consent. This might mean that the information is given verbally rather than requiring them to read an information sheet, and that there is plenty of time allowed for them to ask questions. For children under the age of 16, consent from a parent or guardian must be gained before they participate in evaluation activities. In some cases this can be aged under 18 – check local procedures.

### **Confidentiality and anonymity**

Respecting people's privacy means ensuring all data is stored and reported in a way that protects anonymity and confidentiality (unless consent is provided to waiver anonymity). This includes not using real names and not sharing or publishing details that will identify the client or others. In some cases, it might include disguising the geographical location or other details about the service. Services should also be clear about how to protect confidentiality and anonymity when data are returned by post or email, for example only using client IDs on postal questionnaires and ensuring that all emails are encrypted.

Where there are limits to confidentiality (for example, if someone reveals the intention to cause serious harm to themselves or others), clients should be informed of this, and also informed of what procedures will be followed when breaking confidentiality. In particular, it is important to remember that people who have been bereaved by suicide are themselves at higher risk of suicide, and this is something that might become apparent in the course of evaluation activities.

There is a consensus statement specifically on information sharing and suicide prevention available at: [https://www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/271792/Consensus\\_statement\\_on\\_information\\_sharing.pdf](https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/271792/Consensus_statement_on_information_sharing.pdf)

### **Minimising risk of harm**

In order to minimise risk of harm, services need to think about how and when to collect data, and what to do if people do become distressed or disclose that they or others are at risk of harm. As well as having support in place, this might include providing contact details of other services and sources of support.

Effective piloting of data collection methods with service users or others with lived experience of bereavement by suicide will help to ensure that questions are worded sensitively and elicit the information needed in a way that is respectful of people's time. Think about when and how to ask for information in order to ensure that data collection does not impact negatively on clients or interfere with the provision of the service.

### **Inclusive practice**

It is important to consider if any adjustments need to be made to the evaluation process in order to take into account any communication difficulties, language barriers or other challenges such as learning or physical disabilities.

**Step 8:**

## Monitoring and client feedback: components of a basic evaluation

Monitoring is a periodically recurring task that allows results, processes and experiences to be documented and used as a basis to steer decision making and learning processes. Monitoring is checking progress against plans and forms part of basic evaluation activities.

At a very minimum, all suicide bereavement services should collect basic monitoring information that includes feedback from clients about their experience. This will ensure a service can demonstrate what it is doing, who it is reaching and what its clients say about their experiences of using the service.

Monitoring information is often expressed as numbers (quantitative data), documenting the outputs of a service using aggregated data over a specific time period for example:

- Number of activities delivered
- Number of hours of coverage provided by a telephone helpline
- Number of leaflets distributed

Monitoring data can include information collected as an indicator of service delivery. An indicator is a 'unit of measure' to judge if an activity or service was successful or not. For example, the number of people who:

- Attended support groups
- Emailed the advice service
- Called the telephone helpline

It is also possible to collect profile information on the clients using services, this might include:

- Number of women, men or people with non-binary identity accessing the service
- Number of referrals made to other services
- Number of goals that clients are working towards

Client feedback is useful as it provides an opportunity for individuals to explain 'in their own words' what a service means to them, how helpful or unhelpful it has been, what can be improved and what they felt worked well for them. It is often collected using both an indicator rating and open ended questions.

## An example of client feedback form for gathering indicator ratings

Please rate your agreement with the following statements:	Strongly agree	Agree	No opinion	Disagree	Strongly disagree
'I felt staff had a good understanding of my situation'					
'I felt staff treated me with dignity and respect'					
'I felt staff listened to me effectively'					
'Overall I felt the support I received helped me come to terms with my loss'					
Please tell us what you found most and least useful about the service we provided to you?					
Please provide us with any feedback on how we can improve our services.					

A monitoring process needs to collect information in a way that is systematic: across the service the same information about the activities and people using them should be collected and stored in the same way. It is not sufficient for staff or volunteers to ask questions only when they feel it is the right moment. In practice, the need for a systematic approach should be combined with the need for sensitivity to clients' circumstances.

It is important to design monitoring forms that only ask for information that is essential: think about what you are going to use the data for, and how it helps you to evaluate your aims before collecting it. It is unethical to collect data you will not use. This is where piloting can be helpful. A suggested template for a monitoring form and client feedback form is provided in Appendix 3, 4 and 5. Case study one outlines how one service approached this task using a mixture of service use data and client feedback.

### How can a service collect data if they don't want to ask for people's names?

It is useful to think about routine data collection in terms of aggregated information about the service and people using the service. All services can count the number of people using an activity and collect basic demographic details such as gender, age and ethnicity at the time of contact, without asking for personal identifying data such as name or date of birth. For example:

A person calls the helpline and is asked, at an appropriate time within the call, to provide some basic information to support the service's monitoring requirements to the funder.

*"I hope you don't mind but I would like to ask you three brief questions to help us keep track of who has used our services. If you would rather not give your name that is fine. Can I ask your gender? Your age category (provide options) and your ethnicity? How you heard about our service? Thank you."*

## The benefits of collecting client personal details

Systems can be put in place for routinely collecting and reporting data without complicated data collection processes or the need to break anonymity promises to clients. However, it is useful to consider the benefits of asking for identifiable information.

The main benefit of linking identifiable pieces of information with client feedback is it allows for more detailed analysis – i.e. to be able to find out if certain groups of people appear to be having a more positive, or more negative, experience of the service. To learn how many individual people have accessed a service, rather than simply the number of contacts, because some people receive support multiple times.

The types of data that allow you to create individual evaluation records for clients are:

- First name and surname
- Pseudonyms
- Initials and date of birth linked to date of first contact
- Post code linked to date of first contact

It is important to think carefully about how different kinds of data are linked, and it is also important to store personal details securely.

## Considerations when working with children and young people

The evaluation should be designed and delivered in a way that is child-friendly. This could involve using audio recordings, or staff reading questions out-loud and using different formats to record answers (e.g. using tablets, stickers or pictorial answers).

