

Establishing and Sustaining a Support Group for People Bereaved by Suicide: a Toolbox for Facilitators

Marianna Riello & Sara Carbone

AOUI Verona



Co-funded by
the Health Programme
of the European Union

The Euregenas Project has received funding from the European Union under the Public Health Programme 2008-2013. The sole responsibility for the content of this publication lies with the author and the Executive Agency is not responsible for any use that may be made of the information contained therein.





Establishing and Sustaining a Support Group for People Bereaved by Suicide: a toolbox for Facilitators

Marianna Riello & Sara Carbone

AOUI, Verona

Euregenas

2014

Acknowledgements

This resource has been developed by the University Hospital (AOUI) Verona, which is the lead partner of Work Package 8 of the Euregenas project, with the support of the Euregenas Network of Facilitators and the valuable collaboration of the other Euregenas Associated Partners, local experts on suicide prevention, and the Scientific Board of the Euregenas project, who have been invited to provide their comments and feedback. Furthermore, the regional networks that have been established in five participating regions supported the development of this toolbox. The networks involved policy-makers, public health experts, community players and stakeholders in the field of suicide prevention.



Table of contents

Executive Summary	7
Target audience	7
About Euregenas	9
Glossary	12
1.Introduction	15
1.1 Aims of this toolbox	15
1.2 The Facilitators Network	15
1.3 Added Value and Strengths of the Toolbox	17
1.4 Background of Suicide Bereavement and Importance of Support Groups	18
1.5 Understanding the need of support groups	18
1.6 Initial Expectations and Concerns before attending Support Groups	21
2.Support Group Establishment	23
2.1 Aims, Objectives and Values of SBSG	23
2.2 Access to SBSG	24
2.2.1 Postvention Timing	24
2.2.2 Referral Process	26
2.2.3 Membership	27
2.3 Sustainability	30
2.4 Funding	31
2.5 Legal Status	32
2.5.1 Registration	32
2.5.2 Confidentiality and Privacy Legislation based on European legal framework	32
2.5.3 Appropriate Insurance Cover for Participants	34
3.Facilitation: Infra Structure Issue	35
3.1 Who is a facilitator?	35
3.1.1 The facilitator should be a survivor or not?	35
3.1.2 From which background the facilitator should come from?	36
3.1.3 Therapeutic versus Volunteer facilitation?	36
3.2 Criteria for facilitation	38
3.2.1 Facilitators duties	38
3.2.2 Facilitators Roles	39
3.2.3 Facilitators Responsibilities	40
3.2.4 When to initiate a self-help support group for survivors	41

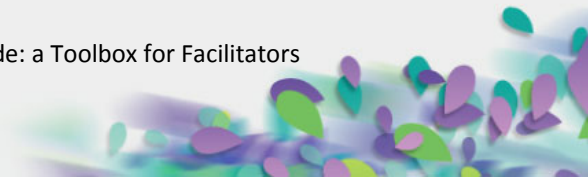
3.3 Facilitator Techniques	42
3.4 Types of Support Groups	44
3.4.1 Types	44
3.4.2 Format for meetings	46
4.Setting Up	49
4.1 Location, Place and Meetings	49
4.2 Resources	50
4.3 Awareness Raising / Community Networking	51
4.4 Suggested improvements of SBSG from SOBs Cumbria members	52
5.Practical Tools	53
5.1 Preparation of the first meeting	53
5.1.1 Agenda of the first meeting	53
5.1.2 Topics to be discussed at the first meeting	54
5.2 Difficult Situations	55
5.2.1 How to intervene in difficult situations	56
5.2.2 Intervention Approaches	56
Appendix 1	65

List of Figures

Figure 1	The Euregenas Regions
Figure 2	The Euregenas core work packages

List of Tables

Table 1	Helping facilitator's choices
Table 2	Helping facilitators according the length of time since the loss occurred for the bereaved person
Table 3	Facilitator's guide through different groups of bereaved people: elements to be exploited and critical aspects
Table 4	Helping facilitators to choose the right moment after the grief to start to facilitate support groups
Table 5	Active Listening Techniques
Table 6	Pros and Cons of Closed Groups referring to the timing
Table 7	Pros and Cons of Closed Groups referring to the membership
Table 8	Pros and Cons of Open Groups
Table 9	Pros and Cons of Online Groups



Executive Summary

Suicide is a major public health problem that can be prevented. Family members and friends who survive the suicide of a loved one, are at risk of developing depression, and prolonged grief disorder, and they become subjects at high risk of suicide. The risks of not therapeutically intervening are still underestimated. Evidence strongly suggests that self-help support groups are powerful and constructive means for people to help themselves and each other, and the availability of support systems is one of the factors influencing the grieving process (WHO, 2008; WHO, 2014). Within this social context it might be important to provide guidance and assistance for those developing and operating suicide bereavement support groups (SBSGs). Those people who manage support groups and help participants to communicate and achieve their goals are generally named facilitators. In order to become a facilitator it is recommended to be trained and educated (see paragraph 3.1.2).

Which strategies and interventions can be used by facilitators who want to start support groups for survivors? How can facilitators establish and sustain support groups and which are the main constraints that they can encounter along this complex path? This resource, embedded in the Euregenas project, aims to address these questions, providing useful tips and tools for facilitators, becoming a comprehensive resource rather than a prescriptive guide.

Target audience

Thanks to the mapping procedure carried out under the Euregenas Project, it has been demonstrated that there is a considerable variety of resources dealing with the support of the people bereaved by suicide (see “Catalogue of Resources for Survivors”: <http://www.euregenas.eu/wp-content/uploads/2014/10/Catalogue-of-resources-for-Survivors.pdf>), such as organizations or different health-care centres, helplines, NGOs, etc...

In parallel, there are many different mental Health professionals and trained volunteer stakeholders involved in the management of such groups. Considering this, this toolbox has been designed to be a resource to all those who wish to work in this field. In line with this approach, the format of the toolbox includes both practical and academic/evidence based information which might be suitable for both these categories of facilitators.

This toolkit deals only with the start-up and management of support groups for adults. For support groups with bereaved children it is recommended to visit the websites cited in the references, since it is



well known that suicide has a huge and massive impact to children and establishing support groups in this case requires specific and particular support techniques, which are not described in this document.

The toolkit includes five main sections:

- The **INTRODUCTION**, focusing on the aims of the toolbox and on the main issues related to the suffering and needs of people who have been affected by the death of a loved one.
- The guidelines for the **SUPPORT GROUPS ESTABLISHMENT** pointing out the importance to always ensuring a legal and safe framework, according to the rules of each Country, when consider these suggestions.
- The third part contains a description of **FACILITATORS REQUIREMENTS**, duties and statements.
- A collection of the **SETTING UP** details in order to ensure the operational framework to facilitators.
- To conclude a range of **PRACTICAL TOOLS**, to support the facilitators in the following tasks: how to initiate a self-help support group for survivors of suicide, how to identify the warning signs or critical success factors in the development of groups.

About Euregenas

The **Euregenas project** aims at contributing to the prevention of suicidal thoughts and behaviours in **Europe** through the development and implementation of strategies for suicide prevention at regional levels which can be of use to the European Union as examples of good practice. The project brings together **15 European partners**, representing 11 European Regions with diverse experiences in suicide prevention (see Figure 1).

Figure 1 – The Euregenas Regions

University Hospital Verona (**AOUI-VR**) – Italy

Flemish Agency for Care and Health (**VAZG**) – Belgium

Region Västra Götaland (**VGR**) - Sweden

Romtens Foundation (**ROMTENS**) - Romania

National Institute for Health and Welfare (**THL**) - Finland

Unit for Suicide Research, University Ghent (**UGENT**) – Belgium

Fundación Intrás (**INTRAS**) – Spain

Servicio Andaluz de Salud (**SAS**) – Spain

Fundación Pública Andaluza Progreso Y Salud (**FPS**) - Spain

Mikkeli University of Applied Sciences (**MAMK**) - Finland

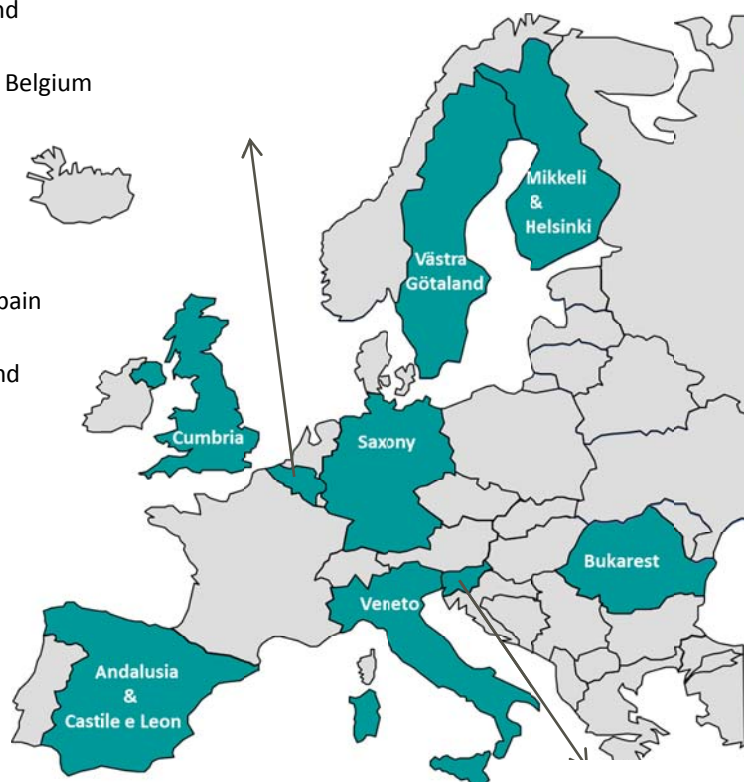
Technische Universität Dresden (**TUD**) – Germany

National Institute of public health (**NIJZ**) – Slovenia

Euregha (**EUREGHA**) – Belgium

De Leo Fund (**DELEOFUND**) – Italy

Cumbria County Council (**CCC**) - United Kingdom





In line with the '*Second Programme of Community Action in the Field of Health*' (European Commission, 2008-2013, see <http://ec.europa.eu/health/programme/policy/2008-2013/>), the project promotes the use of regional cluster management as innovative method to improve the existing services.

