Evaluation of Elements of a Bereavement by Suicide Support Pathway in Lancashire and South Cumbria

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Note of caution to those reading this report

This report includes an evaluation of a suicide bereavement support service, and a training package for professionals, hence the content may be emotive. Please hold this in mind whilst reading the report and get in touch with one of the below organisations if you need support:

Survivors of Bereavement by Suicide (SOBS)

Helpline: 0300 11 5065

Monday and Tuesday 9am-5pm

https://uksobs.org/

Samaritans

Helpline: 116 123 (24 hours)

Email: jo@samaritans.org (24 hours)

https://www.samaritans.org/how-we-can-help/contact-samaritan/

Cruse Bereavement Care

Helpline: 0808 808 1677

Monday to Friday 9.30am-5pm

Varied hours. See website https://www.cruse.org.uk/get-support/helpline/

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Executive lay summary

Background: what did we know already?

Support after suicide, otherwise known as postvention support, is key to the UK Government's national suicide prevention strategy (2012). The findings from the 'Grief to Hope' survey (McDonnell, Hunt et al., 2020) of over 7,000 people bereaved or affected by suicide in the UK led to the development of minimum standards required for suicide bereavement support services, one of which is the need for NHS services and third sector organisations to "collaboratively develop evidence-based postvention pathways that are fit for purpose". Whilst there is no set formula for providing postvention services, it is clear there is a need to provide choice so that all those affected by suicide can access support at different times and in different ways, with support then being tailored to individuals' needs. The full bereavement pathway for Lancashire and South Cumbria therefore incorporates different options for delivering services and support to those bereaved by suicide, all of which must be accessible at any point within someone's grief journey. Evaluating the effectiveness of these services is key to advancing our understanding of the effectiveness of specific parts of the pathway and producing evidence-based recommendations to improve the quality of suicide bereavement support.

Aims: what did want to find out?

This report is an evaluation of two elements of the 'bereavement by suicide support pathway' for individuals in the Lancashire and South Cumbria area. The report includes two studies which originated from pilot projects that were part of the 'Lancashire & South Cumbria Suicide Bereavement Project'. In Study 1 we evaluated the Amparo service which supports individuals bereaved by suicide and wanted to find out whether the service has benefitted those clients who engage with the service in terms of improvements in their emotional wellbeing. In Study 2, we evaluated the Postvention Assisting Those Bereaved By

Suicide (PABBS) suicide bereavement training program which was developed to enhance to professionals' knowledge, skills and confidence in supporting those bereaved by suicide, and wanted to find out whether the training is viewed to be equally as acceptable and effective by different groups of professionals: the armed forces, police officers, hospice staff and staff working in acute hospitals.

Method: what did we do?

In Study 1 (Amparo support service for those bereaved by suicide) 65 clients answered questions about their wellbeing when they first accessed the service, and at a second time point, which in most cases was when they exited the service.

In Study 2 (PABBS bereavement by suicide training for professionals) 61 professionals completed a one-day training course for professionals who support those bereaved by suicide. Professionals rated themselves on knowledge, skill and confidence in responding to suicide, both before and after the training; this allowed us to compare the two sets of scores to see whether professionals' ratings of knowledge, skill and confidence had increased, after the training had taken place. The professionals additionally provided written statements in response to some questions that asked about the appropriateness of the training in terms of content, materials, quality, and impact of the training.

Results: what did we find?

In Study 1 (Amparo support service for those bereaved by suicide) we found that the general wellbeing of clients who have engaged with Amparo shows is low upon entering the service but improved over time and to a level expected within the general population. Also, that around 2/3 of clients who engage improve over time.

In Study 2 (PABBS bereavement by suicide training for professionals) we found that all aspects of the training were viewed as acceptable (i.e., appropriate) by all professionals, and that the training led to improvements in ratings of knowledge, skill, and confidence in responding to those bereaved by suicide. The take-home message is that the PABBS training is acceptable and effective, irrespective of professional group. However, some of the written feedback from professionals shows some differences in how specific aspects of the training were experienced. Specifically, the police and armed forces emphasised the need to adapt the training so that it specifically addresses their unique professional experiences of supporting those bereaved by suicide as part of their job.

Recommendations: what does this mean?

Evaluating the effectiveness of suicide bereavement services is key to advancing our understanding of the effectiveness of specific parts of a full pathway and producing evidence-based recommendations to improve the quality of suicide bereavement support. Both Amparo and PABBS fill an important need in bereavement by suicide support, but both require ongoing evaluation to ensure that we are providing the right support for people at time of significant vulnerability and risk. There are three main recommendations from evaluations of both Amparo and PABBS:

1. Development and implementation of a rigorous evaluation strategy to determine the clinical and cost effectiveness of postvention services, the case of ‘Amparo’.
2. Evidence-based training such as PABBS is embedded within suicide bereavement pathways.
3. L&SC develop and rigorously evaluate the full bereavement pathway aimed at supporting those who are personally and/or professionally bereaved

Background to the Studies

Whilst every bereavement can be painful and upsetting for friends, colleagues and loved ones, a loss by a suspected suicide can be different in many ways, including the number and range of people that the death can affect. According to the World Health Organisation (WHO, 2019, 2021) there are over 700,000 people globally that die by suicide annually and it is the fourth leading cause of death in 15- to 19-year-olds. In England and Wales data from the Office for National Statistics (ONS) shows that there were 5224 suicides in 2020, with 75.1% of the suicides in England and Wales being by males and 77% of global suicides being in low-income countries. According to public health England, it has been estimated that each suicide costs around £1.67 million (Knapp, McDaid & Parsonage, 2011) due both the wider health issues of those bereaved, and the impact on social care and employment networks. This is a figure that has the potential to drop with the support of services.

The personal impact of suicide is far reaching, with research showing that each suicide impacts up to 135 people who knew the person (Cerel et al., 2019). This means that a huge number of individuals may need support following one death. The provision of support can help reduce the risk of poor mental health and subsequent suicides, and simultaneously reduce the economic cost associated with suicide.

According to the NICE guidelines on suicide prevention, children, adolescents and adults are all at an increased risk of suicide themselves following bereavement by suicide. This highlights the importance of having support after suicide, otherwise known as ‘postvention support’. Postvention support is key to the UK Government’s national suicide prevention strategy (2012). There is no set formula for providing postvention services, but it is clear there is a need to provide choice on the pathway of support for a person bereaved by suicide, so that all those affected can access support at different times and in different ways, with support then being tailored to individuals' needs.

Guidance on the design, development and evaluation of postvention services has been published by Public Health England (2020) and the National Suicide Prevention Alliance (2016a, 2016b). The suggested pathway begins immediately after a suicide with the initial contact by the police and coroner, but the full bereavement pathway incorporates different options for delivering services and support to beneficiaries, all of which must be accessible at any point within someone's grief journey. That is, the pathway is not time-limited, and support is available whenever and for as long as is required, in keeping with the individual experience of bereavement; there is not a 'one size fits all' for grieving and grief support. Therefore, it is important that any bereavement pathway incorporates multiple options that are available to the client, as well as a timeline that suits the individual's needs.

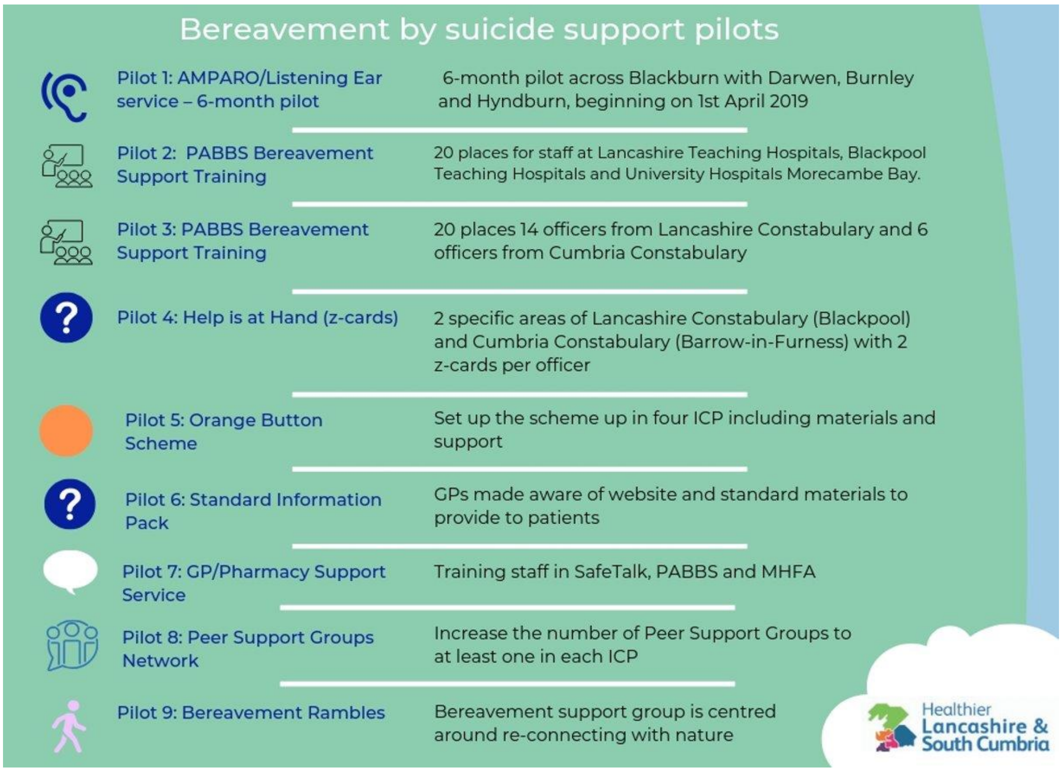
The findings from the 'Grief to Hope' survey (McDonnell, Hunt et al., 2020) of over 7,000 people bereaved or affected by suicide in the UK led to the development of minimum standards required for suicide bereavement support services, one of which is the need for NHS services and third sector organisations to "collaboratively develop evidence-based postvention pathways that are fit for purpose". Evaluating the effectiveness of these services is key to advancing our understanding of the effectiveness of specific parts of the pathway and producing evidence-based recommendations to improve the quality of suicide bereavement support.

The Lancashire and South Cumbria Suicide Bereavement Project

Lancashire and South Cumbria Integrated Care System (L&SC ICS) is a partnership of organisations that share a collective vision of improving health and care services and reducing health inequalities across the region. The partnership covers 14 Local authorities and includes NHS, local authority, public sector organisations such as the police and other emergency services, and voluntary and community organisations. One of the strategic priorities of L&SC ICS is improving the health and wellbeing of our communities via prevention initiatives. Suicide prevention is a key focus with Lancashire County Council alone recording 421 suicides between 2018-20, a figure that must be reduced.

The UK Government's national suicide prevention strategy (2012) and the NHS Long Term Plan and NHS Five Year Forward View set out the objective of reducing suicides in the general population in England by at least 10%, a figure which be achieved only through a cross-government outcomes strategy to save lives (HM Government, 2012, 2017) and nationwide multi-agency partnership working (McDonnell, Hunt et al., 2020). This includes improving support for those bereaved by suicide who are a high-risk group. This is the basis for the 'Lancashire and South Cumbria Bereavement by Suicide' project which was commissioned by NHS England and included nine pilot projects (Figure 1) following a review of the literature and focus groups with stakeholders, including those with professional and/or lived experience of suicide loss. The focus groups resulted in an initial 'gap analysis' of the national, L&SC, and area specific support available from statutory, commissioned and third sector organisations, which led to a total of 82 ideas for improvements to support being proposed before culminating in the 9 pilot projects such as the 'orange button scheme', that is, an orange button that can be worn by all those who have undertaken suicide prevention training as a way of communicating confidence in talking about suicide.

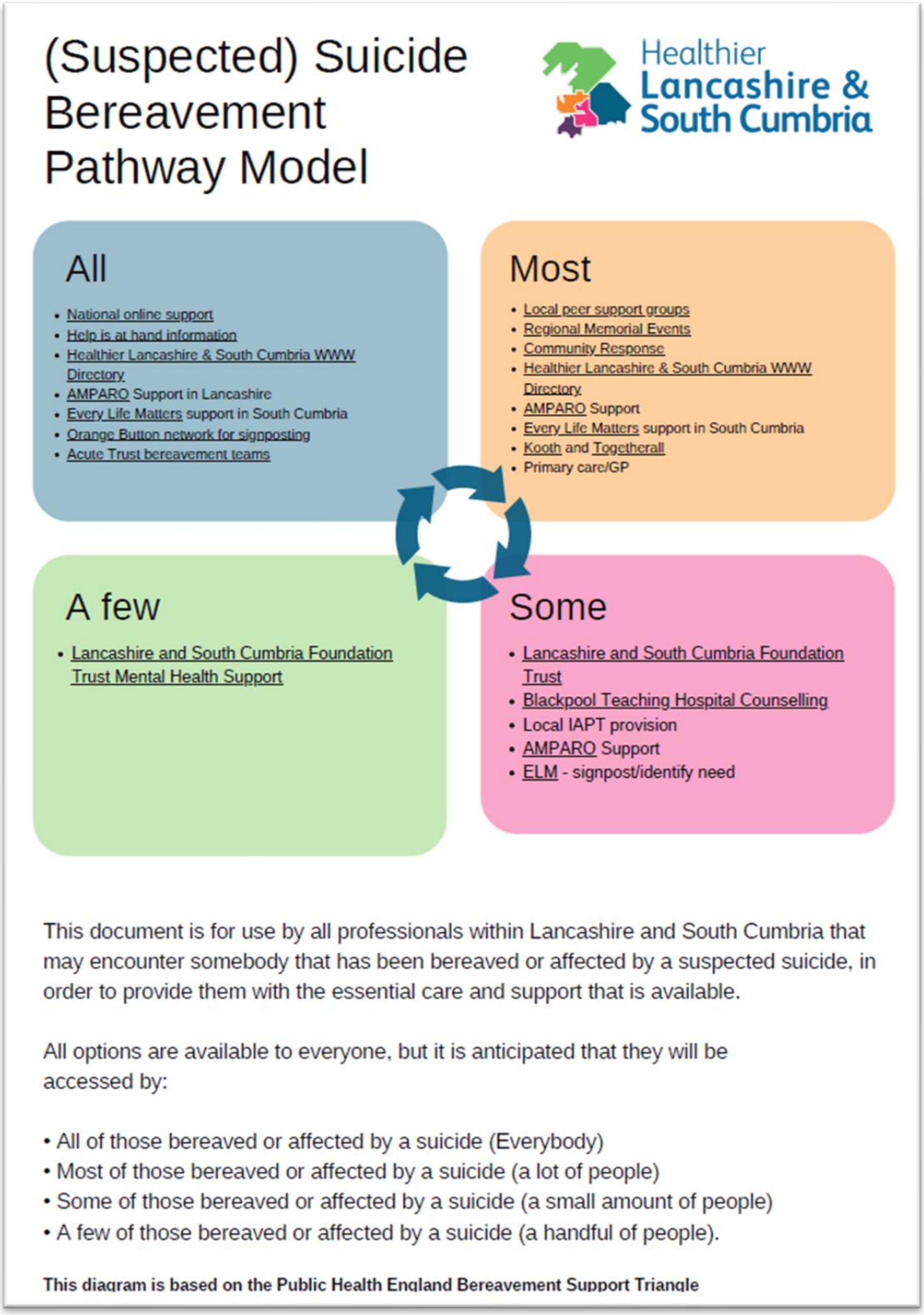
Figure 1: Nine 'bereavement by suicide support pilots' in Lancashire and South Cumbria



Notes: 1) ICP refers to Integrated Care Partnership.