It can be helpful to emphasise that children should be honest rather than say what they think parents or staff might like to hear. It may also be useful to involve parents in another task or conversation whilst a child takes part in the evaluation, so that the child can respond openly.

A child may find it hard to concentrate on answering evaluation questions, or they may experience difficult thoughts and feelings. Children may need breaks and the opportunity to express how they are feeling, beyond the structure of the evaluation exercise.

Services may need to have a policy on information sharing, for instance, requests from parents and carers to know their child's answers to questions. They will also need to consider how to respond when self-harm is raised, and how any limits on confidentiality (see Step 7) are explained to the child prior to engaging in the evaluation.

## Case study 1: Why do evaluation?

**Service:** If U Care Share Foundation (IUCSF) is a north east England charity that provides Support After Suicide for people touched by suicide. The service is linked to the County Durham early-alert system whereby IUCSF receive a police notification within 48 hours of a suspected suicide and follow-up contact is then made immediately with those affected by the death who have consented to be contacted. Support is tailored to the individual's needs and may include emotional support, help preparing for and attending the inquest and serious untoward incident/serious case review, liaising with the coroner's office and signposting to services such as psychological therapy. IUCSF work alongside public and third sector providers and a welfare rights officer who has been commissioned by the public health department. IUCSF are also part of the community response team who meet to discuss potential emerging clusters.

**Evaluation and monitoring:** IUCSF have set up various in-house systems as well as being evaluated by Durham County Council. Data collected includes demographic and service use information and client satisfaction and equality and diversity questionnaires. Participants complete before and after scales to assess changes in mood alongside open-ended questions to provide more detail.

**Learning:** IUCSF build a relationship with individuals before giving out questionnaires to complete, making sure that clients know that providing information is voluntary and anonymous.. The questionnaires were tested for appropriateness and sensitivity with volunteers who had also been bereaved by suicide before use with clients. This identified using brief and simple measures focusing on areas such as interactions with others, ability to cope, and feeling hopeful and supported, rather than on happiness or cheerfulness. As a result IUCSF decided not to use WEMWBS (see page 24).

**Other research:** people using IUCSF services have also contributed to research by Dr Sharon McDonnell at the University of Manchester on developing guidance for practitioners to support families bereaved by suicide.

Further information about early-alert systems is available in the PHE resource: Local suicide prevention planning and there is an evaluation of the approach in County Durham at [www.durham.gov.uk/health](http://www.durham.gov.uk/health)





**Step 9:**

## Measuring outcomes

The measurement of outcomes is an important part of evaluation activities. First the outcomes of interest must be identified and secondly a way of measuring them must be found. There can be confusion around evaluation terminology and so the definitions used in this toolkit are provided below as well as in the glossary (see Appendix 1).

**Inputs** – what is needed to provide a service such as staff / volunteer time and skills, an office or staff base, meeting rooms, funding.

**Outputs** - the activities or services provided by the organisation.

**Outcomes** - the changes and benefits resulting from those activities or services, usually for the service users.

**Impact** - the broader or longer term changes for people using the services and the wider community. Impacts are often influenced by multiple factors not just one suicide bereavement service's systems of support.

Although outcomes and impact are different they are often used interchangeably when people talk about evaluation. This toolkit is focused on the outcomes being achieved by a service and not broader impact.

### Identifying outcomes

There are a number of outcomes that suicide bereavement support services are currently seeking to address. The outcome domains that their work addresses includes:

- Wellbeing
- Grief
- Mental health problems such as anxiety and depression
- Self-harm and suicide ideation
- Coping skills

- Hope
- Understanding of suicide and broader mental health awareness

Case study 2 provides an example of how routine data collection, goal setting and outcome assessment has been approached by one organisation – AMPARO.

### Selecting an outcome tool

An important aspect of outcome measurement is ensuring that data is collected at a minimum of two time points, so that change over time can be measured. Choosing an appropriate outcome measure is not easy. There are two main approaches, with advantages and disadvantages to each:

- Using a validated outcome measure that has been published, also called a standardised assessment measure/scale
- Developing a bespoke measure for the evaluation

In summary, standardised assessment measures allow for comparisons between different services and groups of people because they have been created using a well-established set of procedures to ensure that they are valid and reliable. This means that they measure what they intend to, and they make sense to the people completing them, so the data gathered can be trusted – it is robust. Most standardised assessment measures are available online for free or a small licence fee. A bespoke measure, on the other hand, does

not have the scientific credibility of a validated outcomes measure, but, if well designed, can nevertheless provide useful data about a particular service. It may also be more able to capture the nuances of a particular service than a general tool.

Tools are created to be administered either as self-report measures (completed by the client), or through an interview with an evaluator. The first measure is called the baseline and should be assessed as near to the beginning of receiving support as possible. This provides the index against which change – the service outcome – will be tracked for an individual, or as aggregate scores for the whole service population. Follow-up is arranged at specific time points, often upon exit from the service, then 6 months, 12 months and 24 months after discharge. Follow-up may also take place at intervals during service use, especially if this covers an extended time period.

Examples of standardised measures used by suicide bereavement support services include:

- Warwick-Edinburgh Mental Well-Being Scale (WEMWBS)<sup>8</sup>  
<http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>
- 12-item General Health Questionnaire (GHQ-12)<sup>9</sup>  
<http://www.gi-assessment.co.uk/products/general-health-questionnaire/faqs>
- Strengths and Difficulties Questionnaire (SDQ)<sup>10</sup>  
<http://www.sdqinfo.com>

For evaluation purposes, an outcome measure needs to collect data that directly addresses the evaluation questions and ensure the process does not impact negatively on the clients. This is illustrated below in Box 3, using the example of WEMWBS, which is widely used in service evaluation, including by the services featured in case study 2 on page 25 and case study 3 on page 28.