By encouraging regional interventions and campaigns dedicated to both target groups and non-health stakeholders, **the project aims at implementing the Mental Health Pact** in relation to:

- 1) Prevention of suicide
- 2) De-stigmatization of mental disorders
- 3) Promoting health in youth

The **specific objectives** of the Euregenas project are the following:

- To identify and catalogue good practices/best practice of existing actions and strategies on suicide prevention at a regional and local level;
- To carry out a stakeholders' needs analysis;
- To develop and disseminate guidelines and toolkits on suicide prevention and awareness raising strategies;
- To develop the technical specifications for an integrated model for e-mental healthcare oriented at suicide prevention;
- To improve knowledge and capabilities/skills among local and regional professionals (i.e. psychologists, psychiatrists, GP's).

The project aims at meeting its specific objectives by a **series of Work Packages (WP)**. The Euregenas project includes eight work packages: 3 horizontal work packages, respectively on coordination, dissemination and evaluation and 5 vertical core work packages (see Figure 2).

Figure 2: the Euregenas core work packages



Glossary

The glossary section is included at the beginning of this booklet in order to provide the reader with all the terms and explanations that he will encounter through the text, because the sharing a correct understanding of the concepts is a fundamental prerequisite to exploit the usefulness of the toolbox.

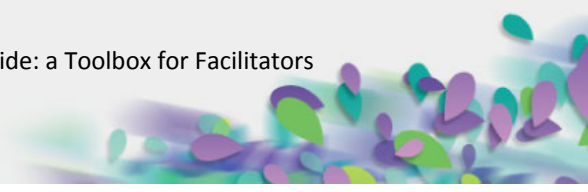
Example: consider terminology and the use of the term “survivor”, that may be interpreted as survivor of a suicide attempt, while the phrase “bereaved by suicide” might be much clearer.

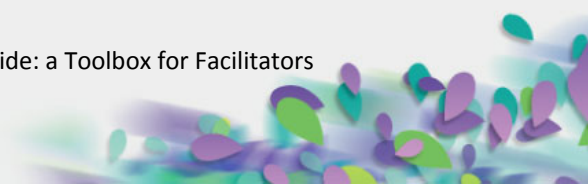
TERM	DEFINITION
<i>Bereavement</i>	The period of grief after a loss (usually the death of a loved one)
<i>Complicated Grief</i>	Grief that is complicated by adjustment disorders e.g. depression, anxiety.
<i>Facilitator</i>	A facilitator is someone who helps a group of people understand their common objectives and assists them to plan to achieve them without taking a particular position in the discussion.
<i>Non-fatal suicidal act</i>	A non-habitual act with non-fatal outcome that the individual, expecting to, or taking the risk, to die or to inflict bodily harm, initiated and carried out with the purpose of bringing about wanted changes (De Leo et al., 2004). It can include attempted suicide, deliberate self-harm and deliberate self-poisoning, with or without injuries.
<i>Postvention</i>	Postvention is an intervention conducted after a suicide, largely taking the form of support for the bereaved (family, friends, professionals and peers).
<i>Suicidal behaviour</i>	A complex process that can range from suicidal ideation, through planning of suicide, to attempting suicide and ending in suicide. Suicidal behaviour is the consequence of interacting biological, genetic, psychological, social, environmental and situational factors (Hawton & Van Heeringen, 2009).
<i>Suicidal intent</i>	Subjective expectation and desire for a self-destructive act to and in death.
<i>Social support</i>	Assistance that may include companionship, emotional backing, cognitive guidance, material aid, and special services.

<i>Suicidal thoughts / Suicidal ideation</i>	Thoughts of engaging in suicide-related behaviour. Suicidal ideation may vary in seriousness depending upon the specificity of suicide plans and the degree of suicide intent.
<i>Suicide (or fatal suicidal behaviour/act)</i>	The act of killing oneself deliberately initiated and performed by the person concerned in the full knowledge or expectations of its fatal outcome.
<i>Suicide attempts survivors</i>	Attempted suicide as a sub-category of para suicide (attempts with strong intention) (Bille-Brahe et al., 1999). Individuals who have survived a prior suicide attempt.
<i>Suicide risk</i>	The degree of danger to self an individual faces based on the absence or presence of suicidal behaviours and factors associated with the likelihood of suicide.
<i>Suicide (loss) survivors</i>	Family members, significant others, or acquaintances who have experienced the loss of a loved one due to suicide. Sometimes the term “suicide survivors” is also used to mean suicide attempt survivors.

OTHER GLOSSARY SOURCES:

- <http://www.suicidepreventionlifeline.org/learn/glossary.aspx>
- <http://www.stopasuicide.org/glossary.aspx>
- Lifeline Australia (2009)
- World Health Organization (2008)





1.Introduction

1.1 Aims of this toolbox

This toolbox is developed in the framework of work package (WP) 8 of the Euregenas project. It targets **facilitators in the management of support groups** aiming at offering background information on how to manage support groups for “people who are left behind” (WHO, 2008), good practices and practical instruments. As such, this toolbox provides an outline of potential contributions to the prevention of suicide within the family and social environment surrounding the traumatic death.

It **provides** brief but **important suggestions** regarding the **distinction between different support groups**, like: pure community based self-help groups and groups lead by professionals, hoping to help facilitators exploiting their resources in the best way.

It focuses on the **understanding of the need for self-help support** (see paragraph 1.3) in creating a response which people can access in psychological and practical terms.

The toolbox makes references to the existing **rules adopted by the different types of support groups** of some regions involved in the Euregenas project (see paragraph 4.4) to highlight the fact that the possibility of group management are multiple.

Not least it wants to help in **establishing links** with relevant voluntary and statutory organisations, e.g. in the United Kingdom (UK), public health and the Samaritans.

1.2 The Facilitators Network

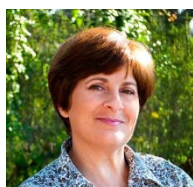
The Euregenas Facilitators Network (EFN) has been created to promote the sharing of the specific know-how and good practices between facilitators from different Euregenas Countries. The facilitators had the possibility to exchange their opinions and experiences during the four Virtual Meetings (VM) that have been arranged starting from the month of April 2014. Through their discussions, the facilitators gave an enormous contribution to the implementation and to the drafting of the toolbox. The facilitators who took part to the VMs are presented below:

- **John Brown** (Survivors Of Bereavement by Suicide, UK)



John Brown is a Social Worker by profession, he lost his father to suicide and is committed to suicide prevention and providing support for people who have been bereaved through suicide. He is a member of the Cumbria Suicide Prevention Group and facilitator of the Survivors of Bereavement by Suicide network in Cumbria (UK).

- **Carmen Acevedo Gonzales** (Asociación Alma y Vida, Spain)



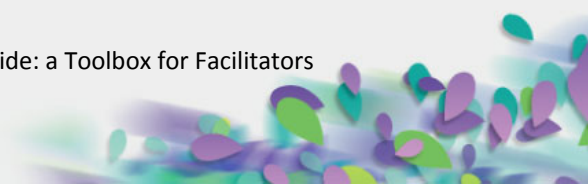
Carmen Acevedo Gonzales has a private office where she works as a psychologist; also she offers counseling to the staff of the Joint Research Center–Institute of Protective Technological Service Seville, which belongs to the European Commission. She has been working for the Association “Alma y Vida” for over five years as a volunteer.

- **Katarzyna Ratkowska** (DeLeo Fund, Italy)



Katarzyna Ratkowska is a clinical psychologist and a researcher collaborating with the De Leo Fund Onlus (Padua, Italy). She is the coordinator of the care services and of the helpline. She provides individual support to survivors of all traumatic losses and is a facilitator of the support group for people bereaved by suicide.

- **The Werkgroep Verder group** (Flanders Organisation for Survivors of Suicide)
- **Onja Tekavcic Grad** (University Hospital Ljubljana, Slovenia)



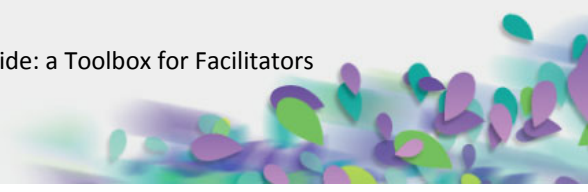
1.3 Added Value and Strengths of the Toolbox

This toolbox gives some very basic information about the role of the facilitator and the practical management of support groups for bereaved by suicide people. It does not represent only a mere revision of what it already exists in literature: its added value is the **direct experience of the Euregenas facilitators**, as this document resumes the contents **raised during the VMs discussions**, run over a six month period.

During the VMs, the importance to create a manual providing a lot of **opportunities and choices** for facilitators, **rather than a mere restricted guide with strict criteria to be followed**, has been underlined. Especially the facilitators highlighted the importance to add some paragraphs describing the **advantages and the risks** of each suggested choice and behaviour in facilitating the group. As a consequence it is expected to support facilitators in their choices and management of the groups, rather than forcing them to follow precise standards. Also the toolbox summarizes some of the **key features** of the different support groups conducted by the various Europeans organizations involved in the project. The toolbox has been developed according to a **bottom-up approach** specifically taking into account the different meanings/methods/procedures that are implemented in the various Regions of the Euregenas project.

The contents of the toolbox are based on:

- **comprehensive literature and good practice review** about standards and good practice guidelines and Lifeline Australia and the LEAP model (Barr & Dailly, 2006), also an international literature review on “bereavement AND support groups” using “Web of Science” (2000-2014);
- **needs analysis** of people who have been left behind thanks to the feedback from Survivors of Bereavement by Suicide Groups (SBSG): specifically semi structured interviews with people who have made contact with Survivors of Bereavement by Suicide groups (SOB’s Cumbria) (Brown & Brown, 2014).
- **collection of the outcome** from the discussions with the Virtual Facilitators Network (VFN).



1.4 Background of Suicide Bereavement and Importance of Support Groups

Suicide is a significant public health issue in Europe accounting for an average suicide prevalence rate of 11.8 per 100000 inhabitants (Eurostat, 2010). Suicide affects people of all ages, cultures and population groups. Men are almost 5 times more likely to commit suicides than women, in all countries of the European Region. Suicide attempts are much more common than suicides. Studies show that nonfatal suicidal acts occur at least 10 times more frequently than fatal suicides. Unlike fatal suicidal acts, non-fatal suicidal behaviours are most common among adolescents and decrease with age (Nock et al., 2008). Every suicide and suicide attempt directly or indirectly also affects other people.

A death by suicide has a severe impact on the survivors, such as spouses, parents, children, family, friends, co-workers, and peers who are left behind, both immediately and in the long-term. It is estimated that each suicide directly affects about six to fourteen family members and friends (Clark & Goldney, 2000; Jordan & McIntosh, 2011).

Those bereaved by suicide often find it very difficult to admit that the death of their loved one was by suicide, and people often feel uncomfortable talking about the suicide with them. Therefore those bereaved by suicide have less opportunity to talk about their grief than other bereaved people. A support group can assist greatly, as a lack of communication can delay the healing process (WHO, 2008).

