Service Specification

Support-after-Suicide Service

EXAMPLE

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1. Introduction

2. Bereavement by suicide

2.1 There is a large body of research on the profound effect a death by suicide can have on families, professionals and communities.[1,2] There is clear evidence that one suicide can trigger a cluster of other suicides, within families and communities.[3,4] Cerel and colleagues (2018) found that each suicide can emotionally affect up to 135 people (Figure 1), who are termed ‘exposed’ to that suicide,[5] although not all of these would be considered bereaved (which tends to be used to connote a closer relationship with the deceased person prior to the suicide and to exclude significantly affected individuals who may have witnessed the suicide death or been involved in a professional context).

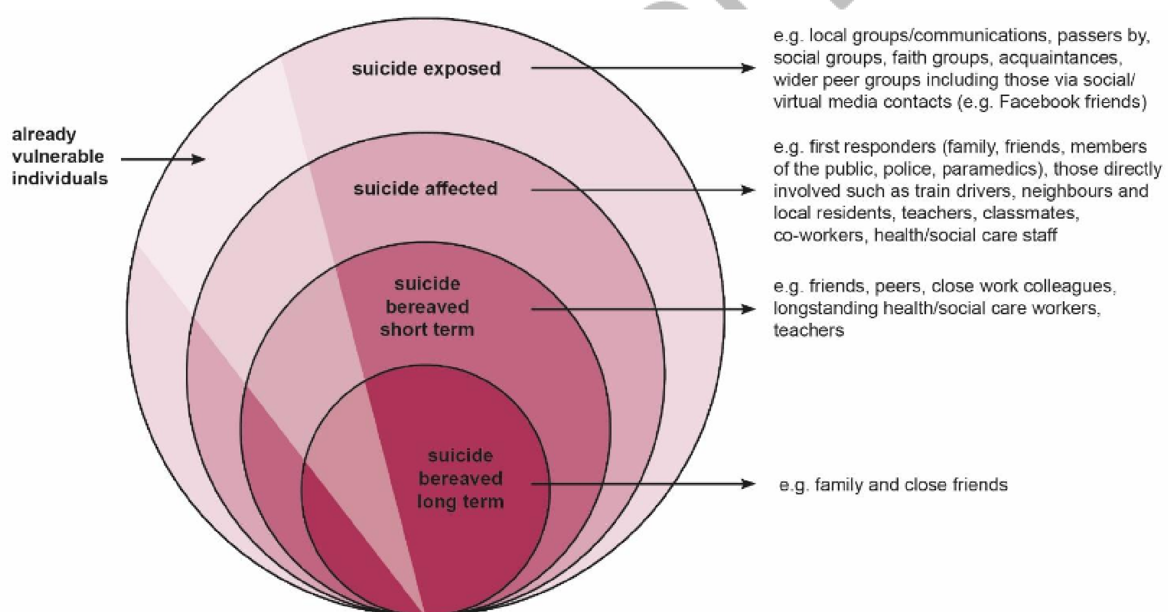

Figure 1: The range of individuals who may be affected by suicide.
Source: [Identifying and responding to suicide clusters: A practice resource. Public Health England. 2019 London, UK.]

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[1] Alexander D A, Klein S, Gray N M, Ian G Dewar I G, John M Eagles J M. Suicide by patients: questionnaire study of its effect on consultant psychiatrists BMJ 2000;320:1571–4
[2] Seguin et al., 2014
[3] McKenzie N1, Keane M 2007. Contribution of imitative suicide to the suicide rate in prisons. Suicide Life Threat Behav. 2007 Oct;37(5):538-42.
[4] Niedzwiedz, C., Haw, C., Hawton, K. and Platt, S. (2014), The Definition and Epidemiology of Clusters of Suicidal Behavior: A Systematic Review. Suicide Life Threat Behav, 44: 569–581. doi:10.1111/sltb.12091
[5] Cerel J, Brown MM, Maple M, Singleton M, van de Venne J, Moore M, Flaherty C. How many people are exposed to suicide? Not six. Suicide and Life-Threatening Behavior. 2018 Mar 7.

2.2 Berman (2011) found after each suicide there were around 60 'survivors', that is people who respondents considered 'intimately and directly affected' by the death; of these, approximately 5 tended to be immediate family members.[6] The 'survivors' social functioning, capacity to work, engage constructively with their communities and contribute economically is significantly diminished.

2.3 If a parent dies by suicide their child is between 3-5 times more likely than the general population to die by suicide.[7] There is clear evidence that people bereaved in this way are more vulnerable to depression, psychiatric admission and suicide when compared with people bereaved by other causes of death.[8]

3. Strategic Drivers

3.1 Suicide prevention policy and guidance in the UK has, in the last decade, developed and expanded considerably (see Table – National developments and guidance).

3.2 The national strategy (2012) outlines two principal objectives: a) Prevention: to reduce the suicide rate in the general population, and, b) Postvention: to provide better support for those bereaved or affected by suicide.