### Pros and cons of a standardised measure: The Warwick-Edinburgh Mental Wellbeing Scale (WEMWBS)<sup>8</sup>

WEMWBS is a scale that is widely used in the evaluation of programmes and services which aim to improve mental wellbeing. It is a validated outcomes measure and freely available. It was designed to measure mental wellbeing rather than mental illness and the items of the scale are positively rather than negatively worded – for example ‘I’ve been feeling useful’ or ‘I’ve been feeling interested in other people’.

The full version contains 14 items, which are measured using a 5 point scale. People are asked to rate their agreement with the statements, reflecting on the previous two weeks. This means that scores can range from 14 to 70 – the UK population average is around 51. The short version contains 7 items. Because the measure assesses wellbeing over a 2 week period, baseline and follow-up must be at least 2 weeks apart. One advantage

of WEMWBS is that it is short and simple in design, and people with mental health problems report positive experiences of using it.

As with all measures there are some drawbacks. While for some, the positive wording of the measure is an advantage, asking people who have been bereaved by suicide to respond to statements such as ‘I’ve been feeling cheerful’ can be experienced as insensitive and lacking understanding and empathy. Suicide bereavement services using WEMWBS sometimes omit items on the scale, focusing on those that emphasise functioning, rather than feelings. However, it is important to remember that this will affect the way in which scores are calculated, and will affect validity of the data.

**For more information on the development of WEMWBS and guidance on how to use it, see: <http://www2.warwick.ac.uk/fac/med/research/platform/wemwbs/>**



## Case study 2: Measuring outcomes

**The service:** AMPARO provide suicide bereavement support to anyone affected by suicide living in Merseyside and Cheshire, regardless of where the suicide occurred. The support provided is both practical and emotional, they also signpost to other services including counselling. Referrals are made by the coroner, and they also accept self-referrals.

**Evaluation:** AMPARO collect routine monitoring information on the number and source of referrals, response time to referrals, the number of needs assessments completed, and demographic information from clients, so that they know who they are reaching. They also report on achievements and lessons learned. Their evaluation approach includes the collection of data using two wellbeing measures: the Warwick-Edinburgh Mental Well-Being Scale (sWEMWBS) and the Well-being Star developed for people with long term conditions. As well as being helpful to clients, allowing them to see how their wellbeing has improved over time, these measures can be used externally to show the difference the service makes. AMPARO find the Wellbeing Star is particularly useful as change is represented visually in a way that can be easily understood and interpreted.

**Building confidence:** One of the biggest challenges for AMPARO in conducting monitoring and evaluation has been supporting staff to collect data from people who are often highly distressed. However,

through building staff confidence with data collection processes and emphasising the importance of data collection, AMPARO have been able to build an extensive evaluation programme that is sensitive to the needs of clients.

**The value of evaluation:** AMPARO have presented their findings to the coroner's office to help them to understand what the service does, and encourage referrals into the service. Every three months, AMPARO has to report their performance against outcome targets to the eight public health departments who together commission the service, in addition to producing a comprehensive annual report.

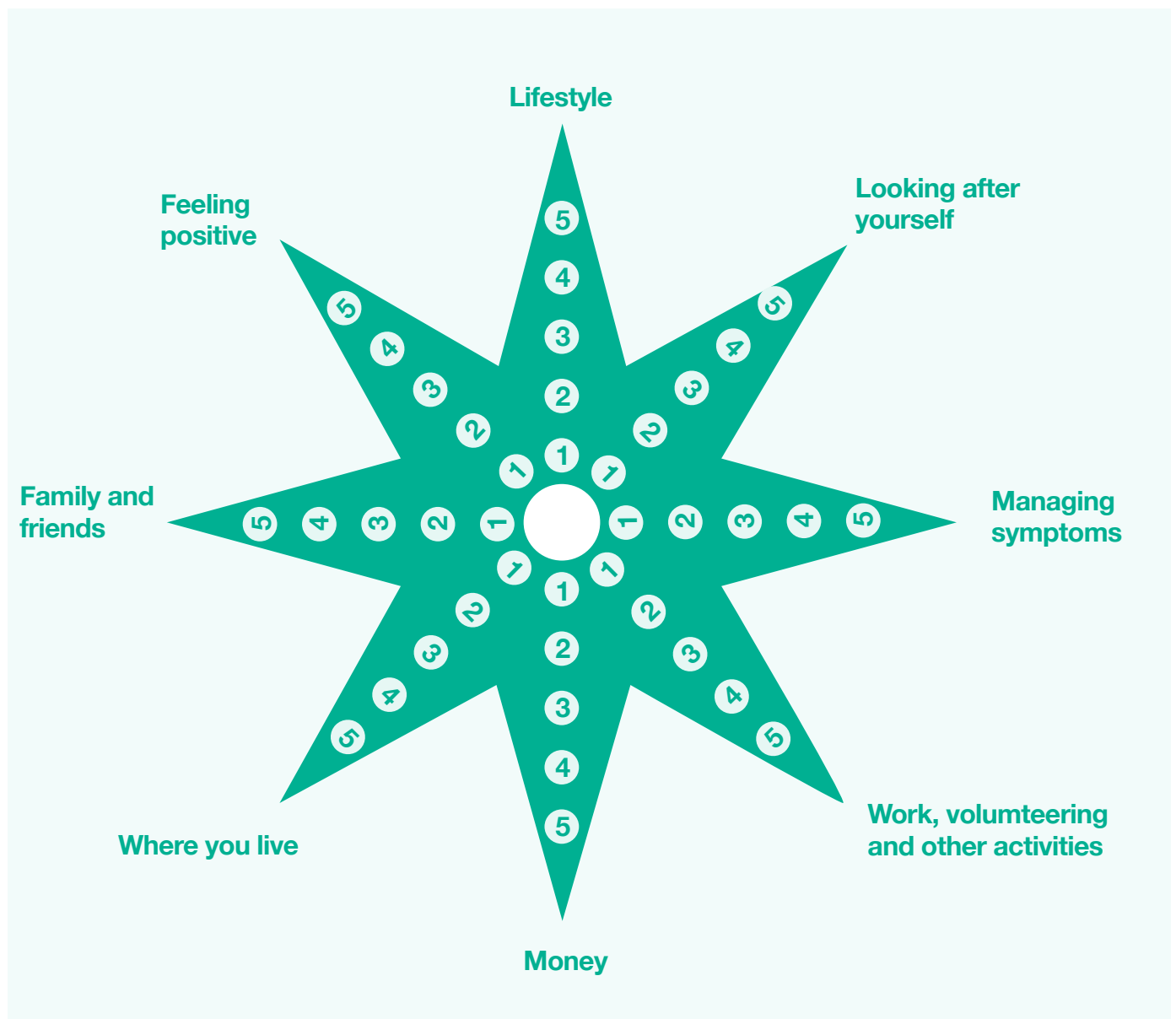
The evaluation process has been essential for demonstrating the service's outcomes and value for money, and for supporting service development. AMPARO believes that the collection of this information will be vital to them attracting funding to support and expand their work in the future.