1.5 Understanding the need of support groups

People bereaved by suicide can often show higher levels of feelings of guilt, blame, rejection, or abandonment by the loved one, which can also manifest as a sense of responsibility or anger (Bailey, Kral, & Dunham, 1999), or shame, stigma and the need for concealing the cause of death (Sveen & Walby, 2007; De Leo et al., 2013), blame, hurt and resignation. In case of complicated grief, which may be more common for people in a close relationship to the deceased (Mitchell et al. 2004), people can show depression and posttraumatic stress disorder (Cerel, 2009). Barlow and Coleman (2003) underlined the importance of the issue in forming

healing alliance outside the family following a suicide death, and later Cerel (2008) noted that *“suicide is a confusing death”* and such *“ambiguity seems to increase the need between a social network to affix blame”*. In fact suicide leaves people behind wondering if there is anything they could have done at any time to help, and they feel very guilty because they think that they somehow were responsible or did not act correctly (De Leo et al., 2013; Groos & Shakespeare-Finch, 2013).

Recognising the above mentioned feelings may help guide group facilitators to work with people bereaved by suicide in the following ways: (Stebbins & Stebbins, 2000)



- organizing meeting that have simple structures
- creating a non-judgmental atmosphere leaving time to express feelings

We also suggest to stress and consider the following elements that participants of the SOB's groups (Brown & Brown, 2014) consider to be more helpful for them in the recovery process:

- knowing that they were not alone and that other people were in the same situation
- having the opportunity to socialise outside of the meetings
- considering themselves able to help other people in their grief process

Table 1 shows different kinds of feelings experienced by people bereaved by suicide and presents the pros and cons that the facilitator should consider in the management of the group.

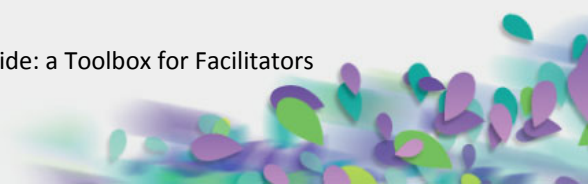
Tab. 1 HELPING FACILITATOR'S CHOICES

THOUGHTS AND FEELINGS	 PROS	 CONS
Sense of normality , feeling normal in the group (extending to acceptance and compassion for self and others).	Fundamental part of the group experience because it develops the thought that "You can survive this" and "We are all in the same boat".	This path anyway can be difficult for people who tend to ruminate afterwards because they find it very difficult to go home and to shut the things away.
Feelings that can arise from the hearing of different stories and perspectives on the suicide and bereavement.	This aspect is an important and useful experience because it provides the sense that suicide bereavement can happen to anyone and the insight that no matter how hard people have tried to prevent it, it is not possible to keep a loved one safe at all times.	People can also feel a sense of being in the wrong group, some participants can prefer greater similarity in bereavement experience. These people can feel that everyone around them is expecting them to move on, but in practice it is too much difficult for them elaborate their pain, and it is impossible for them to move on because they are stuck in their problem.
The feeling that the pain will never go away: "endless pain"	Facilitators can help to reinforce approach coping strategies rather than avoiding thoughts of the deceased by suicide, e.g. helping for example in the expression of feelings to make the person at his/her ease in being able to talk about it to someone, thus eliciting a sense of relief, creating a kind of "comfort zone" with other people that understand.	The facilitator has to be aware of the fact that the person can feel forced to talk about it throughout the group and also they can find it very hard to express what they feel.

Groos and Shakespeare-Finch, 2013



Key Issue: Most people bereaved by suicide do not seek formal support or mental health treatment in the United States (Cerel et al., 2009).



1.6 Initial Expectations and Concerns before attending Support Groups

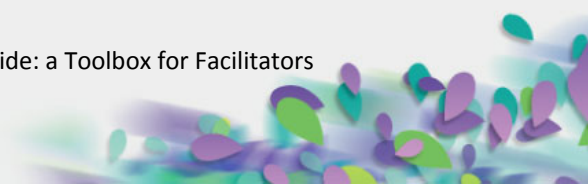
Within the context of management support groups for bereaved people it is of fundamental importance to carefully consider the expectation of the participants in order to manage them in the best possible way and to accompany the participants in the grieving process.

According to evaluation of Self Help Support Groups through SOB's conducted in Cumbria (Brown & Brown, 2014) the main expectation of participants was to meet and talk to other people who would understand one's own situation and have the opportunity to learn the way in which other people have managed to cope with their pain.

Generally people who have already had considerable counselling in the past feel that they know what to expect from the meetings, while others who were went the first time considered the first meeting as an extremely emotional experience. The feelings of concerns and worries about the first attending were mainly feelings of nervousness, anxiety and apprehension about:

- Facing a group of strangers
- Talking about an intimate and painful subject
- Being unable to deal with other's people emotions





2.Support Group Establishment

In this chapter we focus on the specific strategies and guidelines for the creation of Suicide Bereaved Support Groups (SBSG) in order to help facilitators in their management. A review of literature revealed that the common contents of suicide prevention programs in support groups for those bereaved by suicide are:

- development of support networks
- cooperation from internal and external resources
- education
- training of facilitators.

The groups are open to those bereaved by suicide and their support persons, as long as they find the group of relevance to their grieving and support purposes (Lifeline Australia, 2009). In the following paragraphs we try to clearly describe some key aspects of group-management such as access to groups (postvention timing, referral process, membership), sustainability, funding and legal status (registration, Confidentiality and Insurance Cover).

2.1 Aims, Objectives and Values of SBSG

The World Health Organization (2008) report that it is fundamental to highlight the following objectives that SBSG should provide:

- A sense of community and support.
- An empathic environment which gives a sense of being understood.
- The hope that 'a new normality' can be reached eventually.
- Shared experiences in suicide bereavement, such as difficult anniversaries or special occasions.
- Opportunities to learn new ways of approaching every day functioning.
- A sounding board to discuss fears and concerns.
- A setting where the expression of grief may be shared, confidentiality is observed, and compassion and support are offered.



Key Issue: “Nobody can judge whether a person can have access to the groups or not”. This attitude describes the “Facilitators Way” as a free process, as opposed to a “Medical Model” in which the doctor makes a real assessment. (Facilitator Network)

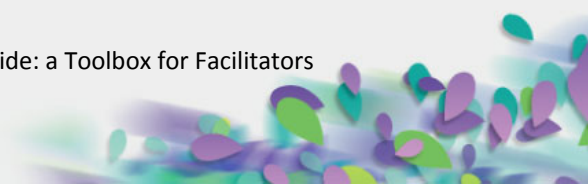
2.2 Access to SBSG

There is no prescription about when getting into a group process would be most helpful, this might rather be determined by the individual, whenever people are ready or looking for such support. During the discussion among the members of the EFN, facilitators agreed on the fact that the **access should be ensured to any person who suffered from a mourning without undergoing any kind of assessment**, thus making the **referral process much more free and as easy as possible**. They think that it is not so much talking about “assessment of potential members”, but it is more a self-help process. In case someone clearly is not able to make that decision, there might be a conversation with the facilitator and information should be provided as well as other forms of support e.g. e-mail / telephone.

Within this framework, the facilitator represents a kind of **guide** who helps the person to understand if he/she is ready or not to join the group, therefore the process is not a judgement, rather a matter of respectful support because nobody but the participant him/herself decides whether somebody is ready or not. In particular the facilitators underlined that the access to the groups is open to everybody but if the person needs a professional help (and not only the self-help) the facilitator should refer him/her to specialized services (if the facilitator is a psychologist or a psychiatrist). Please refer also to paragraph (3.2.3 Facilitator Responsibilities).

2.2.1 Postvention Timing

Postvention, defined as “**intervention after suicide**”, is aimed at reducing the impact of suicide on surviving friends and relatives (US Public Health Service, 2002) by assisting survivors in finding professional and peer support.





Deciding when it would be good timing for such a person to enter the group, it is also an important issue to discuss. There is no research, nor rules or consensus about the optimal time for people bereaved by suicide to join a group after their loss.

In general it results that some people attend a support group almost immediately, some wait for years, others attend for a year or two, and then go only occasionally especially in particularly difficult days (for more information on this please visit: the AFSP website, see references).

In literature it is reported that even when resources are available in communities, the length of time between the death and the bereaved person seeking help is often very long, partially due to the lack of knowledge of the resources by the survivor and by healthcare workers and other gatekeepers (Campbell et al., 2004; Cerel & Campbell, 2008). The authors reported also that, among people who seek treatment following a suicide, those who received active postvention seek services significantly sooner and appear to be more likely to attend support group meetings than those who received no active postvention. In the study of Groos and Shakespeare-Finch (2013) the authors stated that participants in suicide bereavement groups suggested that there was no prescription about when starting a group process would be most helpful but rather that this is determined by the individual, whenever the person is ready to access such support.

Table 2 shows some issues related to the length of time since the loss experienced by people bereaved by suicide and displays both the positive aspects that the facilitator might exploit and the warning signs that should be considered to effectively monitor the group.

Tab. 2 HELPING FACILITATORS ACCORDING TO THE LENGTH OF TIME SINCE THE LOSS OCCURRED FOR THE BEREAVED PERSON

LENGTH OF TIME SINCE THE LOSS AND ADJUSTMENT TO LOSS	 POSITIVE ASPECTS	 WARNING SIGNS
The length of time after the death can be considered an important issue in relation to managing the pain and the grief of the bereaved people. Timing is seen by participants as very important because it is taken as a kind of criterion that governs certain expectations on behaviour on how long will the pain last (Groos & Shakespeare-Finch, 2013)	Seeing the progress towards developing a new normality made by others may help people to instil hope and provide support to some participants. A lack of adjustment to the loss also provides a point of comparison and motivation to try to resolve current issue (Groos & Shakespeare-Finch, 2013). Because members of support groups may be at various points on their adjustment to loss and have different abilities to cope with their circumstances, it could be useful for the facilitator to identify the members that have learned to cope effectively with situations similar to their own in order to allow them to stay more in touch (Yalom, 1985).	Some participants can be stuck in their feelings for years after the death of the loved one. Other participants might be concerned of finding themselves in similar conditions for the future (Groos & Shakespeare-Finch, 2013).

2.2.2 Referral Process

When managing the referral process to the Support Group the facilitator should take into consideration the following aspects:

- Ensure that participants have current information about the group and brochures to hand out, e.g. as length of support group program and length of sessions. Consider that there are some realities, e.g. the SOB's self-help process, in which no time limits, frequency or attendance or other involvement features in the group is defined, therefore

a facilitator may consider to share a timetable proposal and specify that there are no constraints on that.