Many of the nine pilot projects were effective and were scaled up to become embedded into the system, which was the beginning of pulling together multiple different elements into a specific Suicide Bereavement Pathway (Figure 2). The pathway is based on the Public Health England (PHE, 2017) suicide bereavement support triangle which gives an understanding of the service requirements from a PHE/NICE perspective. The triangle outlines multiple types of postvention support alongside the providers (e.g., NHS services, local or national partner organisations) and beneficiaries (all, some, or a few of the bereaved) of each type. Both the bereavement triangle and L&SC bereavement pathway acknowledge the individualised and evolving nature of postvention support; there is no single best approach to providing support, and support needs may change over time.

Figure 2: The Lancashire and South Cumbria (Suspected) Suicide Bereavement Pathway to be used by Professionals



The full bereavement pathway for L&SC (Figure 2) incorporates multiple options such as the Amparo bereavement support service, Kooth and local peer support groups, all of which are accessible at any point within someone's grief journey and none of which follow on from a previous form of support. The pathway was initially sent to healthcare professionals for use with anybody they may encounter that has been bereaved through a suspected suicide, but the collective effectiveness of the specific elements of the pathway in benefitting the client population and providing a 'whole systems approach' is not yet known. An evaluation of this magnitude is a significant undertaking, but progress towards this objective can be achieved in part, through evaluating specific elements of the pathway to understand their effectiveness. Pilot 1, the Amparo postvention support service, is a key part of the L&SC bereavement by pathway and is the focus of Study 1 of this report. This is followed by an evaluation of Pilots 2 and 3 which focused on delivering the PABBS bereavement support training. The PABBS training is for individuals/organisations providing support for the bereaved by suicide (e.g., emergency services staff), hence it does not feature in Figure 2 which lists services that are to be accessed by the bereaved. However, key to effective implementation of any postvention pathway is training for professionals to ensure they are equipped with the confidence, knowledge and skills to provide support and care for the bereaved. The need for training was highlighted by professionals and those with lived experience in the L&SC focus group. The PABBS training is to our knowledge, the only evidence-based training that fills this need.

Study 1: Evaluation of the Amparo support service for those bereaved by suicide

AMPARO: Background to the service

AMPARO (meaning ‘shelter’ or ‘refuge’ in Spanish) Lancashire is a free and confidential service commissioned by Healthier Lancashire and South Cumbria. The service provides both practical and emotional support for anyone that has been bereaved by suicide and sits within the ‘Listening Ear’ charity that provides therapy, support and services in Merseyside and Cheshire. Amparo can now be accessed in other areas, including Cheshire and Merseyside, Lancashire, South Yorkshire, Kent and Medway, Coventry and Warwickshire, Thames Valley, Lincolnshire, Southampton, Isle of Wight and Portsmouth. The service is available not just for the family members bereaved by the suicide of a loved one, but anyone who knew the individual and has been affected. People can access support through contacting Amparo themselves at any stage in their bereavement, or via a referral from a professional (e.g., GP, coroner, police officer, funeral director) if they consent to this. Immediately after either the police or coroner suspect that someone has died by suicide, Amparo aims to make contact (with their permission) with those who discovered the suicide within 24 hours of a referral.

Once an individual has agreed to be supported by Amparo, a skilled community-based suicide liaison worker provides one-to-one emotional support by listening to the person’s experiences and providing accessible practical information and advice regarding issues that have arisen due to the suicide bereavement (e.g., dealing with police and coroners, aiding with media enquiries, preparing for and attending inquests, and helping to find other local support that may be required). The workers are mostly qualified counsellors and are trained in providing postvention support. Their skillset includes safeguarding and an ability to conduct risk assessments and draw up safety plans, to support those who express suicidality. Both short and long-term support can be provided by Amparo, depending on individual or family need, and liaison workers can signpost to other emotional or bereavement services for longer-term support.

Throughout the Covid-19 pandemic in 2020/21, the Amparo service moved online, offering video calls and web chats as well an in-person "walk and talk" service and meetings in community venues. The online aspect improved accessibility of the service for a wide variety of people to talk in a way that they feel most comfortable. During 2022 Amparo continued to work remotely, with a view to moving back to home visits for 2023.

To monitor and evaluate the service, Amparo produce quarterly reports which include the number of referrals, source of referrals (e.g., self, police officer, coroner, hospital, University), demographic details of the clients (e.g., age, gender, ethnicity, relationship to the person who has died by suicide), response time to referrals (i.e., whether this was within the required 24 hours), the number of needs assessments and safety plans completed, and services signposted to (e.g., Cruse Bereavement, Survivors of Bereavement by Suicide). In addition, the performance of the service is measured on the following:

1. Alleviating the distress of those exposed to or bereaved by suicide
2. Reducing the risk of imitative suicidal behaviour
3. Reducing the risk of suicide clusters
4. Reducing the economic costs of suicide

In relation to the third objective, the third quarterly report for Amparo Lancashire 2020-21 states that Amparo received a referral for approximately 38% of suicides, yet suicide impacts a much larger number of individuals and communities, hence Amparo aim to reduce the risk of suicide clusters via a ‘Community Response Plan’ which involves providing support to communities.

The fourth objective (reducing the economic costs of suicide) requires a formal evaluation of the cost effectiveness of the service, though in the absence of this, projected savings can be made based on assumptions that the service is reducing the risk of other suicides and the average cost of each suicide is £1.67 million.

Finally, to measure the first and second objectives of alleviating distress and reducing imitative suicidal behaviour in clients, Amparo ask individuals to report whether they felt better after using the Amparo service as part of their ‘service user satisfaction questionnaire’. Amparo Lancashire reports show that clients are happy with the service e.g., the quarterly report from 2020/21 shows that 90% felt better and 10% partially better, and that no beneficiaries of the service have taken their own life. Amparo also gather data on clients’ mental wellbeing using the Short Warwick-Edinburgh Mental Wellbeing Scale (SWEMWBS). The SWEMWBS is administered when the client begins to be supported by Amparo, and then again at a second time point, which is usually upon exiting the service. Data collection at this second time point is not always possible however, because clients often exit the service without warning. As a result, since 2021 data collection is taking place approximately every 4 months, which increases the likelihood of a second SWEMWBS being completed. The quarterly reports show in most cases that wellbeing scores improve over time, but these reports include only a descriptive analysis of change scores on a small number of cases. It is important to statistically compare pre- and post-wellbeing scores to identify whether this change is a meaningful change. A positive ‘change’ in wellbeing would help us understand whether Amparo as a specific element of the bereavement pathway might have benefitted the clients who use the service in terms of improved wellbeing.

Aims

This study aims to evaluate the Amparo suicide bereavement support service which functions as part of the suicide bereavement pathway within Lancashire. We aimed to identify whether clients who engaged with the service improved in wellbeing over time, as a proxy measure of 'alleviated distress'. The specific objectives were:

1) to identify whether clients who used Amparo report statistically significant improvements in standardised wellbeing (SWEMWBS) scores over time, at the group level.
2) To benchmark/statistically compare the mean group wellbeing scores against UK population norms for the SWEMWBS.
3) to identify the proportion of individuals who report significant changes in standardised well-being (SWEMWBS) scores over time.

Method

Participants

Participants were 65 Amparo clients (6 active and 59 closed cases) from Lancashire between June 2019 and June 2022 for which two sets of well-being data were available. This included three upper tier local authorities: Blackpool, Blackburn with Darwen, and Lancashire County Council (Burnley, Chorley, Hyndburn, Lancaster, Pendle, Preston, Ribble Valley, Rossendale, South Ribble, West Lancashire, Wyre and Fylde). Table 1 shows the demographic characteristics of the sample. As shown, the mean age was 45, the majority were female, and all those who reported ethnicity were "white". The full list of Amparo beneficiaries is shown in Table 1, but most clients were the parent (24.6%), child (20.0%), sibling (16.9%) or spouse (13.8%) of the person who had died by suicide. The service supports both children and adults.

Table 1: *Demographic characteristics of Lancashire Amparo clients*

Characteristic	% or Mean (SD)
Age (65/65)	45.14 (17.29)
	(range age 15 to 81)
Gender (64/65)	
Female	72.3
Male	24.6
Non-binary	1.5
No response	1.5
Ethnicity (59/65)	
White British	80
British	3.1
Unknown	1.5
White other	1.5
White	3.1
White Irish	1.5
No response	10.8
Employment status (65/65)	
Other	16.9
Working part time	12.3
Retired	10.8
Universal credit	3.1
Working full time	30.8
Student/pupil	12.3
Absent from work through sickness	6.2
Unemployed	4.6
ESA (Employment Support Allowance)	3
Direct or indirect referral (64/65)[1]	
Direct	92.3
Indirect	6.2
No response	1.5
Age of deceased	43.4 (17.02)

Characteristic	% or Mean (SD)
Gender of deceased (65/65)	
% Female	21.5
% Male	76.9
% Transgender	1.5
Relationship to deceased (65/65)	
Spouse	13.8
Parent	24.6
Partner	9.2
Sibling	16.9
Child	20.0
Other (e.g., finder)	4.6
Friend	7.7
Extended family	3.1
Phone support only requested (% yes) (65/65)	32.3
Pre or post inquest at referral (63/65)	
Pre inquest	55.4
Post inquest	41.5
No response	3.1

Notes. [1] Direct referral is the first referral/person who was referred to Amparo, related to the suicide. Indirect referrals are those persons who were additionally referred once Amparo were already working with the first person.

Materials

The Warwick-Edinburgh Mental Wellbeing Scales short-form (SWEMWBS) is a standardised 7-item self-report questionnaire that is a measure of global mental well-being (rather than mental health/illness). The measure is a freely available, a reliable and valid measure in both non-clinical and clinical samples and used widely as a routine outcome monitoring measure (Fat et al., 2017; Shah et al., 2018; Shah et al., 2021). A 5-point likert scale is used, ranging from 1 (none of the time) to 5 (all of the time). SWEMWBS raw scores are then converted into metric scales using a conversion scale. Scores on the 7 items are then summed to produce a global well-being score that ranges between 7 to 35, suggestive of lower and higher well-being. Cut-off points that are one standard deviation below or above the mean can be used to identify individuals' own level of well-being and any clinically meaningful change in scores over time. Scores in the 7.00 -19.30 range indicate 'low' mental well-being, 20.00 – 27.00 'medium' and 28.10 – 35.00 'high' (Fat et al., 2017). Cronbach's alpha in this sample was .93 for Time 1 and .87 for Time 2, indicating high internal consistency reliability.

Procedure

Amparo clients were asked to complete the SWEMWBS usually during the first session/s with their Amparo liaison worker. Thereafter, clients completed the measure a second time which was usually upon exiting the service. The average number of days between the first and second SWEMWBS administration was 156.35 (SD = 105.94, range = 6 to 518). Questionnaires were administered verbally by the liaison worker, rather than in written form.

For the first objective, we conducted a group-level analysis of the SWEMWBS across two time points. Statistical analysis was performed using SPSS (v28.0). Normality of distribution of SWEMWBS scores was analysed by visually inspecting histograms and skewness and kurtosis statistics. The main analysis was a one-tailed paired samples t-test to analyse changes in mean SWEMWBS scores at time 1 and time 2, with Cohen's effect size d being used to interpret the size of the change (.20 = small, .50 = medium, and .80 = large, Cohen, 1992). Using the parameters of N = 65, p <.05, and an estimated medium effect size of d = .50, post-hoc power calculations using G Power for a two dependent means design returned an estimated power level of .99. To detect a small effect size d of .20, power would be only .48. In sum, the sample size of 65 was sufficient to detect large and medium, but not small effects.

