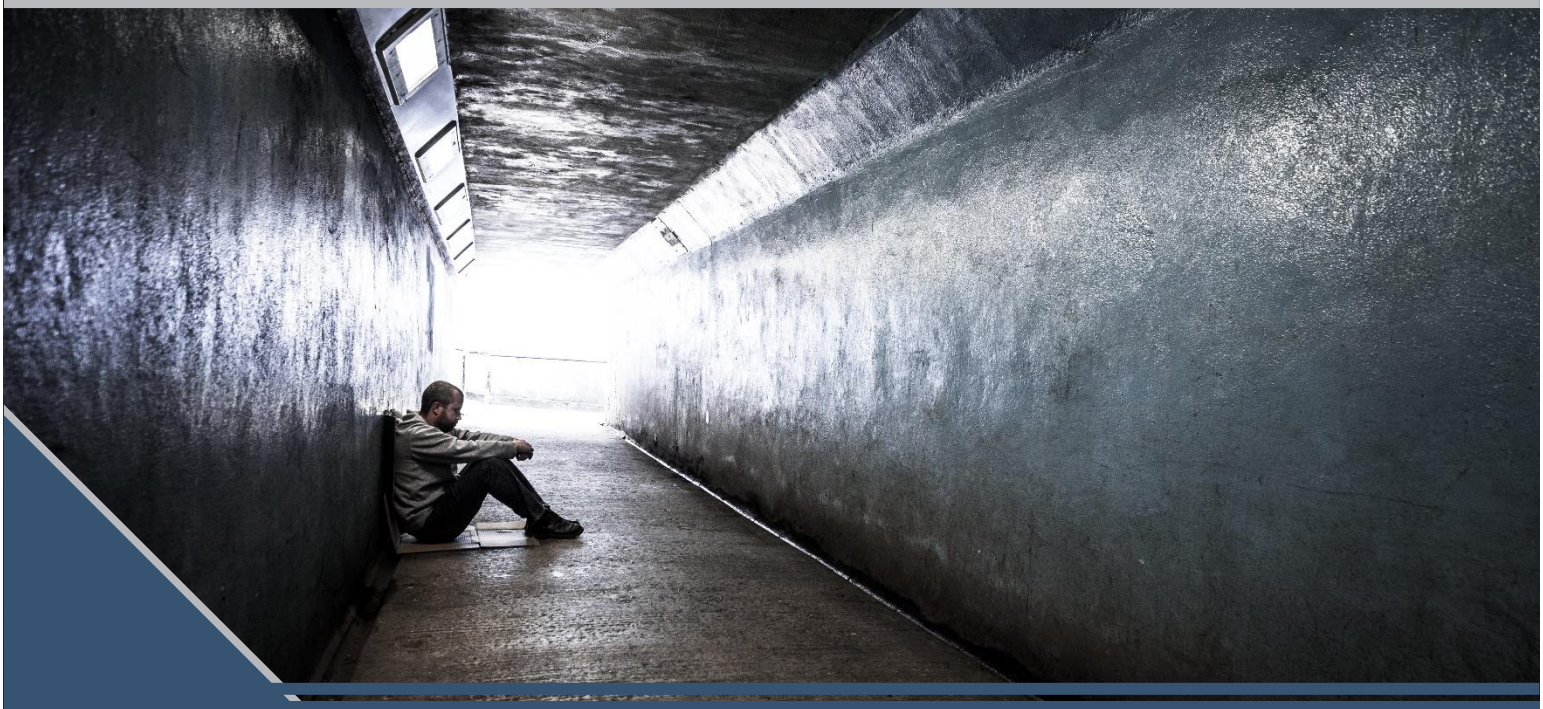
# POSTEVENTION NEEDS ASSESSMENT FOR THOSE BEREAVED BY SUICIDE IN EDMONTON

## LIVING HOPE COMMUNITY PLAN TO PREVENT SUICIDE IN EDMONTON

*September 2022*



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## 1. Introduction

The purpose of this report is to provide the City of Edmonton's Living Hope plan with an initial understanding about what postvention supports are required for those grieving a death by suicide. The needs assessment focuses specifically on the City of Edmonton. This research is intended to support other work being completed through the Living Hope initiative, namely: to assist in determining what additional follow-up services are required by those grieving a death by suicide (Living Hope Priority Action 4.2e).