AMPARO is a project within the Listening Ear charity that provides therapy, support and services to children, young people and adults in Merseyside and Cheshire. <http://listeningearmerseyside.org.uk/amparo/>

**More on the Well-being Star and licence information:** <http://www.outcomesstar.org.uk/well-being-star/>



## The Well-being Star used by the AMPARO suicide bereavement support service



The second approach to outcome measurement is do it yourself (DIY), developing a bespoke tool. This typically occurs when no suitable tool can be found. The disadvantage to this approach is that, as the measure is unique, there will be

no comparison data available to benchmark findings against. However, a tool can start as a bespoke measure, but with development including psychometric testing later emerge as a targeted tool.

**Step 10:**

# Theory of change

A theory of change is very useful for services new and established. For new services it can help to identify the priority outcomes and map out how these might be achieved from the outset. For established services, a theory of change can help to reflect on progress and plan service changes.

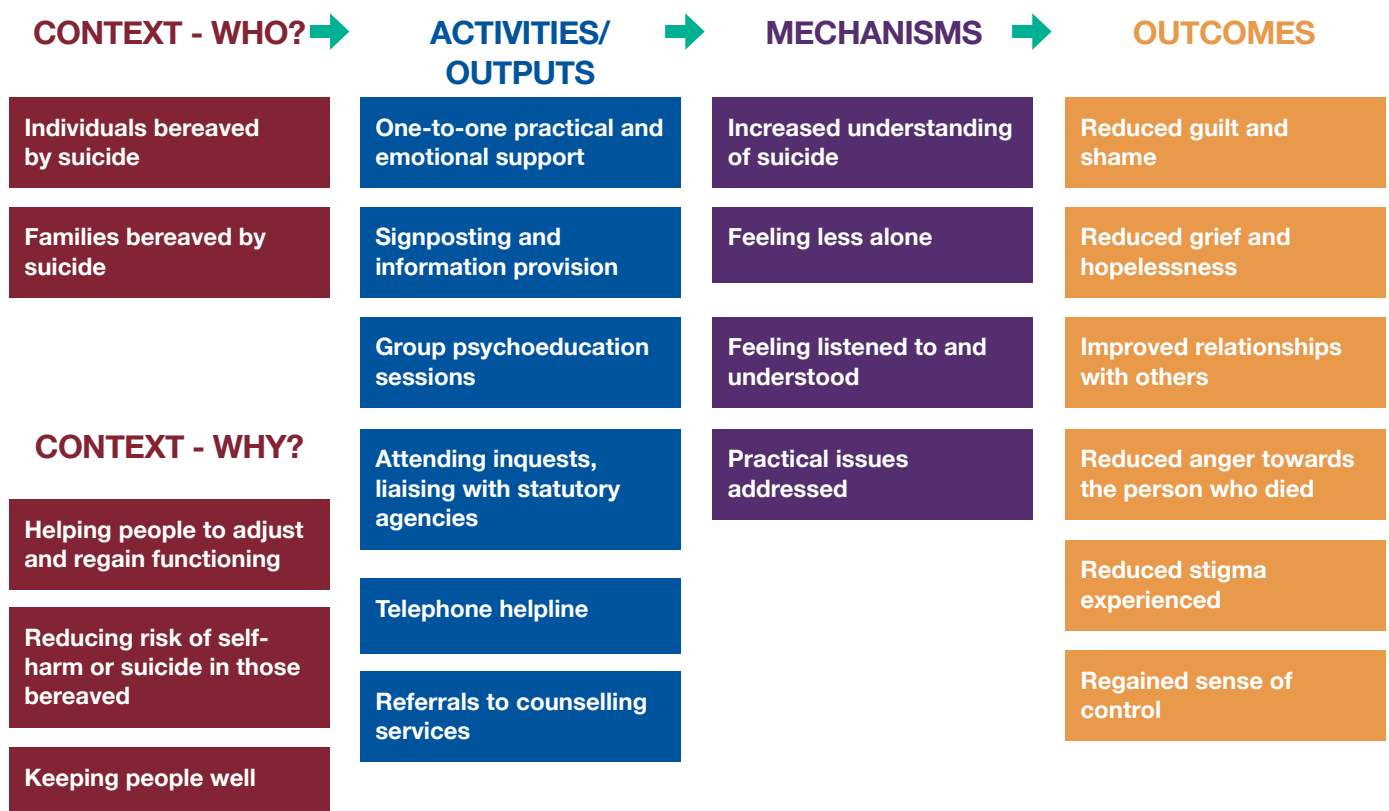
The service (inputs), what a services will provide (outputs), what the service wants to achieve (outcomes divided into intermediate and longer term). It is gaining increased recognition as an approach for evaluation across the health and social care sector. It can be co-produced with staff, clients and funders and it is very helpful in helping others to understand how a service seeks to deliver change.