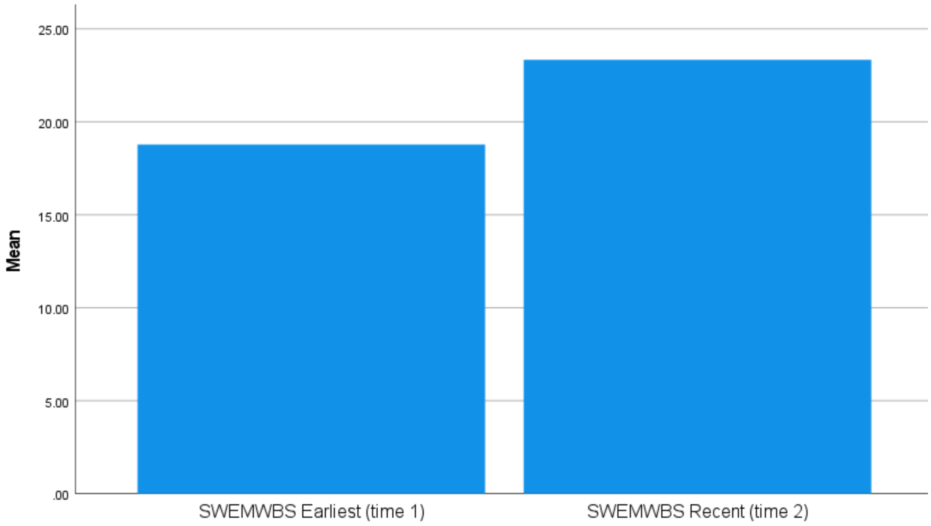
For the second objective SWEMWBS mean and standard deviations were benchmarked against UK population norms (WEMWBS and SWEMBS population norms Health Survey for England 2011) and compared using independent samples t-tests.

To address the third objective we calculated change scores for each individual (Time 2 score – Time 1 score) and then benchmarked these against recommended cut-offs for individual level change. We explored changes at the lowest threshold of 1.03 points (1 Standard Error of the Mean; SEM) and 2.06 points (2 SEM; Maheswaran et al., 2012; Shah et al., 2018).

Results

Time 1 and Time 2 SWEMWBS data were normally distributed with no univariate nor multivariate outliers. A one-tailed paired samples t-test identified that SWEMWBS scores were significantly higher at the second timepoint (M = 23.34, SD = 4.83) compared when people first entered the Amparo service (M =18.78, SD = 3.50): $t(64) = 7.03$, $p<.001$, Cohen's d = .82. Thus, well-being scores significantly improved over time. This change was 'large' by Cohen's standards (Cohen, 1992).

Figure 3: Mean SWEMWBS scores at time 1 and time 2



The two mean SWEMWBS scores were compared against the mean from the SWEMWBS UK population normative data (*M* = 23.6, *SD* = 3.9, N = 27,169; Fat et al., 2016). Independent samples t-tests showed that the Amparo SWEMWBS mean collected at the first time point was significantly lower than the UK SWEMWBS normative mean: $t(27,232) = 9.95$, $p<.001$), whilst the mean for the second time point was statistically comparable: $t(27,232) = .54$, $p = .592$.

Finally, for our individual level analysis, the lower threshold of 1.03 points identified meaningful improvements in 48 (73.8%) of the sample, no change in 9 (13.6%) and meaningful negative change in 8 (12.1%) cases. The threshold of 2.06 points identified meaningful improvements in 43 (65.2%) of the sample, no change in 16 (24.2%) and meaningful negative change in 6 (9.1%) cases.

Discussion

Main Findings

Our analysis of wellbeing scores using the routinely administered SWEMWBS with clients who have engaged with Amparo shows that the general wellbeing of those bereaved by suicide is low upon entering the service but improves over time and to a level expected within the general population. At the individual level, the wellbeing of at least 2/3 of the sample who engaged with the service improved over time, with the remaining individuals either showing no significant change or a worsening of wellbeing.

Strengths and Limitations

A key strength of this study is the longitudinal design and analysis of changes in well-being scores within the same sample of individuals bereaved by suicide in the Lancashire area. We analysed cases with two paired SWEMWBS outcomes with the first administration of the questionnaire occurring when people first begin their support with Amparo, but it is noteworthy that the second outcome was not fixed with regards to *when* the SWEMWBS was re-administered. Rather, the second administration of the SWEMWBS was in most cases upon leaving the service, though the average duration in the service varied from days to almost 1 ½ years, and a small proportion of people were still active beneficiaries who completed the SWEMWBS a second time before they had finished being supported by Amparo. As a result, this second time point is likely to capture individuals at very different stages of their grief and recovery journey, including cases who have disengaged from the service. There is no 'grief timeline' and grief is a very individual and personal experience (Andriessen et al., 2020), but it stands to reason that someone who has very recently experienced a bereavement by suicide has had less time to begin their recovery, compared with someone whose bereavement occurred many years ago and who now feels able to exit the Amparo service. Similarly, cases that close naturally when support is no longer required from Amparo are likely to be qualitatively different in wellbeing to cases that close for other reasons (e.g., disengagement/declining contact from the service), or from active long-term cases who are very much struggling and in need of support. For these reasons alone we are unable to make inferences based on our data about anticipated level of wellbeing at the second time point. Moreover, it is impossible to know the context to any significant improvements or deterioration in well-being for this sample, many of whom may be experiencing ongoing mental health difficulties directly associated with the bereavement (Pitman et al., 2014). It is conceivable that a range of factors contributed to improvements in client wellbeing over time, only one of which, could be the support provided by Amparo. Still, the results suggest that improvements in wellbeing do occur whilst under the care of Amparo, irrespective of context or ‘when’ this time point occurred.

Implications and Recommendations

Recommendation 1: Comprehensive quantitative evaluation of the Amparo service using established standardised measures

Individuals bereaved by suicide are a vulnerable client group and as a result, postvention support is a key government priority. The findings from the ‘Grief to Hope’ survey (McDonnell, Hunt et al., 2020) of over 7,000 people bereaved or affected by suicide in the UK led to the development of minimum standards required for suicide bereavement support services, and this includes an “increased awareness of the complex grief, trauma and adverse behavioural responses associated with suicide bereavement”. We must apply this same logic to the evaluation of suicide postvention services by ensuring that all services are comprehensively evaluated using a range of standardised measures that capture the complexity of grief by suicide, which carries an increased risk of poor mental health and suicide for those bereaved (Andriessen et al., 2020; de Groot & Kollen, 2013; Pitman et al., 2014; Pitman et al., 2016).

Currently, the SWEMWBS is the only standardised outcome measure used to monitor clients and evaluate the impact of the Amparo service, and while useful, our key recommendation is that it is supplemented with other measures that capture suicidality and changes in mental health and social functioning which are not synonymous with wellbeing; this comprehensive approach to assessment will facilitate a rigorous quantitative evaluation of the service.

A key challenge for Amparo is the administration of standardised questionnaires to people experiencing high levels of distress, hence it is important to select measures that are sensitive to the needs of this population, and which are not too lengthy to administer. We recommend that the SWEMWBS is either a) supplemented with a measure such as the General Health Questionnaire 12 (Golberg et al., 1997) which is a global measure of mental health but which can also produces subscale scores of Anxiety and Depression, Social Dysfunction, and Loss of Confidence, or b) replaced with a measure such as the Clinical Outcomes in Routine Evaluation-Outcome Measure (CORE-34; Evans et al., 2002), which is a measure of general psychological distress that also has four separate subscales: subjective wellbeing, problems/symptoms (anxiety and depression), life functioning, and risk/harm (though there is variability in the nature/validity of these subscales across sample types). The CORE-34 is widely used as a pre and post measure in clinical and non-clinical samples and normative data are also available, hence its will provide Amparo with a benchmark level of psychological distress. The conceptualisation of distress is broad enough to capture a range of difficulties within a small number of questions, and includes 'risk to self' questions that are less intrusive than other measures of self-harm and suicide that capture thoughts, behaviours, intentions, frequency and severity etc. Alternatively, the Ask Suicide-Screening Questions (ASQ; Horowitz, 2012) is a psychometrically sound brief screen for suicidal thoughts and can be used to monitor change in suicidality whilst using the Amparo service. Given the highly vulnerable nature of this client group and the embedding of Amparo within the suicide prevention pathway, those providing support have a duty of care to ask about suicide. Qualified staff must be risk assessment trained so they can ask the question in a clear and direct manner, and the ASQ could be used to begin to focus a difficult conversation. It is important however, to understand the limits to screening measures of suicidal thoughts and behaviours. Studies have concluded that they should not be used to predict suicide risk (Chan et al., 2016; a single negative response to the ASQ questions does not preclude suicidal intent which can quickly fluctuate), hence NICE have in place a "Do Not Recommendation" for the "use of risk assessment tools and scales to predict future suicide or repetition of self-harm" (NICE, 2022).

We also recommend administering a generic measure of health-related quality of life, specifically the EQ-5D-5L instrument (Herdman et al., 2011), to facilitate a formal evaluation of the cost effectiveness of the Amparo service. The EQ-5D-5L includes five subscales of mobility, usual activities, self-care, pain/discomfort and anxiety/depression, and therefore overlaps somewhat with the CORE-34. It is not possible to administer a shorter version of the EQ-5D-5L, but a reduced CORE-10 instrument (Barkham et al., 2012) is available and its use would help to reduce overlap with the EQ-5D-5L, albeit at the expense of being able to use separate subdomains of mental health distress that are provided by the longer CORE-34. Another option is to use the short Patient Health Questionnaire (PHQ-9; Kroenke et al., 2001) and Generalised Anxiety Disorder (GAD-7; Spitzer et al. 2006) questionnaire, which capture specific aspects of mental health. Cost effectiveness can then be modelled through incorporating published data on suicide epidemiology and the health care and societal costs of suicide. There is evidence to suggest that each suicide might affect up to 135 people (Cerel et al., 2018), many of whom need clinical services or support following exposure to suicide, Moreover, those bereaved by suicide are 65% more likely to attempt suicide themselves. The average cost of each suicide is £1.67 million, and if an area-wide Amparo service were to achieve only a modest 1% reduction rate in suicides, in most scenarios this remains highly cost-effective. For example, if Lancashire alone had a reported 169 suspected suicides, a 1% reduction in this region alone equates to saving 1 life at a cost of £1.67 million, or 2 lives at £3.37 million.

We have summarised a list of potential measures in Table 2 and suggested four alternative questionnaire packages that could more comprehensively and appropriately quantify the impact of the service. In sum, we recommend that the EQ-5D-5L must be administered to facilitate the economic evaluation of AMPARO, and this measure must sit alongside other outcome measure that capture the constructs of interest, and which extend beyond well-being. In all packages, the EQ-5D-5L is administered. In questionnaire package 1, general well-being is assessed within the CORE-34 and hence the SWEMWBS is redundant and not required. In packages 2 and 3, the SWEMWBS is included alongside either the CORE-10 or GHQ-12, neither of which include a separate well-being domain. In package 4 we illustrate the inclusion of a suicidality questionnaire alongside other core outcome measures, to capture changes in suicidal thinking.

Irrespective of the package, services should routinely administer the measures every three months, until the client exists the service. In addition, the date at which the measures are administered must also be noted alongside information about client engagement with the service, such as the number and frequency of sessions with the suicide liaison worker in between each measurement point. It would then be possible to identify whether mean duration of service engagement is associated with changes across the outcome measures over time. In the longer term, we recommend: 1) ongoing evaluation of a bespoke postvention impact questionnaire package to ensure the service is effectively monitoring clients, and 2) evaluation of these measures across the full Amparo footprint as it continues to be rolled out across the UK.

Finally, since Amparo accepts referrals from both adults and young people, this will need due consideration when designing the evaluation. Some questionnaires may use language or ask questions that are not appropriate for young people, but this can be remedied with the use of age-appropriate measures. For example, the CORE-10 has a youth version that has been adapted for use with 10–16 year-olds (Twigg et al., 2009).

Recommendation 2: Qualitative evaluation of client experience

We did not analyse any qualitative data in this study since these data were not available. Amparo currently administers a 'service user satisfaction' questionnaire but completion rates are low, particularly during the Covid-19 pandemic when letters were not sent to closed cases and text messages were sent instead. To remedy this, Amparo developed an online satisfaction questionnaire, though completion rates remained low with very few clients completing the questionnaire. It is important therefore, that mechanisms are embedded to allow service user feedback to be collected on a continual basis i.e., before cases close. In addition, it is important to ensure that the 'right' mix of questions are asked to capture whether the service is meeting its objectives i.e., ensuring "that accessible information and timely support is available to all those bereaved or exposed to a (suspected) suicide in order to minimise the emotional impact, promote recovery and reduce further suicides" (Amparo Lancashire quarter 1 report, 2020/21). Questions might therefore enquire about clients' experience of the service, and of the emotional and practical support provided by the Amparo liaison workers. It is important to understand whether clients perceive workers to have the right skillset and competencies to provide postvention support, so this feedback can be used to increase engagement with the service from the large number who currently do not access Amparo. Responses to the right questions would essentially allow Amparo to understand whether people are being offered the right type and level of support needed, as stipulated by Public Health England. This would go some way to ensuring that Amparo support is a 'co-produced pathway' by highlighting what specialist Bereavement Support should look like.

Recommendation 3: Ongoing service monitoring of client engagement and risk of disengagement/drop-out

We found that 2/3 of the sample who engaged with the service improved in wellbeing over time, whilst the remaining clients either did not change, or worsened. The current data captured by Amparo do not enable us to identify why some clients did not improve or worsened, but a key consideration is whether 'less well' clients disengaged from the service. Disengagement comes in different forms and can include psychological disengagement, such as emotionally distancing themselves or lessening their involvement with the liaison worker; or physical disengagement by dropping out of the service. Decades of research in the psychotherapy field has shown that the determinants of disengagement from treatment are wide ranging and include client and environmental factors, as well as the client's perceived need for the service (Babitsch et al., 2012; Sharf et al., 2019; Swift & Greenberg, 2014). Disengagement from services can also serve a protective function, allowing the individual to avoid overwhelming and uncomfortable emotions and painful discussions (Frankel & Levvitt, 2009), which is especially relevant to this population given the emotional trauma following the suicide and the potential for social withdrawal and discomfort/stigma over the death (Azoirina et al., 2019). Ultimately, even clients who remain in the service may feel psychologically disengaged/disconnected to the service, hence they do not improve. These individuals may represent a vulnerable high-risk group and the consequences of disengagement can be significant, leading to a potential reduction in well-being, an increase in mental health distress, and/or further suicides. It is imperative therefore, that Amparo implement measures to monitor client engagement and risk of disengagement/drop-out.