To complete this needs assessment, relevant questions were added to the data collection instruments in Year 3 (2021-22) of the *Living Hope Community Plan to Prevent Suicide in Edmonton* evaluation; these questions addressed the following topics:

- What are the differences between those bereaved by suicide and those bereaved by other causes?
- Are service providers and/or clients aware of existing suicide bereavement services?
- Do those with lived experience of suicide have access to the services they need?
- What types of services should be available to individuals bereaved by suicide?
- What are the barriers, if any, to accessing services for those bereaved by suicide?

Data informing this needs assessment was collected across three different lines of evidence in the Year 3Living Hope evaluation (Table 1).

**Table 1: Data Sources Informing the Postvention Needs Assessment**

| | Type of data collected | Number of completions |
|---|---|---|
| Key stakeholders | Interview | 27 |
| Individuals with lived experience | Interview | 10 |
| Service providers | Survey | 117 |

For a fulsome description of the stakeholder groups, data collection activities, methodology, analytic approach and project limitations, please see the Year 3 Living Hope evaluation report.[1]

[1] City of Edmonton. (2022). *Living Hope Community Plan to Prevent Suicide: Final Summative Evaluation Report*.

## 2. Findings

### 2.1. What are the differences between those bereaved by suicide and those bereaved by other causes?

There was a strong belief among both respondents in the service provider survey and stakeholder interviewees that there are key differences between those bereaved by suicide, as compared to those bereaved by other causes.

Experiencing feelings of guilt was identified by respondents as the key difference between those bereaved by suicide and those bereaved by other causes. Stakeholders and service providers identified that this guilt might result from a number of suicide-specific reasons, such as: not having recognized the warning signs; not having done enough to help the person; or not having done enough to prevent the death. In particular, people bereaved by suicide might be burdened by questions such as: "What could I have done differently?" "What did I miss?" "Could it have been prevented?" "Why didn't they talk about it?" "Why didn't they reach out?". This was compared to death by other causes, which were considered easier to accept as they were 'beyond control' and were therefore not typically questioned in the same way.

> "I think the significant difference is that someone who has lost someone to suicide may suffer a lot of guilt for unknown reasons… or maybe there are obvious reasons: that they may have felt that they could prevented it, they didn't prevent it, or they didn't listen".
> – Stakeholder interviewee

> "In my experience those that are bereaved by suicide as opposed to natural causes are left with many more questions, that often leave them feeling guilty for not seeing the signs that their love one was contemplating suicide."
> – Service provider survey respondent

> "Stigma and shame. It's a loaded topic. People have lots of opinions about it. Nobody has an opinion about someone who died from cancer, but there are opinions when it comes to someone who has died by suicide. There are clear avenues of support when individuals die from other causes, but that gets interrupted when someone dies by suicide."
> – Stakeholder interviewee

> "Stigma can impact the level of social support provided and ability to talk about the death of a loved one who died by suicide vs other causes."
> – Service provider survey respondent

Both stakeholders and service providers also recognized that those bereaved by suicide often had to navigate stigma and shame associated with a death by suicide, whereas those bereaved by other causes typically did not. This stigma might include people (including service providers) not knowing what to say, or not wanting to broach the topic of the death, indicating a lack of community capacity to know how to respond. In addition, and perhaps as a consequence, stigma might result in bereaved people not feeling able to, or choosing not to, access personal or professional support systems.

The identification of stigma and shame as key factors of bereavement by suicide was corroborated by those with lived experience of suicide bereavement, who identified similar experiences of stigma following the death of their loved one by suicide. For example, some interviewees reported that the stigma of having a loved one die by suicide resulted in avoidance behaviours (i.e. people actively avoiding them because they did not know what to say) while others reported feeling shame about the death. Indeed, one lived experience interviewee reported that, in the few years

following the suicide of their loved one, they preferred to tell people that their loved one had 'suffered a drug overdose' rather than saying they had died by suicide.