A theory of change approach, which may also include a logic model as in case study 3 on page 28, helps to map out who a service works with and why (the aims), what resources and skills are needed to provide the service (inputs), what a services will provide (outputs), what the service wants to achieve (outcomes divided into intermediate and longer term).

How can a Theory of Change help a service?

It can:

- Build and maintain a staff and volunteer team who have clarity over the aims of a service, and how outcomes can be achieved
- Provide a clear way to communicate with funders and donors why selected activities are important (and need resource) and how they achieve stated outcomes
- Help to engage with potential clients so they can see what the service might be able to help them with
- Support service reviews and innovation plans to develop the service



## Case study 3: Building a Theory of Change

### Outlook South West

The service was commissioned in 2010 by NHS Kernow CCG to deliver specialist suicide bereavement support to people aged over 18, registered with a GP, in Cornwall and the Isles of Scilly. The service offers monthly suicide liaison home visits to provide emotional and practical support to people until the time of the inquest. This support can include liaising with the police, Coroner, health services and other local services and signposting to specialist support, for instance in the legal and financial sector. In addition, clients are able to attend an eight-week psychoeducation course when six or more months post-bereavement.

**Evaluation:** The service began its evaluation two years ago. It collects demographic and service use data, client satisfaction with suicide liaison support and psychoeducation groups, and measures of client wellbeing before and after the psychoeducation course.

Before beginning the evaluation, the service reviewed a number of potential measurement tools for service satisfaction and wellbeing. The key criteria were that they were simple, brief and suitable for use with those bereaved by suicide. They decided to create their own bespoke measures that included a combination of closed 'tick-box' questions and open questions where people could write freely about their thoughts

and experiences. Using the closed questions has enabled them to get a clear sense about whether the service is delivering what it should, whilst the open questions allow them to find out in more depth about how people are benefitting from the service. An important piece of learning has been to incorporate completion of questionnaires into sessions or where that is not possible, giving people stamped, addressed envelopes, to encourage returns.

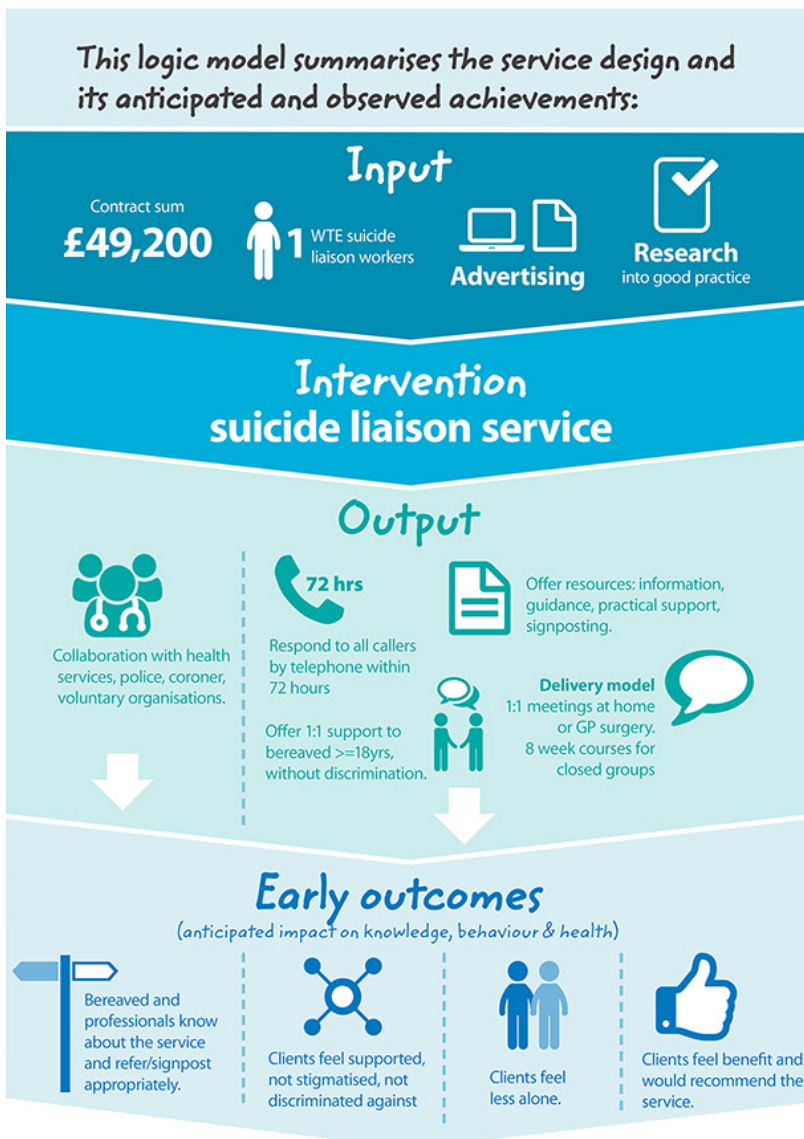
**Findings:** A logic model was used to show the extent to which the inputs and outputs have had an impact on client wellbeing. While there had been some difficulties with referrals and signposting, clients accessing the service felt more supported and less stigmatised or discriminated against; less alone, and would recommend the service.

**Reporting:** The information has to be reported to the commissioners every three months.

outlook:) SOUTH WEST



The logic model used by the Outlook South West suicide bereavement support service



Have the service outcomes been achieved?