- Give regular presentations and send out newsletters. A dedicated person (staff/volunteer) should regularly provide reminders to relevant agencies.
- People bereaved by suicide may not themselves seek out an SBSG, or may be resistant to attending an SBSG, for many reasons. Networks within a community are a valuable way to bring information to an individual, to let them know of the support that exists and encourage and assist them to attend. (Lifeline Australia, 2009).
- According to the evaluation of individual's experience through SOBs' in Cumbria the authors underline that sometimes the first contact might be very difficult for some people. At this regard they reported the thought of one of their participants, who stated that making first contact was daunting and required courage; this person said also that the first contact via text message or email can be great if someone is not yet comfortable with talking on the phone' (Brown & Brown, 2014).



Key Issues: it is vital that the initial contact by someone who has been bereaved is handled well. It is arguably the most vital aspect of the whole situation. For the bereaved person to make contact is a huge step to take into the unknown. In this the role of the facilitator can not be underestimated. (Facilitators Network)



Please see flow chart (Appendix 1) attached to get a sense of what the referral process might look like.

2.2.3 Membership

Support Groups can be attended by people bereaved from different kinds of death: there are groups composed by bereaved by suicide only (e.g., De Leo Fund in Italy) and groups composed by bereaved by any other kind of death. Moreover, some groups are specifically designed for certain types of survivors (e.g., parents who have lost their child, in Spain), while others are open to people with different types of relationship with the deceased (e.g., De Leo Fund's groups are open to people who have lost a parent, a son/daughter, spouse, partner, sibling, etc.).

Table 3 describes different groups of bereaved people and it discusses some elements that can both be exploited or taken into consideration as warning signs by the facilitator.

Tab. 3 FACILITATOR'S GUIDE THROUGH DIFFERENT GROUPS OF BEREAVED PEOPLE: ELEMENTS TO BE EXPLOITED AND CRITICAL ASPECTS

DIFFERENT GROUPS	 ELEMENTS THAT CAN BE EXPLOITED BY THE FACILITATOR	 CRITICAL ASPECTS TO CONSIDER IN THE MANAGEMENT OF THE GROUP
Groups for bereaved by suicide versus groups for bereaved by different types of death	Every kind of group might be supportive, if there is atmosphere of respect and acceptance.	In a group for bereaved by different types of death, the facilitator should be careful about possible comments of some participants to those bereaved by suicide (e.g., "It was the decision of your son to take his own life; on the contrary my son wanted to live").
Members who share similar characteristics , such as age, gender, cultural or linguistic background, type of relationship with the person who has died.	<p>The common ground shared by people of the support groups helps to decrease feelings of embarrassment or being different (Lego, 1984).</p> <p>Group members often express the belief that they are best understood by those who have coped with similar circumstances and have survived (Mitchell et al. 2004).</p> <p>Grouping individuals with others who have experienced a similar death often might help normalize the thoughts and the feelings of the participants, reduce isolation, and might contribute to a better understanding of others and make sense of a death (Walijarvi et al., 2012).</p>	In some cases, groups of participants with similar characteristics (for example, only parents who have lost children) may have limited opportunities to find new solutions and strategies. Heterogeneity among members could enrich the experience of the group.
Bereaved parents	Researchers argue that the bereaved parents may reconstruct life-assumption or integrate what has happened in their existing assumptions (Janoff-Bulman, 1992). Also the opportunity to express thoughts and feelings	Generally when a young family member dies, the experience often results in serious and long-lasting psychosocial problems for the bereaved (Jordan, 2001). Frequently somatic symptoms, anxiety, insomnia, severe depression and post-traumatic

	<p>about a loss to others may contribute to the healing of the biographical disruption caused by the event (Neimeyer, 2000). Therefore it seems that a process of reconstruction or re-ordering of meaning seems to be central to healing processes during grief (Dyregrov, 2004). According to the “Support and Care study” (Dyregrov, 2002) parents need both formal assistance (professionals/community based) and especially informal support (social network) that is represented by extensive support from family and friends, through every kind of contact as letters, poems, books, help with housework, everything that help breaking their isolation.</p>	<p>distress are described (Joseph, 2000). Parents are preoccupied with thoughts of their child, searching for him/her experiencing disbelief about the death and are stunned by, and have difficulties in accepting the death (Prigerson et al., 2000). There is also self-isolation which might be linked to loss of energy and feelings of guilt and self-blame by parents; these social and emotional withdrawal often act as a barrier to accepting offers of social support, and professional assistance (Dyregrov et al. 2003). Substantially the trauma in the lives of the parents make great demands on their capacity to confront and handle the situation both cognitively as well as emotionally (Neimeyer, 2000). Sometimes the social network might be experienced as unhelpful because not everybody has a well-functioning social network system and even if a network exists, network members often show ineptitude on how to encounter people in crisis (Dyregrov et al. 2003).</p>
Bereaved relatives and friends of older people	<p>The process of investigation after the death of an elderly person who lives alone can cause great stress to the family, but it has been demonstrated that a clear and comprehensive explanation of the purpose and nature of the inquest (by the coroner’s officers or by the police) supplemented by written information, might reduce distress (Harwood et al., 2002). This may prove that the formal explanation of the administrative process after the death could benefit participants furthermore in association with providing not only informative but also emotional support. Some people also take part to the groups because they wish to discuss unresolved issues about</p>	<p>The most intimate relationship of an older person dying by suicide might be with a friend or neighbour rather than a close relative. Such people may be less likely to be identified as being in need of help, and so they may receive less emotional and practical support than spouses or close relatives. Often in fact a high proportion of older suicide victims are living alone because of this it might be possible that bereaved relatives and friends report distress caused by the involvement of the media, related to inaccuracies or insensitive wording of newspaper reports. Secondly they may report administrative problems and difficulties with the coroner’s office because of the routine provision of written information about the inquest procedure (Harwood et al., 2002).</p>

	their relative's death.	Compared to other groups of bereaved people this kind of group in particular has been demonstrated to suffer from higher rejection, unique reactions, stigmatisation and shame.
Bereaved with mobility disabilities		The facilitator should consider that they need special facilities such as ramps and disabled toilet facilities, and they might require the use of an interpreter.

⚠ THE FOLLOWING PARAGRAPHS INCLUDE LEGAL ASPECTS WHICH IT IS RECOMMEND TO BE CONSIDERED WITHIN THE REQUIREMENTS OF YOUR OWN COUNTRY

2.3 Sustainability

Developing a group which is short lived is potentially worse than not having a group at all. A strong steering group should be established at the outset to help ensure that the service is sustainable for instance if the facilitator is on holiday, ill, moves away or cannot continue for some other reason. Therefore the sustainability of the support group requires a cohesive and dedicated team. Moreover, the sustainability of the support group depends also on the cohesiveness and support gained by the group members. Making the members responsible for group operation, such as meeting set up, small group leadership, refreshment duty and in-between meeting support, may create greater ownership of the group.

It is crucial that careful consideration is given to sustainability at the outset (Lifeline Australia, 2009): for instance, it is recommended that a succession planning is considered since the beginning, i.e. someone to take over from the facilitator if he/she is ill, when he/she is on holiday or should she/he leave the area or simply decide she/he does not want to continue as facilitator.



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- In Cumbria (UK), facilitators are approved by the board of trustees of SOB's and have to complete an application form to become a facilitator and participate to a one-day training run periodically by head office.
- In Veneto region (De Leo Fund, Italy) facilitators should have good knowledge of suicidal behaviour and experience with those bereaved by suicide. Before starting to lead the group, they should have participated to group meetings led by the senior facilitator. Furthermore, the facilitator is continuously supervised by the senior facilitator.

2.4 Funding

The management of a SBSG requires also careful administration of financial resources. Facilitators can save a lot of time, effort and money if they can find a good sponsor, or auspicing body. Such bodies might be health agencies, community agencies, church organisations, suicide prevention centres or other non-profit organisations. These types of organisations may assist with direct funding, meeting space, utilities (water, electricity), catering, enquiry services, office administration, publicity in newsletters, broader promotion, mail outs and other administrative support (Lifeline Australia, 2009). Therefore it is strongly suggested to make as many contacts as possible with local organisations that may be able to offer support. In view of this it is essential that robust procedures are set to ensure that there is an audit trail in place so that how funds have been raised and the money spent can be accounted for at all times.



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- Raising money, opening and managing an account (with charitable status, in UK) and keeping accounts etc. is a very important issue: in Cumbria (UK) the SOB's groups are autonomous and raise their own funds to support their activity but must have their accounts audited by head office on an annual basis.

- In some cases, groups of support represent just only one of the activities of Non-Governmental Organisations. For example, De Leo Fund (Veneto region, Italy) is a non-profit organisation that provides free services to those bereaved by traumatic deaths as for example groups of bereaved by suicide.

2.5 Legal Status

The rules may vary according to the specific countries, therefore the facilitator should carefully study and pay attention to the rules and the legal framework of his/her belonging region.

2.5.1 Registration

For activities like the SBSG, the legal registration of these groups might be necessary in order to obtain the tax benefits provided by the legal system. Once registration has been completed, if necessary, the group can start with its activities. Here below some examples of types of legal registration of SBSG:



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- In Cumbria (UK), SOBs are registered charity. The charity commission website (www.charitycommission.gov.uk) for offers lots of information about setting up a charity and legal considerations.
- In Veneto region (De Leo Fund, Italy) there is no need for registration because the groups are part of the activities of the organization. However, it is useful to register the group in the online database of self-help groups for bereaved persons since this can be easily consulted by persons in need

2.5.2 Confidentiality and Privacy Legislation based on European legal framework

It is fundamental to consider data protection and confidentiality when storing personal information e.g. e-mail addresses, phone number, details of bereaved persons situation.

Where a facilitator becomes aware of a bereaved person in the community through a third party (e.g. friend rings with a person's details), he/she should be cognisant of the privacy and confidentiality rules. Contact should only be made if permission has been given by the bereaved person. It may be useful to establish a list of individuals and agencies most likely to come into contact with those bereaved by suicide. (Lifeline Australia, 2009).



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

Some examples of legislation that regulates/governs this aspect:

- **In the UK the main consideration is the Data Protection Act**

<https://www.gov.uk/data-protection/the-data-protection-act>

The Data Protection Act controls how personal information is used by organisations, businesses or the government. Everyone who is responsible for using data has to follow strict rules called 'data protection principles'. They must make sure the information is:

- used fairly and lawfully
- used for limited, specifically stated purposes
- used in a way that is adequate, relevant and not excessive
- accurate
- kept for no longer than is absolutely necessary
- handled according to people's data protection rights
- kept safe and secure
- not transferred outside the UK without adequate protection

In Cumbria (UK), SOB's are registered as a charity and as a company in order to limit the liability of the trustees if something goes wrong. More information about setting up a charity and the legal considerations can be found on the charity commission website (www.charitycommission.gov.uk).