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National developments and guidance

Year	Organisation	Document
2012	Department of Health	Preventing suicide in England: a cross-governmental strategy to save lives.
2015	Public Health England	Suicide prevention: resources and guidance
2016	NHS England	The five year forward view for mental health
2017	Public Health England	Support after a suicide: A guide to providing local services
2017	House of Commons Health Select Committee	Suicide prevention
2018	NICE Guidance	Preventing suicide in community and custodial settings
2018	HM Government	First UK Minister for suicide prevention appointed

[6] Berman, A L. Suicide and Life-Threatening Behavior 41(1) February 2011 Ó 2011 The American Association of Suicidology Estimating the Population of Survivors of Suicide: Seeking an Evidence Base
[7] Geulayov 2014
[8] Pitman A, Osborn DPJ, King MB, Erlangsen A (2014). Effects of suicide bereavement on mental health and suicide risk. Lancet Psychiatry 1(1) 86-94.

2019	NHS England	NHS long-term plan
2019	HM Government	Cross-government suicide prevention workplan
2019	NICE Quality Standard	Quality statement 5: Supporting people bereaved or affected by a suspected suicide
2019	Public Health England	Identifying and responding to suicide clusters: A practice resource.

4. The Local Context

In this section you may want to consider:

- *Local context and need for the service*
- *Any local drivers*
- *Expected/projected uptake*

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5. Aims

5.1 The aim of the service is to support those bereaved by suicide to face the immediate, acute, disorientating and painful experience of the first weeks and months after a suicide. The service also aims to support communities bereaved by suicide in partnership with local agencies and community groups.

5.2 Focus on evaluation, iteration and learning from the interventions. This will be key to ensuring that the service is effective, person-centred and responsive to service users' needs, whilst also contributing to the evidence-base and informing the development of future provision.

6. Specification

6.1 Service Activities / Outputs

6.1.1 There are three elements of this service: individual, group-based and community-based support. Below, we have indicated the types of support that we are looking to be provided. This list is not exhaustive, and we welcome further suggestions and alterations:

Individual support	Essential	Desirable
Pro-active contact and offer of support to those referred and who self-refer	X	
An assessment of need from a qualified person	X	
One-to-one emotional support	X	
Telephone or email support	X	
Provision of verbal and written information including “Help in Hand” leaflet	X	
Support those bereaved to cope with the practical tasks and impacts of bereavement by suicide, such as dealing with the police, funeral arrangements or visiting the place of death as well as accessing legal advice or financial support	X	
Advocacy and liaison support, such as offering to accompany clients at inquests, dealing with the media, advocating for clients by speaking to professionals or statutory agencies on their behalf	X	
Signposting and/or referral on to other emotional support services, such as bereavement counselling, mental health services, GPs, or peer support groups, where appropriate	X	
Longer-term follow-up, e.g. through check-in calls at key dates such as the anniversary of the death, with consent		X
Group-based support		
Facilitating or supporting the setting up of peer support groups, to help ensure that there is capacity to meet demand, and/or referring on to pre-existing peer support groups.		X
Away days or weekends to bring people bereaved by suicide together and assist in their recovery		X
Community-based support		
Remembrance/memorial events.		X
Targeted postvention activities, such as providing tailored support and training for key staff after a suicide in a school or workplace, or actions following recognition of a cluster of suicides in a particular group/area.		X
Community-level activities to support wider suicide prevention objectives, such as suicide awareness or intervention skills training or engagement with the media to reduce stigma and raise awareness.		X

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6.2 Key principles

6.2.1 The principles that underpin the delivery of the service include:

- A flexible approach (such as offering the option of sessions at the person's home and options for contact by telephone/text/email if preferred, as well as in relation to the number type of support or duration of sessions), as people's support needs vary substantially and there is no 'one-size-fits-all' approach.
- Close involvement of people with lived experience of suicide bereavement for example as volunteers, staff and through consultation in relation to service design and development.
- A proactive case-finding and outreach strategy in order to identify those needing support, and multiple points of entry, given the many barriers to accessing support that exist. This should include an awareness of the diversity of those affected by suicide to ensure equality of access for all communities within the locality and provision of a culturally sensitivity service.
- Collaborative relationships and strong networking with key partners from across the statutory and non-statutory sectors locally in the locality and more widely.
- A 'whole community' approach including support to those not only directly affected by suicide but those who have exposed to suicide e.g. neighbours, colleagues, school staff, social groups, and healthcare professionals.

- It is expected that experience from service delivery and evaluation, including service user input, will enable the service to be developed and improved through an action learning-based approach. This will be key to ensuring that the service is effective, person-centred and responsive to service users' needs. This will be particularly relevant in relation to the overall delivery model, staffing levels, the case-finding approach, ensuring that any inequalities in access (e.g. by gender or ethnicity) to the service are identified and addressed, and that the service is adapted to the specific needs of different communities in the locality
- Conforming to guidance developed by the Support After Suicide Partnership[9].