Recommendation 4: Increasing awareness and uptake of the Amparo service

According to the Amparo Lancashire quarterly report for 2020-21, work is underway to increase awareness of Amparo across Lancashire with an anticipated uplift of referrals into the service. With up to 135 people being impacted by every suicide (Cerel et al., 2019), there is a gap between the actual and potential number of Amparo beneficiaries. However, suicide bereavement support is not a ‘one size fits all’, and not all individuals will want nor need to access Amparo. The full list of Amparo beneficiaries is diverse and includes parents, children, siblings, spouses, partners, extended family, and friends, but most clients were in the first four categories with only small numbers of friends accessing the service. The findings of the Grief to Hope report (McDonnell, Hunt et al., 2020) and other research (Pitman, Rantell et al., 2017) highlights the vulnerability of friends and recommends that services ensure they are supporting them. As a small percentage of Amparo beneficiaries are bereaved friends, this suggests the service is reaching the wider range of individuals that have been impacted by suicide. Yet, a key imperative is for Amparo to implement strategies to increase awareness of the service and ultimately the number of friend referrals.

Finally, it is also noteworthy that 41.5% of the sample were only referred to Amparo after inquest, highlighting the need for a collaborative multiagency response that aims to improve the referral pathway so that those who are high risk and potentially feeling suicidal during the early stages of loss are being referred.

Directions for Future Research

The implications of this study may extend to other Amparo services which are embedded within suicide bereavement pathways in other regions, but studies are needed to compare services using reliable and valid standardised measures and newly developed qualitative questions. It is important also to evaluate whether any positive changes in wellbeing and mental health are maintained at follow-up, at specific time points after people exit the service (e.g., 6, 12 and 24 months). These scores can be compared again time 1 baseline when clients enter the service, and at least one or two other measurements taken at intervals whilst in the service.

Conclusion

The Amparo suicide bereavement support service functions as key part of the suicide bereavement pathway within Lancashire and we found that clients who use the service improve in wellbeing over time. However, the current measure is only a proxy of ‘alleviated distress’ and other factors may have contributed to changes in client wellbeing. An immediate priority for Amparo is to design and implement a rigorous evaluation of the service, which includes comparison with other postvention services.

Table 2: Summary of routine outcome measures and alternative questionnaire packages that can be used to evaluate the Amparo service with adults

	SWEMWBS	CORE-34	CORE-10	GHQ-12	PHQ-9	GAD-7	EQ-5D-5L	ASQ
Number of questions	7	34	10	12	9	7	25	4
Global construct measured	Well-being	Psychological distress/mental health	Psychological distress/mental health	Psychological distress/mental health	Depression	Anxiety	Health-related quality of life	Suicidal thoughts
Subdomains	-	Four: 1) well-being, 2) anxiety and depression, 3) life functioning, 4) risk/harm	-	Three: 1) anxiety and depression, 2) social dysfunction, 3) loss of confidence			Five: 1) mobility, 2) usual activities, 3) self-care, 4) pain/discomfort, 5) anxiety/depression	-
Strengths	Brief to administer and normative data available	Assesses multiple constructs relevant to Amparo clients (well-being, mental health and suicide risk/self-harm)	Brief to administer and fewer sensitive questions than the CORE-34, but still includes one risk item	Brief to administer and includes subdomains that extend beyond anxiety and depression (two common mental health complaints)	Brief to administer and a robust set of 9 items to assess depression. Also includes a ‘risk to self’ item	Brief to administer and a robust set of 7 items to assess anxiety	Can also be used for economic modelling i.e., to calculate cost effectiveness of the Amparo service	Brief to administer but assesses suicidality which is a key priority in this population
Potential drawbacks	Insufficient for service evaluation	Longer measure and subdomain structure varies	No subdomain scores and hence only	No risk items included	Includes ‘risk to self’ questions so		Clients may feel that some questions are not	Needs skilled professionals to sensitively ask

	SWEMWBS	CORE-34	CORE-10	GHQ-12	PHQ-9	GAD-7	EQ-5D-5L	ASQ
	when administered alone	across studies. Includes more sensitive questions so requires skilled professionally to sensitively ask these questions	assesses overall psychological distress		requires skilled professionally to sensitively ask these questions		relevant (e.g., mobility), but this can be addressed by training staff to appropriately administer the questionnaire	these questions (if administered face-to-face)
Questionnaire package 1		x					x	
Questionnaire package 2	x		x				x	
Questionnaire package 3	x			x			x	
Questionnaire package 4	x		x				x	x
Questionnaire package 5	x				x	x	x	x

Notes:

1 SWEMWBS = Short Warwick-Edinburgh Mental Well-being Scale; CORE-34 = Clinical Outcomes in Routine Evaluation-Outcome Measure; CORE-10 = Clinical Outcomes in Routine Evaluation-Outcome Measure 10-item; GHQ-12 = General Health Questionnaire 12-item; EQ-5D-5L = EuroQol five dimensions; ASQ = Ask Suicide-Screening Questions; PHQ-9 = Patient Health Questionnaire 9-item; GAD-7 = Generalised Anxiety Disorder 7-item

2 Other combinations of questionnaires are possible.

3 Age appropriate alternative measures are required when working with young people.

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Study 2: Evaluation of the PABBS Suicide Bereavement Training in Four Groups of Professionals in Lancashire and South Cumbria

Background

The 'Grief to Hope' study (McDonnell, Hunt et al., 2020; McDonnell et al., 2022) recommends suicide bereavement training for frontline staff. Specifically, evidence-based suicide bereavement training should be mandatory for those who provide postvention services, and it should be recommended for government funded services who might encounter those bereaved or affected by suicide (e.g. health and social care, emergency services, prisons, transport/highways agencies and education). Yet, many professionals do not routinely receive such training, a gap that has recently been addressed with the development of The Postvention Assisting Those Bereaved By Suicide (PABBS) suicide bereavement training program. The PABBS training was developed specifically to enhance professionals' knowledge and skills and is the first evidence-based theory-informed postvention training. The training was originally developed for primary care physicians/general practitioners (GPs) and mental health professionals, with the first evaluation study supporting both the acceptability and effectiveness of the training (McDonnell, Nelson et al., 2020). Acceptability is a complex construct that typically captures perceived appropriateness, based on one's cognitive and emotional response to an intervention (Sekhon et al., 2017), or in this case, the PABBS training. In the study by McDonnell and colleagues, acceptability was assessed by enquiring about the utility and value of the training for changing professional practice, with feedback being overwhelmingly positive in relation to both content and delivery. Qualitative feedback provided an additional window into delegates' personal experiences of the training, and one of the key findings was the importance of hearing about the trainers' lived experiences which increased awareness of the impact of bereavement by suicide and provided a foundation for skill-based exercises and making changes to professional practice. Some of the recommended improvements to the training include embedding the experiences and perspectives of diverse professionals and more case studies, highlighting the need for bespoke training that explicitly caters for the needs of professionals.

Regarding the effectiveness of the PABBS training, McDonnell, Nelson et al., (2020) found significant increases in professionals' self-perceived knowledge, skill, and confidence in responding to those bereaved by suicide, after the training was completed. Whilst the study relied on self-report questionnaires to assess self-perceived effectiveness and acceptability, these perceptions are crucial and capture the professionals' personal experience of the training, as well as the potential impact on how professionals may subsequently provide support for those bereaved by suicide as part of a multi-agency approach.

In keeping with the multi-agency approach to providing suicide bereavement support, the PABBS training has now been delivered to a wide variety of professionals, including GPs, mental health professionals, funeral directors, social workers, faith leaders, teachers, prison staff, housing association staff, and military personnel (Suicide Bereavement UK). The first formal evaluation of PABBS found that the training is acceptable and effective to a wide range of clinicians, mental health professionals and frontline staff (e.g., police officers; McDonnell, Nelson et al., 2020), but the study did not separate out the different professionals to facilitate analysis of acceptability and effectiveness in different subgroups. There is a need therefore, to identify whether the training is equally as acceptable and effective in separate professional groups. Indeed, the findings of McDonnell and colleagues already point to the need for bespoke training tailored towards professionals' needs.

Aims

In 2019 LSCFT were the first NHS Trust to develop a suicide prevention strategy that considers the recommendations of the Grief to Hop report regarding the need for bereavement support services to adopt a multi-agency, holistic approach. LSCFT adopted a four-pronged approach with PABBS training being delivered to four professional groups: the armed forces, police officers, hospice staff and those working in acute hospitals. This study aimed to evaluate the PABBS training in these four professional groups. The specific objectives were:

1) to evaluate whether the training was perceived to be effective by all professionals.
2) to evaluate whether the training was perceived to be acceptable to all professionals.
3) to identify whether perceived effectiveness of the training varied across four professional groups.
4) to explore themes around the acceptability of training within this diverse group of individuals from four professional areas.

Method

Participants

The PABBs training was delivered to 61 individuals from four professional groups: police officers (n = 18), armed forces (n = 15), hospice staff (n = 13) and those working in acute hospitals (n = 15). Gender and age were not collected. Table 3 shows the number and % of professionals from each of the four groups and the specific professions within these groups. The majority were response officers (66.7% of police officers), welfare officers (53.3% of the Armed Forces), and bereavement specialists (38.5% of Hospice staff and 60% of Acute Hospital staff).

Table 3: *Specific professions within the four professional groups*

Professional group	**% (Number)**
Police (18)	
Officer	66.7% (12)
Welfare	27.8% (5)
Mental health	5.6% (1)
Armed forces (15)	
Officer	6.7% (1)
Nurse	6.7% (1)
Welfare	53.3% (8)
Soldier	13.3% (2)
Mental health	6.7% (1)
Admin	13.3% (2)
Hospice (13)	
Therapy	30.8% (4)
Bereavement specialists	38.5% (5)
Nurse	15.4% (2)
Non-specifies	15.4% (2)
Acute hospital (15)	
Bereavement specialists	60.0% (9)
Nurse	20.0% (3)
Religion	6.7% (1)
Assistant	6.7% (1)
Mortuary	6.7% (1)

Table 4 shows the number and % of each profession who have been bereaved of affected by suicide, with the majority of all four groups stipulating that they have been affected by suicide in a *professional* capacity, and a larger proportion of police officers reporting they have been both *personally* and *professionally* bereaved by suicide.

Table 4: *Number (%) of each profession who have been bereaved of affected by suicide*

	Number (%) who said 'yes' to being personally bereaved by suicide	**Number (%) who said 'yes' to being affected by suicide in a professional capacity**	**Both personally bereaved and professionally affect by suicide**
Police	64.7% (11/17)	82.4% (14/17)	52.9% (9/17)
Hospice	53.8% (7/13)	84.6% (11/13)	20.0% (3/15)
Acute hospital	28.6% (4/14)	92.9% (13/14)	21.4% (3/14)
Armed forces	21.4% (3/14)	53.3% (8/14)	35.7% (5/14)
Total (all four groups)	43.1% (25/61)	78.0% (46/61)	34.5% (20/58)

% is the valid% i.e., % of cases from that sub-group when missing cases are excluded.

Materials

The PABBS training is a one day highly interactive face-to-face workshop, delivered by two facilitators with extensive knowledge and practical experience of working in the field of suicide prevention and postvention. The training was developed by Dr Sharon McDonnell, who has been personally bereaved by suicide, and her team; it was informed by a three-year study conducted at the University of Manchester and funded by the National Institute for Health Research (NIHR). The study identified the experiences and perceived needs of those bereaved by suicide and health professionals responsible for their care. Findings were translated into PABBS evidence-based training. The aim of PABBS training is to increase the knowledge, skills and confidence of professionals who encounter those bereaved or affected by suicide. The training topics included suicide prevention, attitudes and stigma, suicide and its impact on health professionals, bereavement, suicide bereavement, parents bereaved by suicide, and building resilience and instilling hope (see McDonnell et al., 2020, for description of each topic).

At the start and end of the training delegates anonymously completed the PABBS evaluation questionnaire, which included 29 quantitative questions in total (this is a reduced number of items compared to the original pilot study questionnaire; McDonnell et al., 2020). The questionnaire included 23 Likert items on a 5-point scale from 1 = strongly disagree to 5 = strongly agree, measuring the following: knowledge, skills and confidence (3 pre and 3 post training questions), materials (5 questions), the quality of the training day itself (5 questions), the quality/effectiveness of facilitators (7 questions). Three visual analogue items on a -3 to +3 scale measured understanding, concerns and motivations/intentions to change future practice following the training, and 3 dichotomous yes/no items measured recommendations for future training. Four open-ended questions provide opportunity to capture delegates' experiences in more depth. The questions enquire about the aspects of the course that were most useful, whether delegates are likely to change their practice as a result of the training, the two most important things that have been learned from the training, and whether there are any further comments.

Analytic strategy

To evaluate whether the training was perceived to be effective by all delegates (objective 1) we followed McDonnell et al., (2020) and used McNemar's tests to assess the differences in proportions of participants reporting adequate knowledge, skill and confidence both pre and post training.

To evaluate whether the training was perceived to be acceptable to all delegates (objective 2), we used descriptive statistics to show the % of delegates who found different aspects of the training (materials/content, and training delivery) to be acceptable.