At the start of every SOB's group meeting, all participants certify in writing that they will respect and preserve the confidentiality of the participants at the meeting.

- In Veneto region (De Leo Fund, Italy), participants have to sign a consent form for handling personal data. With regards to contacts with other agencies, general practitioners and religious institutions of the local area are informed about the existence of these support groups.

2.5.3 Appropriate Insurance Cover for Participants

We want to suggest that an important point to be made is that any group setting itself up would need to be certain that appropriate indemnity insurance is in place.



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- In the UK, on a national basis, this issue is dealt by head office – currently the local groups do not contribute to this cost but this is under review and there is an argument that local groups should contribute to their support costs.
- If the group is part of the organisation's activities, like De Leo Fund in Veneto region (Italy), the general insurance contract may cover all types of activities performed by the association.



Important: to bear in mind that the group cannot work with people who are under the age of 18. This is in itself a big issue as children who are bereaved have significant needs.

3. Facilitation: Infra Structure Issue

3.1 Who is a facilitator?

3.1.1 The facilitator should be a survivor or not?

Should the facilitator be a suicide survivor who has experienced his/her own grief long enough to gain a mature perspective of the process? Most of the SBSG facilitators during the discussion in the virtual meeting stated that as to become a facilitator it is really important to be a survivor, because having experienced the grief path may help him/her in making the members of the groups more comfortable during the meetings. On the other hand, according to the point of view of other facilitators, the experience of a grief should not be a requirement because a person can become a facilitator even if not bereaved by suicide, rather the non-judgemental behaviour should represent an indisputable main point.

Considering these constraints, we suggest to follow the recommendation of your country, considering also that being a survivor can represent, as mentioned above, a valuable characteristic as it has allowed you, the facilitator, to personally face the situation. Also it is recommended that the facilitator considers training and education as a prerequisite to play his role (see paragraph 3.1.2).



Whether this can be considered a requirement or not, it is suggested to pay attention to the requisite of your specific region. Here below we give some examples of what happened in different European national contexts:



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- In Cumbria (UK) to be a survivor is a requirement when developing a Support Group for Bereaved People through SOB's.
- In Veneto region (De Leo Fund, Italy), in order to become a facilitator of Self Groups, you should have experience with people bereaved by suicide, in order to better understand the people in the group. Specifically, groups are not currently facilitated by bereaved by suicide, but by clinical psychologists.

- According to the Flemish team (Belgium), a facilitator does not necessarily need to be a person bereaved by suicide, because it is a common thought that he/she can equally understand and be supportive to the bereaved people, therefore being a survivor is neither an inclusion, nor an exclusion criteria.

3.1.2 From which background the facilitator should come from?

Generally facilitators suggest that a person who wants to conduct SBSG should demonstrate to have different skills that derived from different experiences and training path. Here below some examples are provided:

- experience with people who dealt with **different kinds of death**;
- be able to **understand the dynamic** of the group;
- prior to the facilitation, **training** and **education** should represent a fundamental factor in the facilitator process to become ready, and then it can be much more useful as much the training challenges him/her;
- undergo a **therapeutic process** or at least he/she might be aware of his/her personal difficulties versus a superficial processing of a grief in order to know how to deal with it and help people in the management of the groups. It is extremely important that the facilitators understand how they can live and manage their feelings that they might go through and that they work on in order to avoid that their unresolved problems can affect and have an impact on the members of the groups.



Key Issues: facilitators consider the personal therapeutic path after the grief very important in order to become a facilitator. “It is important that we as facilitators deal with our own baggage” (Brown John, Facilitator Network)

3.1.3 Therapeutic versus Volunteer facilitation?

Some facilitators suggest that quite an important distinction should be made between a ‘treatment / therapy’ approach and one where people take their own decisions about

what will or will not work for them. During the VM facilitators addressed the issue about whether the facilitator should have or not a **theoretical background** about the grief and any traumatic death. According to this question they addressed another important topic about the way self-help groups are run, e.g.: **where is the line between a therapeutic and a self-help process?**

In order to properly deal with this question they suggested to describe the distinction between “pure community based self-help groups” and “groups conducted by professionals” clarifying that this is a complicated issue that is important to take into consideration within this framework. Specifically pure community based self-help support groups (self-help, mutual-help and mutual-aid are used interchangeably) are self-help suicide bereavement groups which do not follow a structured timed program. These groups are focused on decreasing isolation and fostering a supportive peer network. They generally have open membership and content is determined by common needs and shared experiences. Self-help support groups are groups made up of people who are directly and personally affected by a specific issue or condition and are run by their members, therefore those directly affected by the issue are the ones who manage the activities and the priorities of their group. It is also possible to have help support groups with a facilitator who is not a survivor.

Groups conducted by professionals are groups which generally are based on a therapeutic framework (e.g. cognitive behavioural groups, stress coping groups, psychotherapeutic groups), they can involve not only volunteers but also one or more professionals who can lead therapeutic approaches or conduct professional assessment or evaluations of the members in order to identify any grieving process which required specialized help.

There are some Countries in which the support from a professional is a requirement considering the difficulty of having to deal with certain delicate topics. In the study of De Groot and colleagues (2010), the authors came to the conclusion that it's not without dangers to let people just talk to each other in support groups without a professional facilitator.



Key Issues: the best way for helping people who are bereaved by suicide should include a program with different concepts and models providing each bereaved individual with multiple ways to process and cope with the death of their loved one (Walijarvi et al., 2012).



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- In Flanders (Belgium) two facilitators per group are foreseen and at least one of them is a professional. In particular the professionals have to follow a specific training. In this region the importance of an assessment before participating in the group is another requirement.
- In Veneto region (De Leo Fund, Italy) the facilitator is a professional; there is also another person (volunteer or trainee) who takes notes during the meeting, observes the group dynamics and the facilitation process and shares a few considerations with the facilitator after the meeting.

3.2 Criteria for facilitation

3.2.1 Facilitators duties

Among the different duties facilitators should ensure that:

- everybody is able to have a say
- there is no pressure to speak or a judgmental atmosphere
- dominance is prevented and everyone is included
- provision of informal break at least once in the course of the meeting to enable networking to take place

(Lifeline Australia, 2009; De Leo et al., 2013)

The process is about providing a platform through which people who are bereaved can interact in a way that provides the following opportunities:

- To be understood
- To be accepted for who you are
- To express feelings of frustrations and anger without being judged
- To talk about the person who has died and the means of his/her death
- To share coping strategies
- To receive and exchange information about formalities

- To establish friends and networks outside the group setting
- To experience a light and easy approach with few rules to follow

(Lifeline Australia, 2009; De Leo et al., 2013)



Key Issues: establishing and maintaining support for people bereaved by suicide is not just about running a group meeting on a regular basis (Facilitators Network)

3.2.2 Facilitators Roles

The roles of facilitators when conducting SBSG are numerous. Some of the most important roles are described here below and summarized and labelled on the right-hand pane:

- **GUIDE: provide the empathic presence and guide the group through the various activities** that are offered in the groups over the course of the program (Walijarvi et al., 2012, De Leo et al., 2013).
- **CARING INFORMER: share Information**, providing explanation and clarifying information, being careful to use simple sentences is therapeutic because it replaces uncertainty with credible explanations that can be woven into cohesive narratives, helping to restore participants' sense of control over their lives (Dysart-Gale et al., 2003). Examples of explanation and clarifying information: honest explanations regarding the nature of suicide, death and dying and the understanding of the grief process.
- **ENCOURAGING/WELCOMING MODERATOR: establish participants' expectations that the group is a safe place to explore emotions and that it is designed to help members cope with their loss.** To this purpose the facilitator might convey a caring, respectful presence by empathic, active listening. This should promote group cohesiveness through the establishment of safe and respectful boundaries. The facilitator is invited to maintain this environment of safety also while conducting a

variety of supportive activities of verbal, written, artistic and/or interactive nature (Mitchell et al., 2007).

- **VALIDATOR: creation of a supportive atmosphere** by articulating their feelings and emotions, members of the group should be reminded that they still have other people who care about them and will support them, increasing the sense of group cohesion as the participants are able to rely upon each other for acceptance and support. This atmosphere should increase a sense of validation, self-esteem and approval within the group, thus allowing the development of interpersonal communication skills for improved relationships both inside and outside the group (Mitchell et al., 2007, De Leo et al., 2013).

3.2.3 Facilitators Responsibilities

- **Recognise some critical aspects in the management of the group:** E.g. when the person is not processing the grief, consider whether participants need specialized support, identify and intervene in case of dysfunctional behaviour (see paragraph 5.2).
- **Establish what resources already exist in the area and who the key contacts are:** E.g. stakeholders of suicide prevention: GPs, psychologists, police (see paragraph 4.2).
- **Consider data protection and confidentiality issues:** what information is to be held and how will it be held, possible registration with the Information Commissioner. Ensure that appropriate indemnity insurance cover is in place (see 2.5 paragraph Legal Status).
- **Consider terminology:** the facilitator should contribute to the creation of a common vocabulary, as to be sure that participants share the same meanings. For instance the term 'survivor' can cause some confusion also 'open vs closed' group (see glossary section).
- **Prompt, sympathetic response to contact by email or phone and subsequent follow up through group meeting or buddying to meet:** by facilitators, at any time of day or night any contact will be responded to as soon as possible and normally the same day. Person who is bereaved obtains support and reassurance that people who have some understanding are out there and will work to come alongside them as they travel their

difficult journey, if this is what the person making contact wants to happen (Brown, 2014).

- **Make sure that everyone signs in when attending a meeting:** the records for attendance are held by the facilitator, and, in case a statistician exists, the number of people attending the meeting should be sent to him/her. Also, by signing the presence sheet, the people attending the meeting undertake to respect confidentiality within the group.

3.2.4 When to initiate a self-help support group for survivors

Identifying the right moment to start leading a support group is not an easy decision to make. From the discussion with the facilitators of the EFN, it resulted that if the facilitator experienced the loss of a loved one, he/she should feel ready before taking on this role.