6.3 Inclusion Criteria

- Individuals of any age who are bereaved by suicide (including family, friends, work colleagues, and those with a professional relationship with the person who has died, such as healthcare professionals or first responders). Where those

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[9] https://www.nspa.org.uk/wp-content/uploads/2017/01/NSPA-postvention-framework-20.10.16.pdf
https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/590838/support_after_a_suicide.pdf

bereaved by suicide are under the age of 18, we would expect the service to work with parents and liaise with relevant specialist services to decide upon the most appropriate type and venue for support.

- Residents of XXX who are bereaved by suicide.
- People who work or study within XXX who are bereaved by suicide.
- Those who live outside of XXX but are bereaved due to a suicide death which took place within. We understand that there will be limitations to the type of support that can be delivered to these individuals, however we would expect practical support, for example for those going through the Coroner's in XXX, and telephone support should the individuals so wish.

6.4 Exclusion Criteria

- Individuals requiring emergency or crisis support.
- Should situations arise that may necessitate a change to the inclusion and exclusion criteria, these should be discussed with the commissioners.

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6.5 Staffing

6.5.1 Staff are required to hold relevant qualifications and have access to appropriate training necessary to enable them to deliver the service.

6.5.2 The Provider is expected to involve people with lived experience whether as staff and/or volunteers/peer supporters. Volunteers/peer supporters are expected to receive both training and regular supervision from a suitably qualified professional.

6.5.3 The Provider will ensure appropriate management and case supervision at all levels. Staff must have access to regular psychologically-informed supervision, as well as support.

6.5.4 The Provider will have administrative arrangements with clear lines of accountability and an identified manager with overall responsibility for the service. The Provider will also be required to identify an individual as the point of contact for the Commissioner.

6.6 Location

6.6.1 The Service should be delivered in non-stigmatising, safe and confidential settings which are accessible to all parts of the community. This must include service users' own homes.

6.6.2 The Provider is expected to be creative in identifying and securing space in safe alternative community locations such as places of worship, children's centres and other community venues to improve access.

6.6.3 The Provider may wish to consider having more than one base, given the size of the geographic area of XXX.

6.7 Exit arrangements

6.7.1 The Provider must have a system in place in order to support people as they are exiting the service. This may entail liaison with primary care and other stakeholders and include review and follow-up arrangements, as appropriate.

6.7.2 The Provider will arrange with stakeholders including NHS primary care services to agree upon the most appropriate mechanism of information sharing, for example letters to a GP with a summary of the support offered and current situation.

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6.8 External evaluation

6.8.1 Bidders need to be aware that an academic partner will be undertaking an evaluation of the service. Tenderers will need to agree to work with the academic partner and participate in this study.

7. Outcomes

7.1 We appreciate that suicide bereavement is a complex life-long journey that affects individuals differently. Indicators of the effectiveness of support will be varied, and we expect the service to develop its outcome measures in conjunction with the commissioners and academic partner during the course of the service, and following feedback from service users as to what is helpful. Outcome indicators for those bereaved by suicide may include:

- o Improved mental health and wellbeing
- o Specific issues or risk addressed
- o Reduced isolation
- o Reduced feelings of blame
- o Increased capacity for self-care and acceptance of kindness (by self and others)
- o Grief reaction and emotional response normalised
- o Begin to recover hope
- o Reduction in the experience of stigma
- o Reduction in suicidal thought and self-harm
- o No suicides amongst those bereaved by suicide
- o Helped with regaining a sense of control
- o Increased hope for facing the future and the ability to rebuild a life narrative
- o Facilitated access to resources and to available support

7.2 We expect the service to contribute to the following system outcomes:

- o Over the course of the contract, an increasing number of people bereaved after suicide who are identified, assessed and received bereavement support based on their needs.
- o Growing levels of awareness and referrals over the course of the contract from other services such as the police, NHS, funeral directors, and coroners.
- o Increased awareness of suicide, intervention skills and where to refer amongst frontline staff
- o Development of a postvention pathway

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8. Key Performance Indicators

8.1 Commissioners would like to co-develop with the provider and the external evaluator meaningful ways of measuring the positive impact of the service.

8.2 Providers will be asked to submit a range of suggested key performance indicators (KPIs) (including appropriate measures and frequency of monitoring) based upon the project objectives.

9. Data collection and reporting

9.1 Appropriate reporting systems will be established with the provider as part of the contract mobilisation and following agreement of the KPIs (examples are shown in the Table below).

9.2 The provider will be required to demonstrate their compliance with the 2018 Data Protection Act in their collection and use of data.

Data	**Examples**
Service level operational data	Number of activities delivered, number of telephone calls, number of people who received one-to-one support, number of people attending group support, website use
Operational data for individuals	For each client, types of support received from the service, number of sessions, source of referrals, support received from other organisations, client feedback
Demographics	Age, gender, ethnicity, length of time since bereavement
Client experience	Feedback from clients about the service and their experience
Outcome measurement	Using appropriate and evidence-based tools to demonstrate if there has been any changes for the people who used the service

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10. Social value

10.1 In accordance with the Public Services (Social Value) Act 2012, providers will be required to consider how they will secure improvements in the economic, social and environmental well-being of XXX.