To identify whether perceived effectiveness of the training varied across different professional groups (objective 3) we used three two-way mixed factorial ANOVAs, using ‘professional group’ as a between subjects factor with four groups, and either knowledge, skills and responding as the within subjects factors over the two time points, pre and post training (there is no non-parametric equivalent of this test for use with ordinal data, hence findings should be viewed tentatively). Using the parameters of N = 61, $p < .05$, and an estimated effect size of f = .40, post-hoc power calculations using G Power for a repeated measures within-between interaction design returned high power levels of >.90 for knowledge, skills and responding. The F value was used to interpret the size of the effect (.10 = small, .25 = medium, and .40 = large, Cohen, 1992). When a medium estimated effect size f of .25 was used, post-hoc power was .68/69 for knowledge and responding, and .79 for skills. In sum, the sample size of 61 was sufficient to detect large and potentially medium, but not small effects.

Fisher’s LSD tests were planned to probe any significant main effects of professional group. This test is less stringent than Tukey’s which controls for Type I error, and therefore more sensitive to detecting effects in small samples and particularly when using relatively crude 5-point Likert scales. Independent samples t-tests were planned should any simple effects analyses be required to probe a significant interaction effect.

Finally, to explore qualitative themes around the acceptability of training within this diverse group of individuals from four professional areas (objective 4), we used inductive content analysis (Hsieh & Shannon, 2005) which allowed us to explore the frequency of themes across participants and then infer meaning from the themes. We counted the number of times a theme occurred across all the 61 delegates, hence the maximum number of times a theme could occur is 61. We conducted this analysis across the whole sample rather than separately in each professional group, since the former facilitates a richer analysis through comparison (agreements/disagreements) across the different groups. Data were coded and themes were extracted by the first author who was experienced in qualitative data analysis, and the third author who was Research Assistant supporting the project. The final themes were translated into a Table showing the number of participants who mentioned a theme, along with a narrative account.

Results

The perceived effectiveness of training

Table 5 shows the results of the McNemar's tests of the perceived effectiveness of PABBS training (knowledge, skills, and confidence) pre and post training. There were significant differences in the proportion of participants reporting changes in knowledge, skills and confidence in responding, following the training, as described below.

Knowledge

Of those who felt they did *not* have sufficient knowledge before training, 100% said it increased after training. Of those who felt they had sufficient knowledge before training, 100% still felt it had increased after training

Skills

Of those who felt they did *not* have sufficient skill before training, 100% said it increased after training. Of those who felt they had sufficient skills before training, 95% still felt it had increased after training.

Confidence

Of those who felt they did *not* have sufficient confidence before training, 100% said it increased after training. Of those who felt they had sufficient confidence before training, 93% still felt it had increased after training.

Table 5: *Perceived effectiveness of PABBS training (knowledge, skills, and confidence) pre/post training*

		Increased Knowledge after training?[d]			McNemar test chi square statistic[g]	Significance
		No	**Yes**	**Totals *n***		
Sufficient knowledge before training?[a]	**No**	0 (0.0%)	36 (100%)	36	-	<.001
	Yes	0 (0.0%)	25 (100%)	25	-	-
	Totals	61	0	61		
		Increased skills after training?[e]				
		No	**Yes**			
Sufficient skills before training?[b]	**No**	0 (0.0%)	40 (100%)	40	.109	<.001
	Yes	1 (4.8%)	20 (95.2%)	21	-	-
	Totals	1	60	61		
		More confident to respond after training?[f]				
		No	**Yes**			
Confident to respond before training?[c]	**No**	0 (0.0%)	34 (100%)	34	.792	<.001
	Yes	2 (7.4%)	25 (92.6%)	27	-	-
	Totals	2	59	61		

Note. [a] My knowledge of suicide bereavement was sufficient for my current role. [b] My skills to support people bereaved by suicide were sufficient for my current role. [c] I felt confident that I could respond effectively to those bereaved by suicide. [d] My knowledge about suicide bereavement has increased after training. [e] My skills to support those bereaved by suicide have improved after training. [f] I will feel more confident responding to those bereaved by suicide. [g]The McNemar statistic was not computed because post training knowledge is a constant. To compute significance, the integer mode of the Crosstabs command was used.

The perceived acceptability of training

Table 6 shows the % of delegates who found different aspects of the training (materials/content, and training delivery) to be acceptable. Virtually all delegates positively rated all aspects of the training and in most cases the response was one of “strongly agree”. This lack of variability in scores suggests little value in exploring the % of acceptability across the separate groups, since all groups are scoring “strongly agree” for most items.

Table 6: *Perceived acceptability of delivery of PABBS training and materials*

	"Strongly agree" or "Agree" (%)	**"Neither agree nor disagree" (%)**	**"Disagree" [1] (%)**
Materials/content			
The materials were informative	100.0%	0.0%	0.0%
The presentation of the materials was of high quality	95.1%	4.9%	0.0%
I am likely to use the practitioner manual in my workplace	91.8%	8.2%	0.0%
I found it helpful to have a separate manual and workbook during the training	86.9%	8.2%	4.9%
The video clips enhance my learning	91.8%	4.9%	3.3%
Was effectively designed	93.5%	6.6%	0.0%
Contained about the right amount of material for the time	88.5%	6.6%	4.9%
Use audio/visual aids effectively	98.4%	1.6%	0.0%
Delivery			
Met my expectations	98.4%	1.6%	0.0%
Was well facilitated	98.4%	1.6%	0.0%
Met the stated objectives	98.4%	1.6%	0.0%
Were well prepared	98.4%	1.6%	0.0%
Were receptive to questions	98.4%	1.6%	0.0%
Stimulated interest in the subject	96.7%	3.3%	0.0%
Gave delegates individual attention	95.0%	3.3%	1.7%
Created a supportive learning environment	98.3%	1.7%	0.0%
Encouraged participation	98.3%	1.7%	0.0%

1 No participant selected "Strongly disagree" for any question

The perceived effectiveness of training across different professional groups

Table 7 shows the results of the three two-way mixed factorial ANOVAs. As shown, in all three ANOVAs there was a significant main effect of the within-subjects factor, with the means post training being significantly higher in either knowledge, skill or confidence in responding compared with pre training. Professional group was a significant between subjects factor in the models for knowledge and confidence but not skill, suggesting significant differences across the groups in both knowledge and confidence, irrespective of the training course. There were no significant interaction effects in any model (Tables 7 and Figures 4-6) suggesting that the training did not differentially impact knowledge, skill and confidence across the four groups.

Table 7: *Three two-way mixed factorial ANOVAs showing the effect of professional group and either knowledge, skill or confidence in responding*

	Df	***F***	***p***	***Partial n^2***
ANOVA 1: Knowledge				
Professional group	3, 57	2.399	.077	.112
Knowledge	1, 57	150.445	**<.001**	.725
Professional group x knowledge	3, 57	.701	.555	.036
ANOVA 2: Skills				
Professional group	3, 57	7.045	**<.001**	.270
Skills	1, 57	123.402	**<.001**	.684
Professional group x skills	3, 157	1.654	.187	.080
ANOVA 3: Confidence in responding				
Professional group	3, 57	6.169	**<.001**	.245
Confidence in responding	1, 57	95.723	**<.001**	.627
Professional group x confidence in responding	3, 57	.799	.499	.040

Figure 4: Knowledge ratings pre and post training by professional group

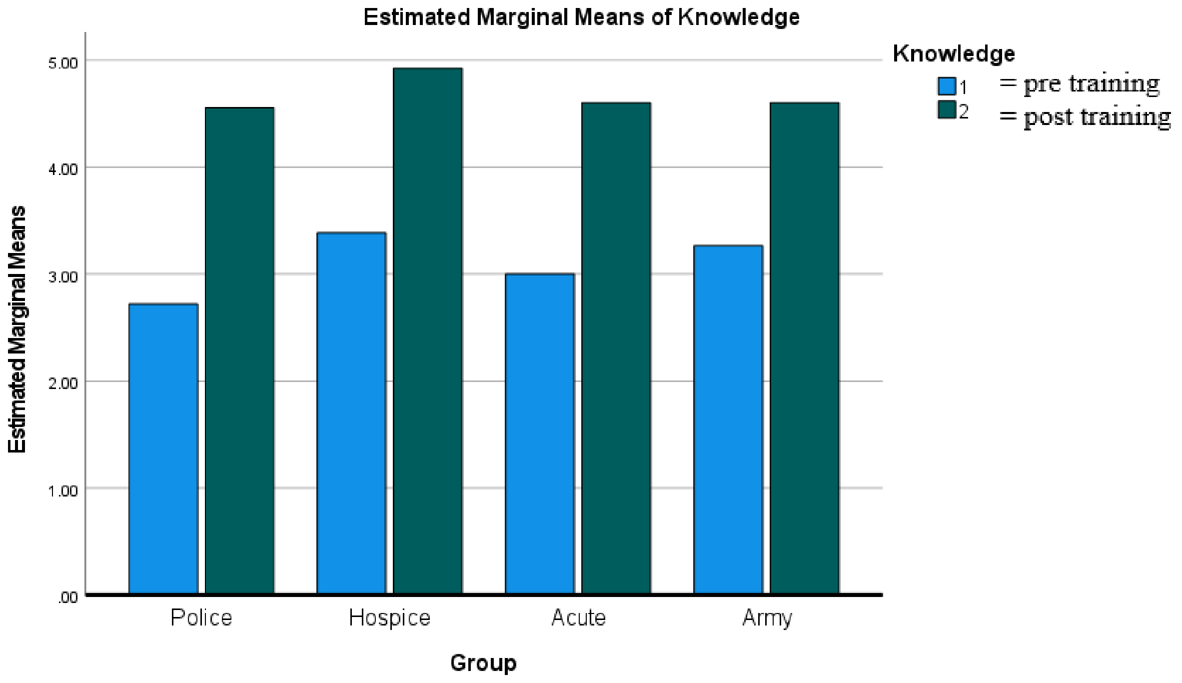


Figure 5: Skills ratings pre and post training by professional group

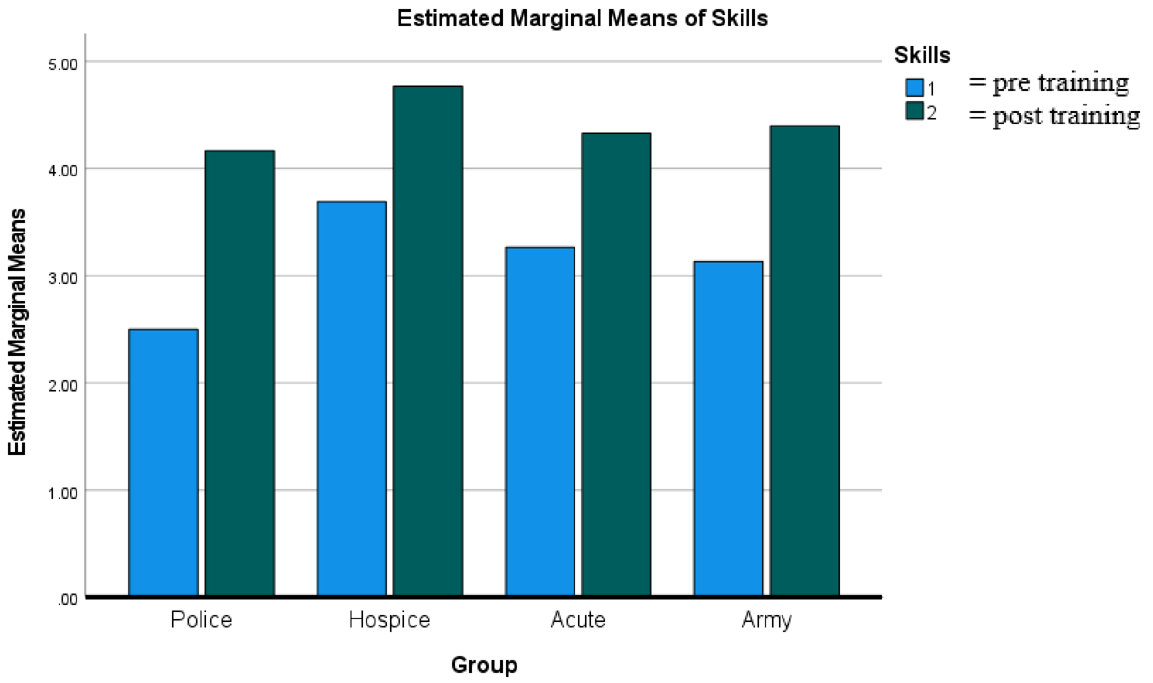
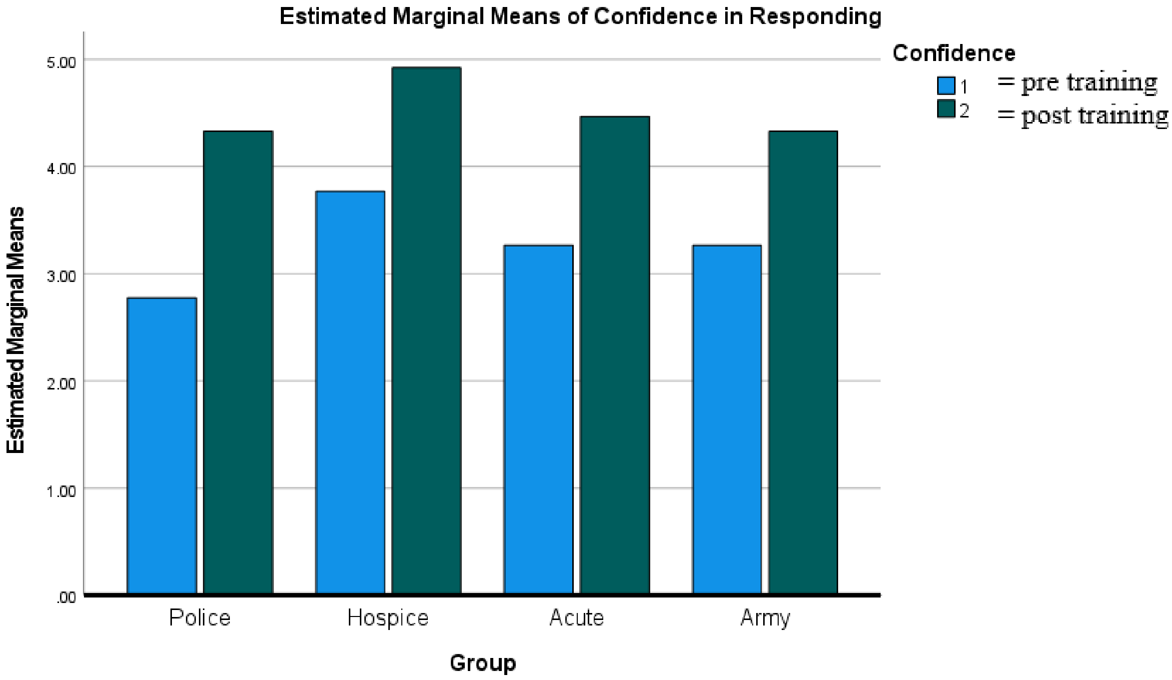


Figure 6: Confidence in responding ratings pre and post training by professional group



Fisher's LSD Post-hoc tests were conducted to explore the significant main effects of skills and confidence in responding across the four professional groups. This resulted in six comparisons: 1) Police-hospice, 2) Police-Acute, 3) Police-Army, 4) Hospice-Acute, 5) Hospice-Army, 6) Army-Acute. The results are summarised below (Tables x to x and Figures x to x).