<p><b>✗</b></p> <p>Low levels of awareness and referrals/signposting resulting in late referrals. Dissatisfaction with other services.</p> <p>"If I had known about the service sooner, after my daughter killed herself, I would not have gone downhill myself to the same extent."</p> <p>"Other services were not helpful... were useless.... disrespectful.... judgemental"</p> <p>"Bereavement service couldn't answer questions like the liaison service could. They are not trained in suicide and it is a totally different experience from any other death."</p>	<p><b>✓</b></p> <p>But more females than males used the service, by a ratio of nearly 4:1.</p> <p>"Suicide liaison worker was very respectful. We felt much better when she came and had strength from her visits to carry on."</p> <p>"She explained that my feelings were normal."</p>	<p><b>✓</b></p> <p>"This was a massive help to me. You feel you are not alone in this hideous club of 'suicide victim'."</p> <p>"She was my lifeline, the only person I could talk to about my loss who really understood. There was nothing else to compare."</p> <p>"I think it saved my sanity."</p>	<p><b>✓</b></p> <p>"The fact you have a worker with you to the inquest is invaluable."</p> <p>"Cannot thank this service enough. Counselling in home environment then attending support group."</p> <p>"The person who visited me answered all my questions. She helped me to heal up."</p> <p>"I would most definitely recommend the service, though I hope I never have to. Please continue."</p>
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Authors:

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**Step 11:**

## How to understand findings and write up

“An evaluation also gathers information that, if it’s presented in a helpful way, can help families make an informed decision about whether they want to access the service.”

Suicide bereavement support provider

The value of the evaluation rests on robust analysis and careful reporting of the findings. A systematic approach must be taken to both of these activities.

When analysing quantitative data, the things a service will need to think about are:

- Having a clear process for data entry, data storage (including anonymising data) and data cleansing. Data should be checked before it is analysed. It is useful for one person to have responsibility for this task
- Setting up a data entry spreadsheet, for instance using Excel. This can also be used to analyse quantitative information; which can provide totals, percentages and averages. These can be displayed using tables, graphs, or a combination of these

Analysing qualitative data requires a different process:

- Qualitative text collected from questionnaires and feedback forms can also be entered into a spreadsheet. Keeping the quantitative and qualitative information together means it is possible to link responses and ask questions of data, such as, “what do male clients say about their experiences compared to female clients”?
- Qualitative data needs to be analysed using coding, which is a way of organising data into different themes and sub-themes. Text books are a useful resource for learning more about this process for example David Silverman (2013) *Doing Qualitative research* (4th Edition). Sage; London

- When qualitative data is analysed, the data set must be considered as a whole, without cherry picking specific extracts (for example, only using the positive feedback!). It is important to have at least two people involved in coding the qualitative data independently to ensure this is not based on one person’s interpretation (introducing bias). Coders should then discuss how they coded the data and describe the themes. It is important to keep a record of coding and make notes on discussions and decisions made about the codes, so that it is possible to demonstrate how the analysis is based on the data
- When writing up qualitative data findings, it is important to explain how many people the data was collected from, and include a summary of the themes and sub-themes. The themes can be illustrated with quotes from the data. This helps to show the evidence to support the analysis and interpretation

The format for presenting evaluation findings will vary to meet the needs of specific audiences. The basic structure for a full evaluation report might be:

- Background to the service, including aims and objectives
- Evaluation methodology: how was the evaluation carried out, which tools were used, who took part?
- The results of the analysis

**Step 12:**

## How to make the most of what you have learnt

“We’re a pilot so it’s important that we understand what impact the service is having, if any, on the provision of bereavement support, the impact it is having locally with external organisations and obviously the more important thing, what impact it is having with bereaved people.”

Suicide prevention charity

Evaluations must be put to good use on completion. There are different ways that findings can help a service, but primarily it will be to:

- Report back to funders or a donor on what has been achieved using the resources they provided
- Promoting the service to potential new clients, families and the local community, referring bodies or individuals and funders
- Identifying where the service’s strengths are, and where there are areas for improvement, which can form the basis for service development
- Developing a lay summary document or one page poster that can be sent to all the clients who participated in the evaluation and placed on the service website for others to read
- Producing a PowerPoint presentation to deliver to a meeting or conference

The evaluation report can also be very helpful for producing other outputs, which allow findings to be shared with others. For suicide bereavement support services, this will help build the evidence base in this under-researched area, and encourage further evaluation and research. Suggestions include:

- Developing a YouTube video with someone from the service talking about what they have learnt from the evaluation and how they will use the findings – to place on the service website
- Asking the evaluation team or individual to write a blog, summarising key findings and recommendations

When deciding how to present the findings, it is important to consider carefully how commercial and individual confidentiality will be protected. Individuals should not be in any way identifiable, including from the experiences described, unless they have consented to this.

## Planning an evaluation – a check list

Use the table below to write down ideas to help plan your evaluation.

<b>What are the aims and objectives of our service?</b>	
<b>Which stakeholders do we want to involve in planning our evaluation?</b>	
<b>What data do we want to collect?</b>	
<b>What resources do we have for the evaluation?</b>	
<b>Who will carry out the evaluation?</b>	
<b>How can we integrate the evaluation into service delivery?</b>	
<b>What are the ethical considerations and how will we address them?</b>	
<b>What data collection methods are we going to use to collect monitoring data and client feedback?</b>	
<b>Are we going to measure outcomes, and if so, what tools will we use?</b>	
<b>Are we going to develop a Theory of Change, and if so, what data do we need to collect?</b>	
<b>How will we analyse and write up our findings?</b>	
<b>How will we report on and use our findings?</b>	