In particular, the difficulties which can arise for a survivor could be:

- To have no time to express his/her own feelings, but it is very difficult to consider the best timing and sometimes even three years, which is actually the time that has to pass for facilitators in UK, might not be enough;
- He/she should feel the need of supervision, therefore we suggest to start by taking part as a rapporteur/observer of a group facilitated by someone else, before becoming a facilitator;

In occasion of the VM all the facilitators gave their view on this, and there was a common agreement on the **importance for facilitators to feel actually ready when taking on the role of group facilitator** because of their experience with the grief and because a proper amount of time is passed, or because they underwent a training and they feel ready:





EXAMPLES FROM SPECIFIC REGIONS IN EUROPE

- According to the rules of SOBs UK facilitators have to wait at least 3 years after the grief before becoming a facilitator. Until October 2014 the requirement was 2 years but this was changed to 3 by the board of SOB's UK. This norm has been introduced because if an insufficient amount of time between the grief and the starting time pass, this could have a negative impact on the conduction. According to the view of some facilitators, 3

years is the minimum required time after the grief to wait before becoming a facilitator , but if the person doesn't feel ready of course there is no reason not to wait longer.

Table 4 describes some important aspects (pros and cons) that we suggest to consider when deciding the right moment to facilitate, after the grief.

Tab.4 HELPING FACILITATORS TO CHOOSE THE RIGHT MOMENT AFTER THE GRIEF TO START TO FACILITATE SUPPORT GROUPS

LENGTH OF TIME SINCE THE LOSS TO BECOME A FACILITATOR	 PROS	 CONS
The length of time after the death can be considered as an important issue in relation to when to start to be a facilitator .	An effective facilitator is able to empathize objectively, refrain from making judgmental statements and from imposing particular religious beliefs, understand the stages and tasks of grief work, and be skilful in managing discussion. The facilitator should be familiar with depressive illnesses, their link to suicide, and their treatment (www.save.com)	The facilitator should feel ready to lead the group. He/she should have the availability of some space outside the group to talk about own feelings and difficulties.

3.3 Facilitator Techniques

The evaluation on the SBSG in Cumbria (UK) suggests that a successful support group/network provides an environment in which people feel empathetic, supportive, open, non-judgmental, being there when needed and which provides:

- A listening ear
- Meaningful discussion (Brown, 2014)
- For building a sense of meaning: studies have indicated that when the survivor is able to achieve a sense of meaning in connection with the death, the distress of the traumatic death is reduced (Neymeyer et al., 2006).

Here below are described some of the **Active Listening Techniques**

Tab. 5 ACTIVE LISTENING TECHNIQUES

TECHNIQUES	Purpose	Approach	Language
ENCOURAGING	To convey interest. To keep the person talking.	Do not agree or disagree with speaker. Use non-committal words with positive tone of voice.	I see... Uh-huh... That's interesting... Tell me more about... Go on...
RESTATING	To show that you are listening and understanding. To help speaker grasp the facts.	Restate the speaker's basic ideas. Put in your own words.	If I understand, <u>your situation</u> is... In other words, your <u>decision</u> is...
REFLECTING <i>The power of silence should not be underestimated.</i>	To show you are listening and understanding. To let the speaker know you understand <u>how he/she feels</u> .	Reflect the speaker's basic feelings. Put in your own words.	You <u>feel</u> that... You were pretty annoyed about that... You <u>believe</u> that...
SUMMARIZING	To pull important ideas, facts, etc. together. To establish a basis for further discussion. To review progress.	Restate, reflect, and summarize major ideas and feelings.	These seem to be the key ideas you expressed... If I understand, you feel this way about this situation.



(Facilitator Toolkit, 2007)

3.4 Types of Support Groups



3.4.1 Types

Closed Groups: generally the adjective “closed” can refer to the timing (e.g. a time limited group where the same members attend for a specified period of time), or to the membership (e.g. the groups are open only to people bereaved by suicide).

Tab. 6 PROS AND CONS OF CLOSED GROUPS REFERRING TO THE TIMING

 PROS OF CLOSED GROUPS	 CONS OF CLOSED GROUPS
The time-limit placed on the group clearly defines the start and finish allowing people to know and trust each other.	The timing structure can limit referral and access of people to the group because they have to wait until the next group starts.
If there is a program for every session the agenda can be easily followed .	A strict time program can be hardly applied in smaller communities because it might constitute a limit to reach a sufficient number of participants who are committed to start the group in that precise moment.

Tab. 7 PROS AND CONS OF CLOSED GROUPS REFERRING TO THE MEMBERSHIP

 PROS OF CLOSED GROUPS	 CONS OF CLOSED GROUPS
When membership is stable, it helps to build strong interpersonal relationships that may extend beyond the group meetings.	This structure limits the possibility for each member to enlarge his/her social support network.



EXAMPLES FROM SPECIFIC REGIONS IN EUROPE



We want to underline that the difference can arise when we refer to open or closed groups across the different EU countries because someone can refer to closed groups meaning the membership rather than the timing:

- the SOBs groups of Cumbria (UK) are regular meetings which are closed in the sense that they are open only to people who have been affected by suicide, no one else may attend, and at the same time there is no time limit;

- the Association Alma y Vida in Spain offers group therapy for parents who have lost their child. The basic rule for attending this group is to have lost a child to whatever reason or cause. The parents receive a basic interview to get information about them, their child, and the circumstance of the death;
- De Leo Found in Veneto region (Italy) organizes open groups but the entrance of just 1 member per family is allowed.

Open Groups: generally a group without a set end-point, meaning that the group members attend and stop attending according to their needs. The group is permanent and meets at certain times throughout the month/year. It becomes known within the community as a resource for individuals to participate in as the need arises (WHO, 2008).



Tab. 8 PROS AND CONS OF OPEN GROUPS

 PROS OF OPEN GROUPS	 CONS OF OPEN GROUPS
The nature of the group makes the group appear open and available to the community in case of need.	Maintaining the leadership/facilitation of the group over a longer period may be difficult.
Members do not need to have an ongoing commitment, which can be overwhelming in the early stages of grief.	Maintaining the group's size can be difficult at times, since numbers will fluctuate. Some survivors may become stuck in the group rather than dealing with their own individual issues and moving forward in their healing process. The contents of the discussions can be repeated when new people come in, and this can be boring or difficult to bear for the "old" members. It can also bring more insecurity, and less trust .

Online Groups: an online group is a virtual community whose members interact each other primarily via Internet. Generally members who wish to be part of an online community have to become members via a specific site. An online community can also act as an information system where members can post, comment or discuss, give advice or collaborate. For example:

(<http://webdesign.about.com/cs/communityonline/a/aa082599.htm>)

Tab. 9 PROS AND CONS OF ONLINE GROUPS

 PROS OF ONLINE GROUPS	 CONS OF ONLINE GROUPS
<p>For the bereaved by suicide this can be particularly beneficial because they may have difficulty in finding a face-to-face support group in their own community and at the time they are in need (Schotanus-Dijkstra, et al. 2013). A possible explanation for this finding could be that the bereaved by suicide often experience social stigma (Sveen & Walby, 2008). Therefore it could be difficult for them to share experience in their own social network, and an online-forum could be the only place where they can tell and re-tell stories without feeling judged or ignored (Schotanus-Dijkstra, et al. 2013). Sharing experiences and discussing taboo topics seem to be the most important features of these groups (Chapple & Zieblans, 2011).</p>	<p>People often live far away from each other, and it could be difficult to go out together and socialise. Therefore, the support can be limited to meeting time.</p>

3.4.2 Format for meetings

There should be two formats for consideration: Structured or informal

1. **Structured format:** this format provides for a set procedure to be followed at each meeting. The group will decide on how the meeting will open, what will happen during the meeting, and how it will close. A structured format does not need to be restrictive, but can offer members stability because they know what to expect.

A suggested format might be as follows:

- (a) Welcome and introductions;
- (b) The “code of ethics” determined by the group is read out;
- (c) Sharing experiences;
- (d) Information or education on prepared topic;
- (e) Recapitulation of the content of the meeting and planning for the next meeting;
- (f) Refreshments and socializing.

2. **Unstructured or informal format:** this format does not have a set agenda. The group discusses whatever issues arise from the participants' needs. However it is recommended that step (b) of the procedure for the structured format be adhered to.

(World Health Organization, 2008)



4.Setting Up

In order to ensure an operational framework to facilitators, here below is a collection of details for setting up the location of the meetings and the resources required for the conduction of the groups .

4.1 Location, Place and Meetings

It is important to determine a **meeting schedule** that can be nominated and adhered to without change. In doing this we suggest to consider the schedule of other support groups that might be within driving distance. E.g.: in Cumbria (UK) open meetings are held on an annual basis in different parts of the county, the reason for this was that meeting on a weekday evening resulted to be a barrier to some people.

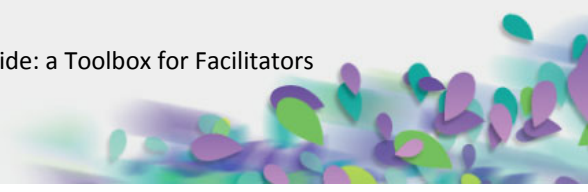


It is advised not to make the venue and time publicly available, but rather disclose this information at initial contact (via phone, text, email etc). This provides an opportunity to ensure that the person is genuinely bereaved and has no ulterior motive; also it ensures that the person will not come directly to the meeting without making before the first contact with the facilitator.



When deciding the **location** of the meetings, we suggest to consider the following aspects:

- Accessibility: need to consider locations in terms of accessibility e.g. public transport;
- Availability on a permanent basis: consider time of meeting (day/night/week end);
- People who do not have e-mail access receive less effective support;
- Safety: also consider health and safety aspects, e.g.: fire regulations, disabled access, hazard free;
- Space for breaking, space for refreshments: e.g.: a large dining room where the group participants and, occasionally, all families gather for meals or shared moments.



Please consider the following recommendations related to the location and timing of the meetings, raised from the evaluation conducted by SOBs' Cumbria (Brown & Brown, 2014): for some people meeting in the evening is a problem due to other family commitments. In addition, the distance to reach the meetings location is not always ideal in terms of time required to travel. As such, it was suggested to:

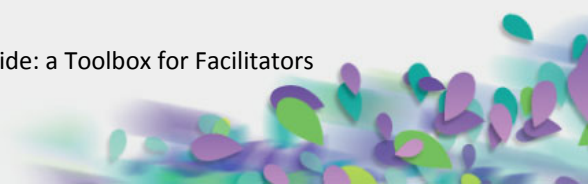
- organise more day time meetings on weekends;
- have a directory of people who may live near each other, in order to permit people to be able to link up outside of meetings and closer to home.