Knowledge

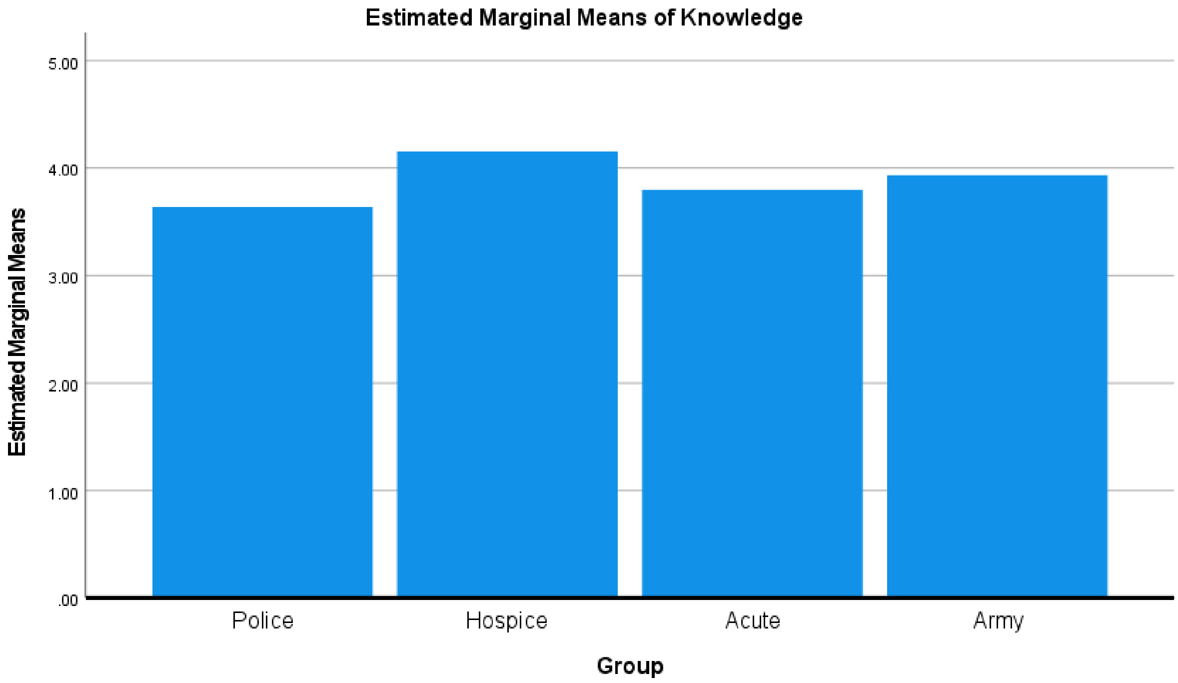
There was no significant main effect of professional group for knowledge, hence additional tests are not required. Yet for completeness, we looked at the group comparisons, finding that one of six were significant with police staff scoring significantly lower in knowledge than hospice staff (p = .012).

Table 8: Estimated marginal mean of knowledge across professional groups

	Mean[1]	**Standard error**
Police	3.64	.13
Hospice	4.15	.15
Acute hospital	3.80	.14
Armed forces	3.93	.14

1 Estimated marginal means produced from Mixed design ANOVA (i.e., means are based on the model rather than data. They are the mean response for each group, adjusted for other variables in the model)

Figure 7: Knowledge ratings by professional group



Skills

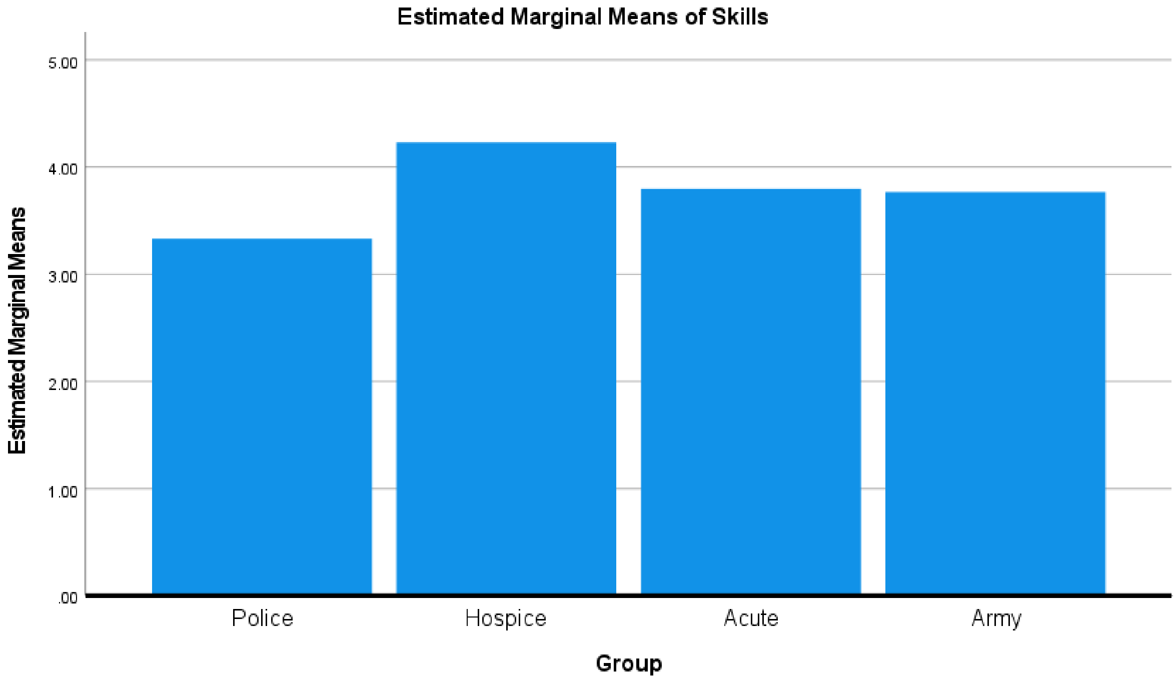
Five of six comparisons of skills were significant. Police staff rated their skills as significantly lower than hospice (p<.001), acute hospital (p = .017), and armed forces staff (p = .025). Hospice staff rated their skills significantly higher than acute hospital (p = .040) and armed forces staff (p = .027). Finally, there were no significant differences in the ratings of skills between acute hospital and armed forces staff (p = .866)

Table 9: Estimated marginal mean of skills across professional groups

	Mean[1]	**Standard error**
Police	3.33	.13
Hospice	4.23	.15
Acute hospital	3.80	.14
Armed forces	3.77	.14

1 Estimated marginal means produced from Mixed design ANOVA (i.e., means are based on the model rather than data. They are the mean response for each group, adjusted for other variables in the model)

Figure 8: Skills ratings by professional group



Confidence in Responding

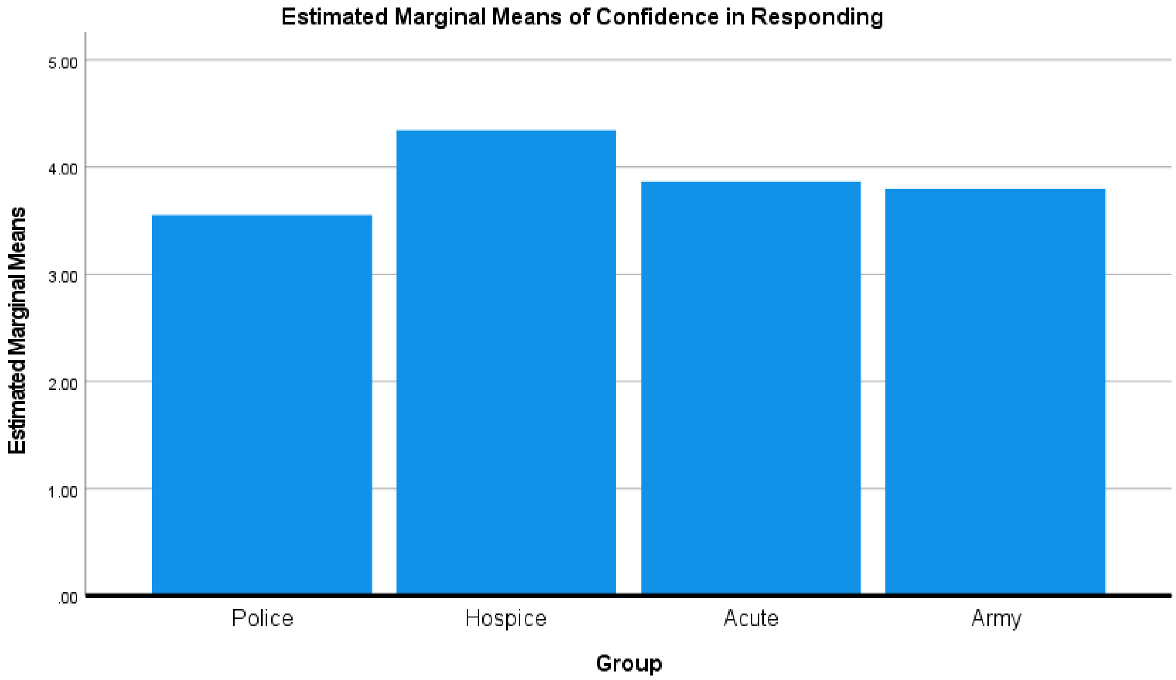
Three of six comparisons were significant. Police staff rated their confidence as significantly lower than hospice (*p*<.001), but not acute hospital (*p* = .086) nor armed forces staff (*p* = .175). Hospice staff rated their confidence significantly higher than acute hospital (*p* = .016) and armed forces staff (*p* = .006). Finally, there were no significant differences in the ratings of skills between acute hospital and armed forces staff (*p* = .866).

Table 10: Estimated marginal mean of confidence in responding across professional groups

	Mean[1]	**Standard error**
Police	3.56	.12
Hospice	4.35	.14
Acute hospital	3.87	.13
Armed forces	3.80	.13

1 Estimated marginal means produced from Mixed design ANOVA (i.e., means are based on the model rather than data. They are the mean response for each group, adjusted for other variables in the model)

Figure 9: Confidence in responding ratings by professional group



Summary of Findings and Supplementary Exploratory Analyses

A lay summary of the significant main effects of the ANOVA and the results of the follow-up LSD tests are in Table 11. The summary shows how each professional group, on average, rated their knowledge, skills, and confidence in responding in comparison to the other three professional groups. It should be held in mind that these patterns are independent from the PABBS training, that is, they are simply general differences across the groups, regardless of whether they have undertaken the PABBS training.

Table 11: Summary of 'self-perceived' levels of knowledge, skills and confidence in responding in comparison to other professional groups

	Knowledge	Skills	Confidence in responding
Police	As knowledgeable as the other three professional groups	Less skilled than the other three groups	Equally as confident in responding in comparison to the armed forces and acute hospital staff but felt less confident than hospice staff
Hospice	As knowledgeable as the other three professional groups	More skilled than the other three groups	More skilled than the other three groups
Acute hospital	As knowledgeable as the other three professional groups	Equally as skilled as the armed forces staff, more skilled than police staff, and less skilled than hospice staff	Equally as confident in responding as police staff and the armed forces, but less confident than hospice staff.
Armed forces	As knowledgeable as the other three professional groups	Equally as skilled as acute hospital staff, more skilled than police staff, less skilled than hospice staff	Equally as confident as police staff and acute hospital staff but less confident than hospice staff

The positive significant effect of training on knowledge, skill and confidence, combined with a) the significant effect of professional group for skills and confidence but not knowledge, and b) the *absence* of significant professional group x training interaction effects in all three models, suggests two things, the first of which applies to the training: 1) the training is equally as effective for all four groups of professionals by initiating positive changes in perceived knowledge, skill in supporting, and confidence in responding to those bereaved by suicide; 2) in general (i.e., on average), these professionals are likely to report highly similar levels of knowledge, but groups such as the police report feeling less skilled and confident in supporting those bereaved by suicide, as shown in Table 11. To further understand the latter, we ran a supplementary One-Way between subjects ANOVA on professional group using only the 'pre' training knowledge, skill and confidence scores (i.e., before any training had taken place), and found a significant main effect of skill ($F(3, 57) = 5.75$, $p = .002$), and confidence ($F(3, 57) = 3.45$, $p = .022$) but not knowledge ($F(3, 57) = 1.58$, $p = .205$). Fisher's LSD post-hoc tests for skills and confidence revealed that police staff had significantly worse pre-training ratings of skill than hospice ($p < .001$), acute hospital ($p = .009$), and armed forces staff ($p = .030$); while for pre-training confidence, police staff rated themselves significantly lower than hospice staff ($p = .002$).