## References

1. Pitman A, Osborn D, King M, & Erlangsen A. Effects of suicide bereavement on mental health and suicide risk. *The Lancet Psychiatry*. June 2014;1(1):86-94
2. Pitman A, Osborn D, Rantell K & King M. Bereavement by suicide as a risk factor for suicide attempt: a cross-sectional national UK-wide study of 3432 young bereaved adults. *BMJ Open*. 2016 Jan1;6(1)
3. HM Government. Preventing Suicide in England: A cross government strategy to save lives. London: Department of Health; 2012
4. Sanford R, Cerel J, McGann V & Maple M. Suicide loss survivors experiences with therapy: implications for clinical practice. *Community Mental Health Journal*. 2016;52(3):1-8
5. McDaid C, Trowman R, Golder S, Hawton K & Sowden A. interventions for people bereaved through suicide: systematic review. *BJP*. 2008;193:438-443
6. Schut H & Stroebe M. Challenges in evaluating adult bereavement services. *Bereavement Care*. 2011;30(1):5-9
7. Rolls L. Challenges in evaluating childhood bereavement services. *Bereavement Care*. 2011;30(1): 5-9
8. Tennant R, Hiller L, Fishwick R, Platt S, Joseph S, Weich S, et al. The Warwick–Edinburgh mental well-being scale (WEMWBS): development and UK validation. *Health Qual Life Outcomes*. 2007;5:63
9. Goldberg D.P. et al (1997) The validity of two versions of the GHQ in the WHO study of mental illness in general health care. *Psychological Medicine*. 1997 Jan;27(1):191-197
10. Goodman R. The strengths and difficulties questionnaire: A Research Note. *Journal of Child Psychology and Psychiatry*. 1997 Jul;38(5):581-586

## Appendices **Appendix 1: Evaluation glossary**

Research and evaluation activities are a technical undertaking with a language of their own. Below some of the terms we use in this guide are explained.

<b>Aims</b>	The changes or differences that the service is trying to achieve as a result of its work. Aims are often specified as written statements.
<b>Analysis</b>	The process of systematically examining data that has been collected, to determine what it shows about progress towards achieving outcomes.
<b>Anonymity</b>	The principle of storing information so that any references to individuals are removed, and that where data is presented, identifying information about clients is not revealed.
<b>Informed consent</b>	The freely given written or verbal agreement of a clients to take part in an evaluation, with clients being fully informed about the evaluation and what their involvement will be.
<b>Confidentiality</b>	The principle of protecting all information provided by clients, so that it is not shared beyond the service or organisation who has collected the information.
<b>Data</b>	Any information gathered by a service which can be used to monitor progress. It can be in the format of both words or/and numbers, but also visual material such as photos.
<b>Evaluation</b>	The process of using data to assess how a service, project or programme is performing against a set of criteria, and using this information to inform changes and improvements.
<b>Indicator</b>	Information that can be used to judge whether an output or outcome has been achieved.
<b>Inputs</b>	All the resources used by an organisation to deliver the service. Inputs include funding, staff time and skills, equipment and facilities.
<b>Measures</b>	A term used to describe published questionnaires (also known as tools) that assess one or more outcome dimensions such as quality of life or grief, assessing change over time when administered over multiple points in time.

<b>Monitoring</b>	The systematic and routine collecting and recording of information for the purpose of determining a service's progress against its plans, aims and objectives.
<b>Objectives</b>	Written statements specifying the practical steps and activities that the service will take in order to achieve its aims. Objectives should be measurable and time-bound so that it is possible to determine whether they have been met in any given period.
<b>Outputs</b>	All of the specific activities, services or products provided by a service broken down into numbers.
<b>Outcomes</b>	The impact of a service, for example, in terms of attitudes, behaviour, learning or skills, which occurs as a direct result of the service provided. Outcomes do not always involve change, as they could include maintaining a current situation or prevent something from happening. They are measured at more than one point in time to follow progress.
<b>Qualitative data</b>	Information that is collected to provide an account of people's feelings, attitudes and experiences in their own words.
<b>Quantitative data</b>	Information expressed as numbers, originating from measures or counts, or questionnaires where people answers are coded into a numerical format.
<b>Standardised assessment instruments</b>	Tools that have been specifically designed to collect information on a specific outcome domain. They have been rigorously tested and proven to measure for example quality of life or depression or social networks or grief.
<b>Tools</b>	Another term used in evaluation to describe the data collection questionnaires (also known as measures) used to assess an outcome and change over time.

## Appendices

### Appendix 2: Useful links and resources

There are a number of evaluation resources available to download free of charge. Below are some that might be useful in working through the 12 steps in this toolkit.

INVOLVE, the National Institute for Health Research's advisory group to support public involvement in health and social care research has published a comprehensive health and social care research jargon buster for the public:

<http://www.invo.org.uk/resource-centre/jargon-buster/>

*Evaluation Works* is an online toolkit for commissioners of health and care services:

<http://www.nhsevaluationtoolkit.net/what-is-evaluation/>

The Charity Evaluation Service <http://www.ces-vol.org.uk/> provides a number of helpful resources, including the following introductory guides:

<http://www.ces-vol.org.uk/Publications-Research/publications-free-downloads/first-steps-monitoring-evaluation.html>

<http://www.ces-vol.org.uk/Publications-Research/publications-free-downloads/you-project-outcomes-download.html>

The Charity Evaluation Service has also developed a resource on theory of change:

<http://www.ces-vol.org.uk/Publications-Research/publications-free-downloads/making-connections.html>

Save the Children's guide to research and evaluation with children can be found here:

<http://www.savethechildren.org.uk/resources/online-library/children-and-participation-research-monitoring-and-evaluation-children-and>

The Samaritans' Research Ethics Policy gives guidance on the ethics of evaluation and research:

<http://www.samaritans.org/sites/default/files/kcfinder/files/research/Samaritans%20Research%20Ethics%20Policy%202013.pdf>

The WHO have produced guidance on how to evaluate a mental health plan which has useful information about monitoring and evaluation.

[http://www.who.int/mental\\_health/policy/services/14-monitoring%20evaluation\\_HKprinter.pdf](http://www.who.int/mental_health/policy/services/14-monitoring%20evaluation_HKprinter.pdf)

## Appendices

## Appendix 3: Example monitoring form

**Demographic information**

It is important for us to monitor the characteristics of people accessing our services, so that we can make sure that people from different groups are able to access and benefit from our service.

It is your choice whether you complete this form. If you would prefer not to answer any questions, please leave sections blank, or tick 'prefer not to say'. All of the information that you provide will be treated as confidential and stored on a secure database.