4.2 Resources

The facilitator must have the following resources and skills:

- A mobile phone which can receive voicemail messages specifically for the purpose of enabling contact at any time.
- An email address which is checked regularly.
- A good knowledge of key resources both documents and people.
- A relatively small amount of finance through fund raising.
- Co-operation from a range of key agencies: Police, Coroners and their officers, undertakers etc.
- Support from people who have been bereaved to 'buddy' other people who live in the same area.
- Training and support from the National head quarter, including training for group facilitators.
- He/she must be able to respond to any enquiry or contact as soon as possible and certainly within 24 hours.
- He/she should act as a treasurer willing to ensure financial probity of the group.

(Brown, 2014)

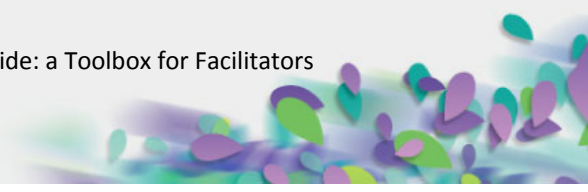


4.3 Awareness Raising / Community Networking

Active community networks help the organizations who lead SBSG to thrive. They provide a way for professionals/non-professional facilitators to connect with their peers and share knowledge. Building relationships with other people working in the same field is an important thing to consider in order to build an operational framework.

Here below we give some basic information on what to do as to facilitate the networking:

- **Make contact** with and utilise any existing links with local organisations: e.g.: funeral directors, church, (charities) also ensuring that group contact details are in the local papers, providing information for health services (e.g. GPs) and Coroners Officers working with the media to achieve positive and adequate press coverage of the work of the group (Brown, 2014). In the recent evaluation of individual experience of self-help groups through SOB's in Cumbria (UK), the most frequent way in which individuals were made aware of the support group was through local media avenues, GPs and internet searches (Brown & Brown, 2014).
- **Attendance to annual meeting:** a facilitator should attend annual meetings and ensure that issues and themes raised by people bereaved by suicide are considered and taken forward, e.g. current work on encouraging the media to report inquests and the death itself sensitively and to use their power to support the health and wellbeing of the community (Brown, 2014). A SBSG facilitator may consider giving regular presentations and newsletter articles. Given the staff turnover, it is important to regularly provide reminders to relevant communication agencies (Lifeline Australia, 2009).
- It is of little benefit to have a great group if those who need to know (the bereaved) are not told, in a timely way, of its existence. **Two strands to awareness raising** should be pursued: the initial and then continuous awareness raising. This is recommended as people bereaved by suicide may not themselves seek out an SBSG, or may be resistant to attending an SBSG, for many reasons. Networks within a community are a valuable way to bring information to an individual, to let them know of the support that exists and encourage and assist them to attend. It may be useful to establish a list of individuals and agencies most likely to come into contact with those bereaved by suicide.



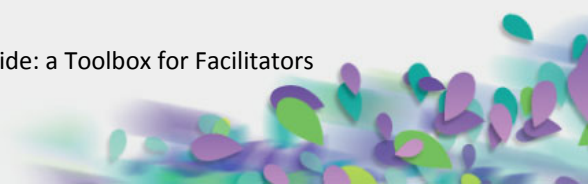
4.4 Suggested improvements of SBSG from SOBs Cumbria members

With regard to the “setting up” phase, some of the suggestions, comments, views and experiences from members and facilitators of Self Help Support Groups, raised in the context of the evaluation that SOB’s conducted in Cumbria, are reported.

They are precious information to consider when setting up a SBSG:

- Raise awareness, spread the word about the groups and improve marketing;
- Send frequently information by post as there are some people who do not have access to email;
- Raise awareness that support is available for close friends and not just relatives;
- Provide more information on the website about what to expect from the group;
- Provide opportunities for people to give something back in terms of helping and supporting others;
- Invite people to talk about certain issues as part of the meetings, e.g. occasional inclusion of professionals;
- Give exercise classes;
- Organize fund raising events;
- Arrange for café drop .

(Brown & Brown, 2014)



5. Practical Tools

To conclude we want to give a range of practical tools to support the facilitators in the following tasks: how to initiate a self-help support group for survivors of suicide and how to identify the warning signs or critical success factors in the development of groups.

5.1 Preparation of the first meeting

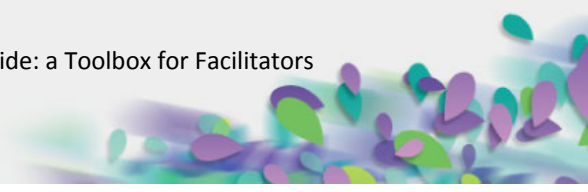
One of the major practical issue relates to the planning for the first meeting. In order to support facilitators we propose this kind of frame which is likely to include the following steps:

- **List of things to do:** draw up a list of all the things that need to be done;
- **Confirmation of the place:** book and confirm the meeting place;
- **Agenda of the day:** prepare an agenda for the first meeting, as it is essential that the format of the meeting is planned and that those attending know what to expect (suggestions for a possible agenda are listed below);
- **Collection of information:** prepare to collect written information, e.g. contact details of people attending, have name tags available;
- **Professional intervention:** consider whether the support of a professional or an experienced group leader/facilitator may assist in this first meeting.

5.1.1 Agenda of the first meeting

A possible **agenda** for the first meeting would be:

- (a) **Welcome** from the meeting organizer;
- (b) **Introduction and Presentation:** those attending may be asked to give their first name and say how they found out about the group;
- (c) **Objectives:** a clear and simple explanation of the broad purpose of the group;
- (d) **Contents:** explain the topics relating to the formation of the group (see points below);
- (e) **Refreshments and socializing:** organize a refreshment to allow group members to know each other and interact.

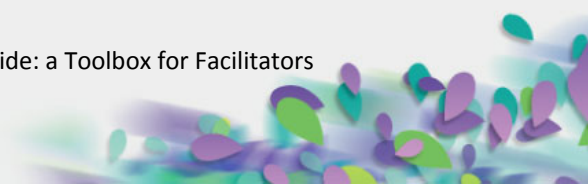


5.1.2 Topics to be discussed at the first meeting

Here below are reported a series of elements that should be discussed at the beginning of the meetings as to ensure the normal continuity of the group:

- **Interest to form a group:** Is there sufficient interest to form a group? Having attended the initial meeting, do people wish to continue?
- **Number of persons per group:** consider that while some survivors prefer a small group of five or fewer so that each person can talk more, others like a larger group where they can “get lost in the crowd”.
- **The frequency of the meetings:** should they be held weekly, every two weeks or monthly? Factors to consider are that if meetings are too frequent the individuals may develop dependency on the group; on the other hand, if meetings are too infrequent bonds may be difficult to form (see paragraph 4.1 for other details). It could be useful to have frequent meetings at the beginning in order to help participants to build bonds, and subsequently decrease the number of meetings.
- **Length of meetings:** how long should the meeting last? Most groups find that meetings of one and a half to two hours work well. If meetings are longer they can be too emotionally draining for the participants. . A two-hour time frame allows for settling in, running the meeting, and socializing with refreshments. The group size may determine the length of the meeting, as larger groups may need longer group meetings. Keep in mind that if the group is large, it may be suitable to split it into subgroups for part of the meeting. The preferable size is 10-12 members. The bigger size brings problems in sharing and managing the group dynamics.
- **Explore the expectations:** what are the expectations of those attending? Develop a clear picture of why people are attending. Are the expectations realistic?
- **Contacts:** contact details of those who wish to continue to meet. The group may also wish to exchange contact numbers for support between meetings.
- **Schedule:** fix the date of the next meeting.

(World health Organization, 2008)



5.2 Difficult Situations

Here below are illustrated the details that characterized some critical situations which can hinder the normal conduction of the groups:

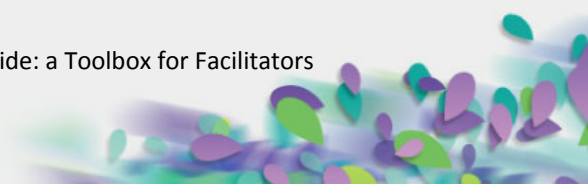
Group Conflict: conflict might be healthy in a group. It shows that members are sharing their ideas and feelings honestly. However, there are times when healthy conflict escalates and become deconstructive. Since emotions resulting from conflict tend to intensify over time, it is important to address the conflict as soon as it begins to become unhealthy.

Deconstructive Behaviour: Recognizing and understanding typical deconstructive team member behaviours will be very helpful to the facilitator (Brunt, 1993). These behaviours can affect team development and performance. Members of the team may exhibit these behaviours at varying times throughout the development cycle of the team. Keep in mind that a facilitator needs to model constructive behaviours to help the team.

How to Recognize Destructive Team Behaviours

- **Dominating:** takes much of the meeting time expressing self-views and opinions. Tries to take control by use of power, time, etc.
- **Rushing:** encourages the group to move on before task is complete. Gets tired of listening to others and working as a group.
- **Withdrawing:** removes self from discussions or decision-making. Refuses to participate.
- **Discounting:** disregards or minimizes team or individual ideas or suggestions. Severe discounting behaviour includes insults, which are often in the form of jokes.
- **Digressing:** rambles, tells stories and takes group away from primary purpose.
- **Blocking:** impedes group progress by obstructing all ideas and suggestions. "That will never work because..."

(Facilitator Tool kit, 2007)



5.2.1 How to intervene in difficult situations

Sometimes it will be necessary to intervene with a particular individual or an entire group because of behaviour or actions during the meetings. The goal of any type of intervention is to maintain the group's autonomy and to develop its long-term effectiveness.

An intervention is never an easy task, so it is important to recognize when to intervene and whether to intervene with an individual or the entire team.

There is no set time or tried and true method for when or how to intervene, but the following list of questions will help to reflect in order to decide whether an intervention may be appropriate:

Questions to ask yourself

If I do not intervene, will another group member do it?

Will the group have time to process the intervention?

Does the group have sufficient experience and knowledge to use the intervention to improve effectiveness?

Is the group too overloaded to process the intervention?

Is the situation central or important enough to intervene?

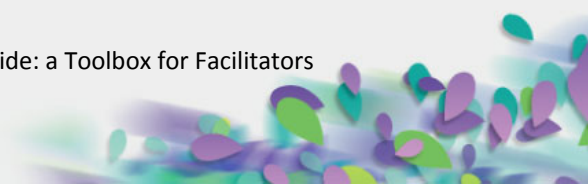
Do I have the skills to intervene?

5.2.2 Intervention Approaches

The approaches and methods listed below will provide the facilitator with some options and alternative types of interventions to use depending on the situation.

Prevention

- Before the first meeting, take time to introduce yourself, understand the needs of each team member, and establish rapport and credibility with each individual.
- Early in the first meeting, establish ground rules to guide how the group will work together. Ground rules are useful in setting common expectations for behaviour and provide a basis for team members to regulate each other's behaviour.