It is noteworthy that only 'some' of the above patterns remain when we look at post-training scores. Again we found a significant effect of skills ($F(3, 57) = 3.02$, $p = .037$) and confidence ($F(3, 57) = 3.87$, $p = .014$) but not knowledge ($F(3, 57) = 1.19$, $p = .154$). Fisher's LSD tests for skills and confidence showed that police still rate their skills as lower than hospice staff ($p = .004$), but no different to acute hospital ($p = .396$), and armed forces staff ($p = .237$); while hospice staff now rated their skills lower than acute hospital staff ($p = .044$). For pre-training confidence, hospice staff now rated themselves lower than both acute hospital ($p = .027$) and armed forces staff ($p = .005$).

In sum, these analyses demonstrate why we did not find any significant interaction effects in the mixed methods ANOVA. To find a significant interaction effect, the trends in knowledge, skill and confidence pre and post training would need to show *differential trends* across the professional groups.

The perceived acceptability of training within a diverse group of individuals

The themes around acceptability of the training within this diverse group of professionals are summarised in Table 12 along with the number of participants who touched on that theme. Four main themes were identified, which we report below. Multiple professionals from each group contributed to most subthemes. For sub-themes with larger amounts of data, we have noted the % of participants of that professional group, to quantify the importance of the issue. Participants 1-13 are hospice staff (red), 14-28 armed forces (blue), 29-46 police (green), and 47-60 acute hospital (black)

Table 12: *Summary of themes from inductive content analysis and number of participants discussing each theme*

Main theme	Main theme definition	Sub theme[1]	Sub-theme definition
1. Content and delivery	Topics covered in the training session and associated materials	1a. Repetition and time P4, P21, P22, P36, P37, P41, P44, P48, P50, P54	Repeating the same information multiple times vs. the need for more time
		1b. Utility of materials and relevance to role P5, P7, P8, P12, P13, P15, P16, P17, P19, P20, P21, P25, P26, P29, P30, P31, P37, P38, P39, P40, P45, P47, P56	The course information being relevant or not to their role
2. The value of the course trainers	The people delivering the course	2a. Knowledge is power P3, P6, P8, P12, P27, P43, P44, P54	The expertise that trainers had on the topics covered
		2b. The value of skilled and "Passionate facilitators" P1, P6, P10, P11, P24, P33, P42, P60	The self: the skills, personality, and delivery style of the presenters
		2c. The value of the expert-by-experience P4, P14, P15, P17, P25, P29, P38, P45, P60	The importance of being able to draw on real-life experiences
3. Gaining new knowledge and confidence	The information and confidence that participants had gained through partaking in the course	3a. Recognising the value and importance of my role: P15, P16, P18, P26, P54	Learning the importance of the role that they have in suicide bereavement support
		3b. A multiagency approach: understanding the importance of working with other professionals P3, P5, P25, P26	Enhancing understanding of the role and value of a range of professionals working together in suicide bereavement support
		3c. Those golden nuggets: reflecting on the learning gained from the course	New knowledge and confidence gained from the course

Main theme	Main theme definition	Sub theme[1]	Sub-theme definition
		P1, P2, P3, P4, P6, P7, P8, P9, P10, P11, P12, P13, P14, P15, P16, P17, P18, P19, P20, P23, P24, P25, P26, P27, P28, P29, P30, P31, P33, P36, P37, P38, P39, P40, P41, P42, P43, P44, P45, P47, P50, P51, P52, P53, P55, P56, P58, P59, P60, P61	
4. Contemplating the impact of the training on professional practices and services	The impact of the training on views about delegates' professional practice and service they work for	4a. Changing my practice, or not P1, P2, P3, P5, P7, P8, P9, P10, P11, P12, P13, P15, P16, P20, P21, P23, P24, P25, P26, P27, P28, P29, P30, P31, P33, P36, P37, P38, P39, P40, P41, P42, P43, P44, P45, P46, P47, P48, P50, P53, P54, P55, P56, P60, P61	Whether delegates' practice will change or not within the service they work
		4b. Systematic factors and the need for service improvements P4, P18, P50, P51, P53, P54, P57, P58	The changes that need to be made within delegates' service and the barriers to implementing changes

[1] Participants 1-13 hospice (red), 14-28 armed forces (blue), 29-46 police (green), and 47-60 acute hospital (black)

Content and delivery

It was stated across all four groups that materials were excellent, implying that the training and its content are relevant to different professional roles. At least one person from each group requested an adaptation to content. Of the handful of hospice staff who mentioned materials/content, most described them using adjectives such as “brilliant and useful (P5), with only Participant 4 requesting more time for the training to get through the content, stating that “data was sped through without chance to discuss in group”. Several acute hospital staff also requested more time for training and conversations, though no other changes were requested. In the armed forces, views were mixed, with some describing the materials, case examples and resources as being useful, and others as lacking relevance to their role. For example, Participant 21 described how it was an “informative training day” but they already been given training by the military that was then repeated during this training. Participant 16 further highlighted the need for a more bespoke training package as it made “no reference to Armed Forces death by suicide”, and this was echoed by Participant 20 who stated that the training would be “much more beneficial if tailored to military environment considering systems in place.” The issue of relevance was also highlighted by Participant 22 who described the need to move beyond the traditional notion of the nuclear family: “The videos were good aids, however the modern family has changed (e.g.,) single parent/same sex parents”. Finally, the themes around repetition and the need for training that is bespoke to the profession were echoed by several police staff, with Participant 45 commenting that it “would be good to see specific course material to different sectors”. The desire to know “what is available locally” (P31) was also mentioned by two police staff. In sum, the materials and content were well received, but some content was more suited/targeted towards health care professionals than the armed forces or police.

The role of the course trainers

The participants comments about the trainers fit within three domains, which are knowledge, the self/personality, and lived experience. Across all groups there was recognition that trainers were clearly capable of delivering this sensitive topic, being described as “informative” (P6, P12, P43), “knowledgeable” (P8, P27, P33, P44, P54), and “articulate” (P54). One participant from the police also described how trainers “were understanding to our role” (P44). Subject knowledge interacted with personality style and other attributes, with trainers being described as “engaging” (P1), “passionate” (P3, P10, P11, P33, P54), “genuine/honest” (P10), “approachable” (P33), “enthusiastic” (P33), and “open” (P42). Yet, it was clear that alongside knowledge and attributes, the lived experience of the trainers was a third key component. One participant from the armed forces described the intersection of knowledge and delivery with lived experience, stating that the aspect of the course they found most useful was the “personal experience provided by you both & how you used it to shape what you were teaching” (P14). There was a sense that these experiences were highly valued by all, irrespective of professional group. A quote by one hospice staff member perhaps summarises the general mood amongst participants: “Sharing of experiences, both personal and professional was truly heart-warming." (P4). The training was also eloquently summarised by Participant 10: "fabulous. Keep advocating for the bereaved". In sum, the trainers were seen to be highly valued by participants, irrespective of professional group.

Gaining new knowledge and confidence

The knowledge acquired from the training enabled participants to understand the importance of their role in supporting those bereaved by suicide. Indeed, the value of one's own profession was implied by a small handful of participants, with one member of the armed forces commenting that the training "should be rolled out to the wider military" (P15). Participant 16 further stated that "the MOD seem to 'have it right – good support'", and this was echoed by Participant 26 who described how the "MOD are already good at some of this". One acute hospital staff member seemed to describe a lightbulb moment where they realised that they are doing a good job by "practicing well in my field already", suggesting a sense of confidence in their professional role. The need to adopt a multiagency approach to training dissemination was also highlighted by a small handful of participants, though this was usually in relation to widening the availability of the training to other roles within one's profession. For example, in the hospice group, Participant 3 commented that "I think A&E staff, GP's, Nurse Practitioners, in primary care should all have this training", with Participant 5 also commenting that "non-clinical staff are just as important as clinical staff" (P5). The notion of shared responsibility across professionals was also touched on by one armed forces member, who learned that "you don't need to know all the information in a bereavement situation" (P14). This multiagency approach extended to participants' acquisition of knowledge about multi-agency support, with the most frequent take-home point being an understanding of the availability of support for families and professionals bereaved by suicide, and agencies to signpost to; this was mentioned by around 30% of hospice, acute hospital, and police staff, and just over 50% of the armed forces.

The next most frequent learning point captured participants' reflections on the interpersonal skills and qualities required to support those bereaved by suicide, with around 40% of the police and armed forces, 30% of hospice staff and 20% of acute hospital staff touching on this. This included an understanding of the ability to: listen and provide support whilst empowering clients; be honest, empathic and confident; and exercise compassion and humility. One acute hospital staff member summarised their learning as "you can't fix it, but you can support, acknowledge, listen, and care" (P59). Understanding the wider impact of suicide and the increased risk of those impacted was also noted by all professional groups, particularly in the armed forces (27% vs 11% of police and 7% of hospice and acute hospital staff). The importance of language (e.g., not using the phrase 'commit suicide', and the need to ask about suicide) was a key learning point for 28% police, compared to 13% of the armed forces and only 7% of hospice and acute hospital staff. Learning about the need for early contact with the bereaved and/or timely referrals was mentioned only by 5 acute hospital participants (33%) and 1 hospice staff member (7%). These two professional groups also touched on the need for self-care (P13) and the to provide "support" (P51, P55) to those supporting the bereaved by suicide. These comments highlight a new-found awareness of a much wider impact of bereavement by suicide in terms of the risk to those who are providing support. In sum, similar learning points were found in each professional group, though there are some nuances to the learning which may reflect larger knowledge gaps in particular professional fields.

Contemplating the impact of the training on professional practice and services

Most participants within each group stated that they would make changes to their practice following the training. Across the four groups and all those who responded to this question, 100% of hospice staff and the police said they would change their practice, whilst two acute hospital staff (13%) and three armed forces participants (20%) stated that they would *not* be making changes. For example, Participant 21 noted: "No Changes - Happy with training already given in military", whilst Participant 16 stated that they would make no changes, but they had an increased "awareness of the impact of death by suicide". Thus, despite changes in knowledge, a small number of participants felt this would not translate into changes in their professional behaviour, perhaps because they perceived themselves to be capable/skilled in supporting the bereaved. A small number of the participants noted that the training had raised their awareness of the need for larger systematic changes to their service. One acute hospital staff member described their service as "deprived…and inadequate" (P54), whilst another said that the training itself "highlighted" that their service is "way behind with the bereavement area compared to the other two trusts" (P57), a reflection that was echoed by a participant from the same Trust (P58).

Discussion

Main Findings

Organisations/services such as the hospital and hospice staff, the armed forces, and police play a crucial role in supporting those bereaved by suicide. Pivotal to an effective multi-agency approach is the availability of evidence-based suicide bereavement training for these frontline staff (McDonnell, Hunt et al., 2020; McDonnell et al., 2022). The PABBS training, is to our knowledge, the first international, theoretically informed, evidenced-based training (McDonnell, Hunt et al., 2020). We found that all aspects of the training were perceived to be acceptable by all professionals, and that the training was also rated as being effective by all professionals in initiating positive changes in perceived knowledge, skill, and confidence in responding. The take-home message is that the PABBS training is acceptable and effective, irrespective of professional group.

We also found evidence that some professionals groups rated their skills or confidence in responding to the bereaved by suicide, as lower or higher to other professional groups, but it is important to understand that these are general group differences that exist regardless of whether someone has undertaken the training. Still, they are important to understand because even though our statistical analysis did not identify that perceived effectiveness of the training differed across diverse professional groups, our in-depth qualitative analysis of the acceptability of the training suggested some nuances to how specific aspects of the training were experienced and received.

Strengths and Limitations

This is the first study that has formally empirically examined the acceptability and effectiveness of the PABBS training in different professional groups. Still, there are several limitations to the work that warrant comment. First, the small sample size means that we could identify only large and potentially medium changes in pre and post knowledge, skills and confidence across the professional groups, hence findings must be replicated with larger groups sizes to allow detection of smaller changes. Similarly, qualitative findings will need re-producing with the same and different professional groups. The dynamic and complex nature of experiences means that new experiences and themes could also be identified in further evaluations and may vary by sample type. It is noteworthy that this study included a large proportion of police reporting they have been both personally and professionally bereaved by suicide, which justifies why PABBS always have two trainers delivering the training, to manage risk; and will undoubtedly have shaped how they experience the training. Comparing the experiences of the training across those who are personally bereaved, professionally bereaved, or both, is an important endeavour. Third, questions that assessed self-perceived knowledge, skill and confidence were worded differently at the pre and post training evaluation, which may have introduced a degree of bias such as socially desirable responding, as noted by McDonnell, Nelson, et al., (2020). Future evaluations of the PABBS training must use identical pre and post questions.

Implications and Recommendations

Our work leads to several key recommendations that if implemented, could improve the capability, skills and confidence of frontline staff in supporting those bereaved by suicide who are a vulnerable and high-risk group at increased risk of suicide (Andriessen et al., 2020; Pitman et al., 2014; Pitman et al., 2016). The increased availability of PABBS will help those who support the bereaved by suicide, improve their practice and care, which in turn may reduce suicide risk in this group.