**Which age group do you belong to?**

- |                                   |                                  |  |
|-----------------------------------|----------------------------------|--|
| <input type="checkbox"/> Under 18 | <input type="checkbox"/> 36 - 45 | <input type="checkbox"/> 66 - 75           |
| <input type="checkbox"/> 18 - 25  | <input type="checkbox"/> 46 - 55 | <input type="checkbox"/> Over 75           |
| <input type="checkbox"/> 26 - 35  | <input type="checkbox"/> 56 - 65 | <input type="checkbox"/> Prefer not to say |

**How would you describe your ethnic background?**

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> White English/Northern Irish/Scottish/Welsh/British           | <input type="checkbox"/> Black/Black British Caribbean  | <input type="checkbox"/> Arab   |
| <input type="checkbox"/> White Irish   | <input type="checkbox"/> Black/Black British African  | <input type="checkbox"/> Any other ethnic group, please describe<br>_____     |
| <input type="checkbox"/> White Gypsy or Irish Traveller                                | <input type="checkbox"/> Any other Black/African/Caribbean background, please describe<br>_____ | <input type="checkbox"/> Prefer not to say                                    |
| <input type="checkbox"/> Any other White background, please describe<br>_____          | <input type="checkbox"/> Indian/British Indian  | <input type="checkbox"/> Chinese/British Chinese                              |
| <input type="checkbox"/> White and Black Caribbean                                     | <input type="checkbox"/> Pakistani/British Pakistani  | <input type="checkbox"/> Any other Asian background, please describe<br>_____ |
| <input type="checkbox"/> White and Black African                                       | <input type="checkbox"/> Bangladeshi/British Bangladeshi  |   |
| <input type="checkbox"/> Any other Mixed/Multiple background, please describe<br>_____ |   |   |

**How would you describe your gender?**

- Female    Male    Other    Prefer not to say

**How would you describe your sexuality?**

- Heterosexual    Bisexual    Gay/Lesbian    Other    Prefer not to say

**Please give the first half of your home postcode, e.g. RG12** \_\_\_\_\_

## Appendices

## Appendix 4: Example service use form

It would be helpful to us to find out a bit more about your current situation, the support you are receiving and your contact with services.

It is your choice whether you complete this form. If you would prefer not to answer any questions, please leave sections blank, or tick 'prefer not to say'. All of the information that you provide will be treated as confidential and stored on a secure database.

### What was your relationship to the person who died?

### How has it been since the death? Please give the date of death if you are uncertain about the length of time.

### Who referred you to this service?

- |  |  |
|--|--|
| <input type="checkbox"/> Coroner                 | <input type="checkbox"/> Relative or friend        |
| <input type="checkbox"/> Healthcare professional | <input type="checkbox"/> Self                      |
| <input type="checkbox"/> Police                  | <input type="checkbox"/> Other, please state _____ |

### If you referred yourself, how did you find out about the service?

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Our website                         | <input type="checkbox"/> Counselling service | <input type="checkbox"/> Police                    |
| <input type="checkbox"/> Another website, please state _____ | <input type="checkbox"/> Healthcare service  | <input type="checkbox"/> Word of mouth             |
|  | <input type="checkbox"/> Coroner             | <input type="checkbox"/> Other, please state _____ |

### Are you receiving support from any other services at the moment (e.g. GP, mental health team, counsellor)

- Yes  No

### If yes, please can you tell us who is supporting you and briefly state the type of support they are providing?

## Appendices

## Appendix 5: Example service experience questionnaire

We would like to find out about your experiences of our service. The feedback you give will help us to find out whether the support we are providing is helpful, and how we might improve it, so that it better suits the needs of people in similar situations to you.

It is your choice whether you complete this form. If you would prefer not to answer any questions, please leave sections blank, or tick 'prefer not to say'. All of the information that you provide will be treated as confidential and stored on a secure database.

**In the table below, please tick to show how much you agree with the statements, from strongly agree to strongly disagree.**

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree
I feel that I was listened to					
I feel that I could express my thoughts and feelings					
I feel staff had a good understanding of my loss and situation					
I received relevant information to help me understand the role of the service and how they might support me					
I feel that the support I received helped me to move forward					
If someone I knew needed this kind of help, I would suggest they used this service					

**We would also like to hear your thoughts on the following questions. In answering these questions, please avoid giving information that would allow you to be identified.**

What did you like about the service?

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**Appendices**

**Appendix 5: Example service experience Questionnaire**

**What did you think the service could do better?**

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**Has anything changed for you as a result of accessing this service?**

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**Do you have anything else you would like to tell us?**

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**Thank you for taking the time to give your feedback.**



# Acknowledgements

Many people have helped produce this resource and we thank each of them for their careful and thoughtful input. In particular, we are grateful for input from:

Richard Brown, chief executive, Listening Ear/Amparo

Ann Culley, chair, Survivors of Bereavement by Suicide

April Dickens, If U Care Share Foundation

Diogo Duarte, project manager, Facing the Future, Cruse Bereavement Care/Samaritans

Anne Embury, suicide liaison service lead, Outlook South West

Ged Flynn, chief executive, POPYRUS Prevention of Young Suicide

Caroline Harroe, chief executive and founder, Harmless and The Tomorrow Project

Karen Lascelles, suicide prevention lead nurse, Oxford Health NHS Foundation Trust

Sharon McDonnell, director, Suicide Bereavement UK and honorary research fellow, University of Manchester

Alison Penny, co-ordinator, Child Bereavement Network

Suzannah Phillips, clinical services development lead, Winston's Wish

Shirley Smith, founder, If U Care Share Foundation

We also thank members of the Support after Suicide Partnership (SASP) for their advice and support.



[www.nspa.org.uk](http://www.nspa.org.uk)



[www.supportaftersuicide.org.uk](http://www.supportaftersuicide.org.uk)



[www.mcpin.org](http://www.mcpin.org)