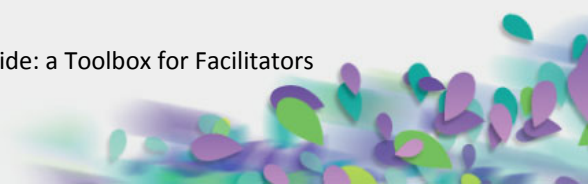
Low-level intervention: there are several techniques that can be employed at this level to change behaviour in a non-threatening way and prevent it from escalating to a serious disruption:

- Embrace the person's concerns. Listen so intently and repeat back what you've heard so accurately that the person feels he/she has been heard.
- Break into small groups to work on the task that was interrupted. Address the problem as a group concern, referring back to ground rules and naming the tension between the differing needs you have heard in the group.
- Use the occasion as an opportunity to increase the group's capacity for working together effectively by teaching a concept or method from change management or group development theory.

High-level intervention: when a team member's behaviour escalates to the point where high-level intervention is necessary, both the success of the team and the standing of the facilitator are at risk:

- To work through an impasse that may be causing high levels of frustration for one or more team members, invite individuals to describe how they feel about being stuck.
- Help the team identify new options, exploring the very positions that are dividing them as potential sources for a solution.
- If a team member's behaviour continues to disrupt and threaten the progress of the team, the facilitator can publicly name the behaviour and ask the group how it wishes to handle the situation.

(Facilitator Tool kit, 2007)



References

Bailey, S. E., Kral, M. J., & Dunham, K. (1999). Suicide survivors do grieve differently: Empirical support for a common sense proposition. *Suicide and Life-Threatening Behavior*, 29, 256-271.

Barlow, C. A., & Coleman, H. (2003). The healing alliance: How families use 755 social support after suicide. *Omega*, 47, 187–201.

Barr, A., & Dailly, J. (2006). *Step by Step: an introductory guide to the LEAP framework*. Second edition.

<http://www.scdc.org.uk/what/LEAP/resources/>,
<http://www.scotland.gov.uk/Publications/2007/12/05101807/1>
<http://www.planandevaluate.com/>

Billi-Brache, U. (Ed.). (1999). *Facts and Figures*. Copenhagen: WHO Regional Office for Europe.

Brown, J. M. (2014). Survivors of Bereavement by Suicide Cumbria - project evaluation. (in press)

Brown, J.M., & Brown, R.E. (2014). *An Evaluation of a Self-Help Support Group for People Bereaved by Suicide in Cumbria*. (in press)

Brunt, J. (1993). *Facilitation skills for quality improvement*. Madison, WI: Quality Enhancement Strategies.

Campbell, F. R., Cataldie, L., McIntosh, J., & Millet, K. (2004). An active postvention program. *Crisis*, 25, 30-32

Chapple, A., & Ziebland, S. (2011). How the Internet is changing the experience of bereavement by suicide: A qualitative study in the UK. *Health*, 15, 173–187

Clark, S. E., & Goldney, R. D. (2000). The impact of suicide on relatives and friends. In K. Hawton & K. van Heeringen (Eds.), *International handbook of suicide and attempted suicide* (pp. 467–484). Chichester, UK: Wiley & Sons.

Cerel, J., & Campbell, F. R. (2008). Suicide survivors seeking mental health services: A preliminary examination of the role of an active postvention model. *Suicide and Life-Threatening Behavior*, 38, 30–34.

Cerel, J., Jordan, J. R., & Duberstein, P. R. (2008). The impact of suicide on the 770 family. *Crisis*, 29, 38–44.

Cerel, J., Padgett, J. H., Conwell, Y., & Reed, G. A. (2009). A call for research: The need to better understand the impact of support groups for suicide survivors. *Suicide and Life-Threatening Behavior*, 39, 269–281.

De Groot, M., Neeleman, J., van der Meer, K., Burger, H. (2010). The effectiveness of family-based cognitive-behavior grief therapy to prevent complicated grief in relatives of suicide victims: the mediating role of suicide ideation. *Suicide Life Threat Behav.*; 40(5): 425-37.

De Leo, D., Burgis, S., Bertolote, J.M., Kerkhof, A., & Bille-Brahe, U. (2004). Definitions of suicidal behaviour. In De Leo, D., Bille-Brahe, U., Kerkhof, A., & Schmidtke, A. (eds) *Suicidal behavior: Theories and research findings*. Göttingen, Germany: Hogrefe & Huber.

De Leo, D., Cimitan, A., Dyregrov, K., Grad, O., Andriessen, K. (2013). *Bereavement After Traumatic Death. Helping the Survivors*. Hogrefe Ed.

Dyregrov, K. (2002). Assistance from local authorities versus survivors' needs for support after suicide. *Death Studies*, 26, 647–668.

Dyregrov, K., Nordanger, D., & Dyregrov, A. (2003). Predictors of psychosocial distress after suicide, SIDS and accidents. *Death Studies*, 27, 143–165.

Dyregrov, K. (2004). Bereaved parents' experience of research participation. *Social Science and Medicine*, 58, 391-400.

Dysart-Gale, D., Mitchell, A., & Wesner, S. (2003). Client narratives: A theoretical perspective. *Issues in Mental Health Nursing* 24(1), 81–89.

Eurostat, statistics 'death due to suicide'. Available on: <http://epp.eurostat.ec.europa.eu/>
Accessed February 2014.

Facilitator Tool Kit (2007) *A Guide for helping groups get results*. Edited by Nancy Thayer-Hart. Office of Quality Improvement, University of Wisconsin – Madison.

Groos, A.D., Shakespeare-Finch, J. (2013). Positive experiences for participants in suicide bereavement groups: a grounded theory model. *Death Stud.*; 37(1):1-24.

Hawton, K., Van Heeringen, K. (2009) Suicide. *The Lancet*, 373, 1372-1381.

Harwood, D., Hawton, K., Hope, T., & Jacoby, R. (2002). The grief experiences and needs of bereaved relatives and friends of older people dying through suicide: A descriptive and case control study. *Journal of Affective Disorders*, 72, 185–194.

Janoff-Bulman, R. (1992). *Shattered assumptions: Towards a new psychology of trauma*. New York: The Free Press.

Jordan, J. R., & McIntosh, J. L. (2011). Suicide bereavement: Why study survivors of suicide loss? In J. R. Jordan & J. L. McIntosh (Eds.), *Grief after suicide. Understanding the consequences and caring for the survivors* (pp. 3–17). New York, NY: Taylor and Francis

Jordan, J. R. (2001). Is suicide bereavement different? A reassessment of the literature. *Suicide and Life-Threatening Behavior*, 31, 91–102.

Joseph, S. (2000). Psychometric evaluation of Horowitz's Impact of Event Scale: A review. *Journal of Traumatic Stress*, 1, 101–114.

Lego, S. (1984). *The American handbook of psychiatric nursing*. Philadelphia, PA: J.B. Lippincott.

Lifeline Australia (2009). Practice handbook: Suicide bereavement support group facilitation. Lifeline Australia and Commonwealth Department of Health and Ageing. www.lifeline.org.au/find_help/suicide_prevention/suicide_bereavement_and_postvention

Mitchell, A.M., Kim, Y., Prigerson, H.G., & Mortimer-Stephens, M. (2004). Complicated grief in survivors of suicide. *Crisis*, 25, 12-18.

Neimeyer, G.J. (2000). The indescribable moment. In K. Taylor and M. Fiddler (Eds.) *Constructivism in Adult Learning and Development*. New York: Jossey-Bass Publications, 257-261.

Neimeyer, R.A. (2006). Making meaning in the midst of loss. *Grief Matters*, Vol.9, No.3, pp.62–65

Nock, M.K., Borges, G., Bromet, E.J., Alonso, J., Angermeyer, M., Beautrais, A., Bruffaerts, R., Chiu, W.T., de Girolamo, G., Gluzman, S., de Graaf, R., Gureje, O., Haro, J.M., Huang, Y., Karam, E., Kessler, R.C., Lepine, J.P., Levinson, D., Medina-Mora, M.E., Ono, Y., Posada-Villa, J., Williams, D., et al. (2008). Cross-national prevalence and risk factors for suicidal ideation, plans and attempts. *British Journal of Psychiatry*, 192 (2), 98-105.

Prigerson, H. G. (2002). Measuring complicated grief. Retrieved December 4, 2002 from http://info.med.yale.edu/psych/cgrief/measure_CG.htm

Schotanus-Dijkstra, M., Havinga, P., van Ballegooijen, W., Delfosse, L., Mokkenstorm J., Boon, B. (2014). What do the bereaved by suicide communicate in online support groups? A content analysis. *Crisis*; 35(1):27-35.

Stebbins, J., & S. (2000), Papers for Suicide Prevention Australia Conference.

Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, 38, 13–29.

Sveen, C. A., & Walby, F. A. (2008). Suicide survivors' mental health and grief reactions: A systematic review of controlled studies. *Suicide and Life-Threatening Behavior*, 38, 13-29.

Tal Young, I., Iglewicz, A., Glorioso, D., et al. (2012). Suicide bereavement and complicated grief. *Dialogues in Clinical Neuroscience*; 14:177–186

US Public Health Service. (2002). *National strategy for suicide prevention: Goals and objectives for action*. Washington, DC: Department for Health and Human Services.

Waljarvi, C.M., Weiss, A.H., Weinman, M.L. (2012). A traumatic death support group program: applying an integrated conceptual framework. *Death Stud.*; 36(2):152-81.

World Health Organization (2008). Preventing Suicide: How to Start a Survivors' Group, Department of Mental Health & Substance Abuse, World Health Organization, Geneva.
www.who.int/mental_health/prevention/suicide/resource_survivors.pdf

Yalom, I. (1985). *The theory and practice of group psychotherapy*. New York: Basic Books

Additional Resources:

Safe Website: <http://www.save.org/index.cfm?fuseaction=home.viewPage&page>

AFSP website: American Foundation for Suicide Prevention: <http://www.afsp.org/>

For Support Groups of Bereaved Children:

Supporting children after suicide, South Western Sydney Area Health Service, 2002:

[www.health.nsw.gov.au/pubs/2002/pdf/supporting_children .pdf](http://www.health.nsw.gov.au/pubs/2002/pdf/supporting_children.pdf)

National Centre for Childhood Grief: www.childhoodgrief.org.au/

Young people bereaved by suicide: www.childbereavement.org.uk/files/images/20_Y.pdf

Appendix 1

Appendix 1: Flow Chart of Referral Process