Recommendation 1: PABBS training is made available to all those providing workplace suicide bereavement support

The findings highlight the value of evidence-based suicide bereavement training for professionals and thus speak to the importance of making this training accessible and mandatory to all those who support individuals bereaved by suicide. This will ensure that the workforce is appropriately trained so that all systems will have suicide bereavement support services providing timely and appropriate support to families and staff by 2024' (NHS Long Term Plan, 2019). The PABBS training addresses key objectives in Government, national and local suicide prevention strategies, and Public Health England (PHE) and NHS Health Education England (2016) include PABBS in their list of suicide prevention training. The training has been referenced by the National Institute for Health and Care Excellence (NICE, 2018), and NIHR Greater Manchester Patient Safety Translational Research Centre (PSTRC) supported the national roll out of

PABBS. Finally, Suicide Prevention Guidelines in Community and Custodial Settings also used findings from the PABBS study as evidence (Foggin, McDonnell et al 2016).

Recommendation 2: PABBS training is adapted and tailored to the needs of different professional groups

Our findings suggest the need to retain the core materials and essence of PABBS, but adaptation is required to develop custom training packages that are bespoke and tailored to the needs of different professional roles. To implement an effective bereavement pathway it is crucial to understand the nuances to the roles of the professionals who support those bereaved, and for these to be embedded within the training. In our study we found that on average, police staff perceived themselves to be equally as knowledgeable but lower in skills and confidence in responding to suicide bereavement both at baseline (i.e., before training), and when considering their average pre and post training scores. This, coupled with the high proportion of police in our study who are both personally bereaved and professionally affect by suicide, calls for bespoke training and support for the police. Police response officers are often first on the scene and/or one of the first initial contacts of those bereaved by suicide, and they must make a timely referral to postvention bereavement support services such as ‘Amparo’ and ‘Survivors of Bereavement by Suicide’ (SOBS). Being first on the scene of a suspected suicide is undoubtedly a unique and potentially traumatic experience that is qualitatively different from the other ways in which professionals may encounter and work with those bereaved by suicide. Some of these differences were captured in our qualitative analysis, which suggested that the PABBS training was most relevant to clinical staff (e.g., GPs) for which it was first developed (McDonnell, Nelson et al., 2020), rather than either the police or armed forces staff. The need for ‘suicide and bereavement response’ training is recognised by the College of Policing who provide an asynchronous online module that covers several areas, including: the importance of suicide prevention and the role played by the police, identifying those at risk, the need for a standardised approach to suicide prevention, managing risk and recording data accurately, and the need to support those bereaved by suicide. This is a step in the right direction, but our findings call for the development of a synchronous (‘live’) training package that is bespoke to police officers and/or emergency workers more generally, and a second that is tailored to the needs of military personnel. Such training should be co-produced and embedded within the bereavement pathway.

In April 2022, Suicide Bereavement UK developed ‘Responding To Suicide’(RTS) evidence and practice-based emergency-services training, to help professionals advance their understanding on how to respond to those bereaved by suicide. RTS was launched June 2022 and its development was informed by additional research conducted by McDonnell and colleagues, which explored the experience of emergency service personnel in responding to those bereaved by suicide (e.g. Nelson, Cordingley et al., 2020). RTS training aims i) to advance emergency services personnel knowledge, confidence and skills in responding to those affected by suicide; and ii) help attendees understand, explore and manage their exposure to and potential trauma response to suicide. Ultimately, RTS training has been designed so that it is fit for purpose for emergency services responding to this sensitive issue, helping to ensure that it addresses a national unmet need and the limitations of PABBS training for emergency services. However, this leaves a gap for military personnel. Hence, we recommend that PABBS is adapted to cater for the unique needs of this workforce. More broadly speaking, our findings highlight the importance of police forces providing additional support to their staff who may be personally bereaved by suicide but also likely to have professionally experienced at least 1 suicide or an average of 35 throughout their career (Cerel et al., 2019). These figures highlight the potential vulnerability of some members of this workforce and call for the embedding of dedicated suicide liaison officers as part of the full pathway, who can support not just the families of the bereaved but those providing support.

Recommendation 3: Ongoing monitoring and rigorous quantitative and qualitative evaluation of PABBS training

Finally, we recommend some changes to the PABBS evaluation questionnaire to facilitate ongoing monitoring of impact and a robust evaluation. First, the questionnaire would benefit from use of a more fine-grained Likert scale (i.e., at least 7 scale points) that is more sensitive to change (Finstad, 2010). Second, the evaluation should capture additional demographic characteristics and experiences of delegates such as gender, age, length of time in current professional role, previous professional roles, and any previous engagement in training (generic mental health, risk/suicide, or specific suicide bereavement training). Collecting these data will allow identification of *who* the training works best for and will simultaneously capture the impact of the training on its participants.

Directions for Future Research

Studies are needed to explore the experiences of different stakeholders in supporting those bereaved by suicide and the perceived effectiveness in other professional groups (e.g., coroners, suicide liaison officers) and sub-groups (e.g., separating out health professionals such as GPs, nurses, and mental health practitioners). It is important also to explore whether the positive effects of the PABBS training leads to objective measurable changes in professional practice in both the short and long-term, which in turn, positively impact clients. The evaluation of PABBS currently rests on introspective self-report of knowledge, skill and confidence, and whilst these perceptions provide a window into experience and "inner process…behavior matters too" (Baumesiter et al., 2007, p. 400). That is, future studies must conceptualise and *objectively* operationalise 'effectiveness'. Indeed, the PABBS training is a *pathway* to client benefit, hence the real value of the training lies in whether practitioners ultimately apply their learning in a way that impacts their behaviour within their organisation (e.g., through sharing and cascading knowledge to colleagues), subsequently leading to improvements in client mental health, well-being or quality of life. Re-contacting and following up those who have already attended the PABBS training is an important first step in evaluating the impact of the training.

Conclusion

To the best of our knowledge the PABBS training is the first theoretically informed evidence-based training of its kind and functions as key part of the suicide bereavement pathway within Lancashire. The training is effective in eliciting changes in the perceived knowledge, skills and confidence in responding of a diverse range of frontline workers, but revisions to the training are required to ensure a more personalised and tailored delivery that draws on the professional experiences of those who are undertaking the training. An immediate priority is to design and evaluate these bespoke training packages and evaluate whether the training leads to measurable impact in terms of changes in practitioner behaviour when supporting those bereaved by suicide.

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Overall Strategic Recommendations from both Studies

Evaluating the effectiveness of suicide bereavement services is key to advancing our understanding of the effectiveness of specific parts of a full pathway and producing evidence-based recommendations to improve the quality of suicide bereavement support. Both Amparo and PABBS fill an important need in bereavement by suicide support, but both require evaluation as elements of the full L&SC bereavement pathway to ensure that we are providing the right support for people at time of significant vulnerability and risk. Our evaluations lead to three overarching recommendations:

Recommendation 1: Development and implementation of a rigorous evaluation strategy to determine the clinical and cost effectiveness of postvention services, the case of 'Amparo'

The findings from our evaluations of the Amparo service identified some gaps in the evaluation strategy. The use of a brief wellbeing scale as a measure of client improvement is a step in the right direction but must be supplemented with additional quantitative standardised measures of client distress and suicidality, as well as qualitative questions to facilitate a 'deep dive' into clients' experience of the service of what is working well/less well. Indeed, "The success of the National Strategy is reliant on good quality data at both national and local levels" (HM Government, 2017, p.33), and postvention services such as Amparo are no exception to this. Moreover, an effective evaluation strategy should endeavour to identify *who* the service works for and why some clients disengage during periods of high risk. The clients who either do not engage with Amparo, or who engage then disengage, may have support needs that can't be met by Amparo, highlighting the importance of a bereavement pathway that includes multiple options for support.

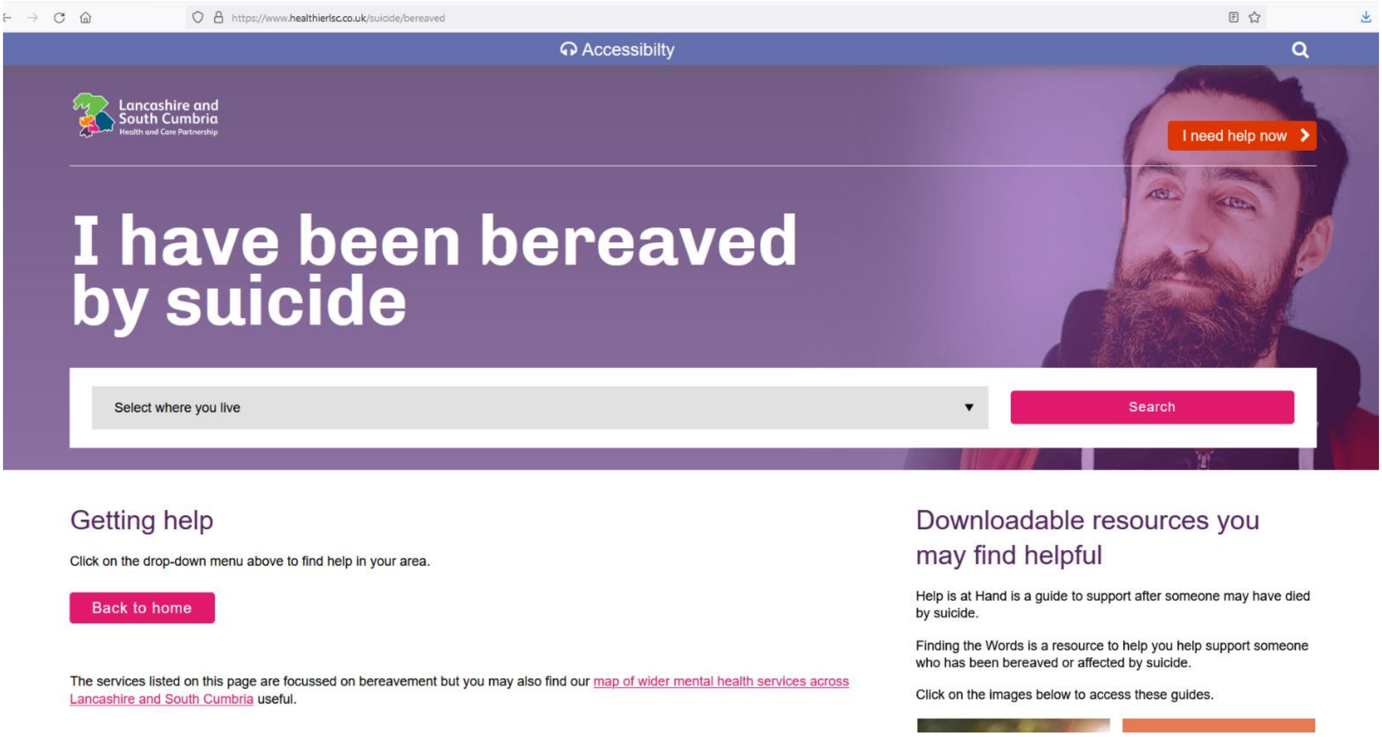
Recommendation 2: Evidence-based training is embedded within suicide bereavement pathways

Our evaluation of the PABBS training has identified an area of best practice in postvention support, irrespective of whether this is provided within L&SC or another region. We know from past studies that professionals in many fields feel ill prepared and ill equipped to support those bereaved by suicide (e.g., Foggin et al., 2016; Nilsson et al, 2017), highlighting the need for training to upskill and improve confidence. An ideal scenario is that PABBS training is accessible to and undertaken by all professionals working in this field, yet a pragmatic economic perspective leads to the conclusion that this might be difficult to achieve. In times of economic hardship it is important to explore financially viable and sustainable models of training so that the workforce is supported in their role of supporting the bereaved by suicide. This might include embedding new ways of working such as ensuring that organisations have dedicated suicide bereavement liaison workers who are ‘PABBS trained’ and able to support the cascade of information and transfer of knowledge and skills to other colleagues within the organisation. This is akin to the concept of ‘train the trainer’, whereby trainers enhance the capability of those they are training, who can then in turn, train - or in this case support – others. Cascading information and skills throughout multiple layers of an organisation is not without its challenges however, as the message and flow of information can become diluted at different stages (Gask et al., 2019). This highlights the importance of further evaluating PABBS to identify whether the training does indeed lead to tangible impact within professionals' organisations more widely, and in relation to supporting clients. Through enquiring about whether/how those attending the training have changed their professional practice when working with colleagues and supporting clients, will we learn about the potential impact the training has had on the bereavement by suicide pathway in L&SC. Suicide prevention is everybody's business, and we have a moral and economic obligation to meet the objectives of the National Suicide Prevention Strategy (2012) by improving support for those bereaved by suicide. The PABBS evidence-based training can help meeting this objective.

Recommendation 3: L&SC develop and rigorously evaluate the full bereavement pathway aimed at supporting those who are personally and/or professionally bereaved

Finally, a difficulty that currently occurs is that the full suicide bereavement pathway for L&SC (Figure 2) is not formally published nor embedded within the system, hence it remains unknown to most professionals. Moreover, this pathway is currently a professional facing pathway and is separate from the public facing pathway which is a website run by L&SC Health and Care Partnership (Figure 10). The public pathway provides links to local services, information and resources and works in a similar manner to the professional pathway by signposting to services, that is, elements of the pathway. Yet, the concept of a separate public and professional facing pathway is a false dichotomy of the ‘bereaved by suicide’ and ‘those who provide support’. Our evaluation of those attending the PABBS training clearly shows that a high proportion of professionals, especially those in the police, are *both* personally and professionally bereaved by suicide. Thus, separate pathways may confuse users of the pathway and complicate what is already a very difficult challenge for those bereaved by suicide and the services that support them. A key priority is for L&SC is to continue developing the full bereavement pathway as *one* simple pathway, aimed at supporting those who are personally and/or professionally bereaved. The final pathway should be evaluated, adopting a whole systems approach to understanding what works and why and identifying collective actions when areas of improvement are identified.

Figure 10: The Lancashire and South Cumbria Public Facing Suicide Bereavement Pathway



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