> "As a person bereaved by suicide, it's as if you are part of a group. You have this lingering cloud over you all the time. It's very hard to share your story to somebody new."
> – Lived experience of suicide interviewee

Individuals bereaved by suicide further reported that it was common to be asked intrusive questions about the death, in a way they felt would not be the case had the death been by other causes. These individuals reported being asked about their deceased loved one's mental health status and, in particular, about how and why they had ended their life. How others reacted to, and dealt with, suicide could therefore result in bereaved individuals not wanting to talk about it, potentially isolating them further from support networks.

In addition to the key differences of guilt, stigma and shame discussed above, other experiences identified as unique to bereavement by suicide included shock, trauma, confusion, disbelief and anger. Some service providers recognized that, while many of these emotions are common across all deaths and are not specific to deaths by suicide, the intensity with which these emotions were experienced was more pronounced. For example, it may be common to experience anger following a loved one's death regardless of the cause; however, the acuteness of the anger was considered to be far greater following a death by suicide as compared to a death by other causes.

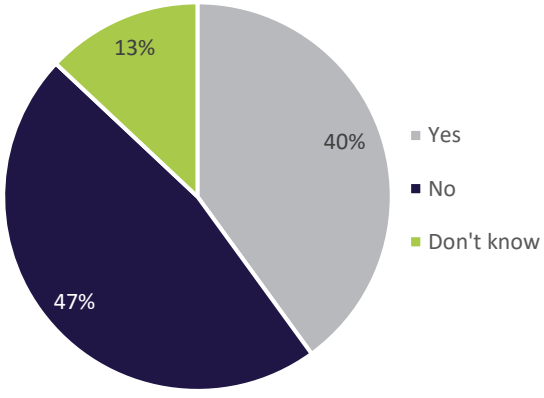
### 2.2. Are service providers and clients aware of existing suicide bereavement services?

The majority of lived experience interviewees who were bereaved by suicide stated they had not received any information about available supports, and that it was only 'with time' that some began to learn about support services. Sources of information included the funeral home, ICU counsellors, social workers or religious groups.

Among service provider survey respondents, only 40% reported awareness of existing suicide bereavement services, while the majority (60%) either did not know, or were not sure if they knew, about such services (Figure 2). Among those that reported awareness of services specifically targeting those bereaved by suicide, the most frequently-identified support was the Canadian Mental Health Association (CMHA). Other identified supports tended to be general in nature, rather than being suicide-specific, and included:

- Helplines (e.g. 211);
- Social service agencies (e.g. Jewish Family Services, Support Network);
- Private supports (e.g. psychologist, counselling); and
- Alberta Health Services (AHS).

**Figure 2: Are service providers aware of existing suicide bereavement services?**




Source: Service provider survey QG2a (n=116). 'Prefer not to answer' responses excluded.

"I think some people are aware of the bereavement services, especially if they're with their cultural groups or a church group or their small community. But if they're a group of people who just recently came to Edmonton. I'm certain that they don't know".
– Stakeholder interviewee

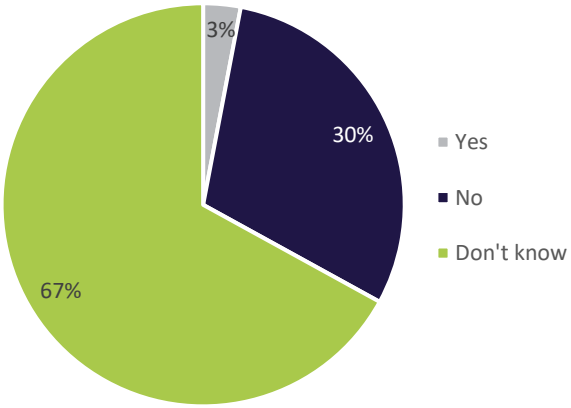
In terms of client awareness, the majority of stakeholders reported that clients are only somewhat aware of existing bereavement services, with some stakeholders noting that certain populations might have more knowledge about specific services, as compared to others. However, awareness seemed to relate to general bereavement services rather than those specifically focusing on death by suicide.

### 2.3. Do those with lived experience of suicide have access to the services they need?

While some stakeholders believed that there were no services in Edmonton that met the unique needs of those bereaved by suicide, the majority of stakeholders were unclear whether services that met unique need were available. Indeed, many stakeholders recognized that they themselves did not have clear or comprehensive knowledge of available suicide bereavement services; they thus felt that more work had to be done to support both professionals and bereaved individuals to know how or where to access services.

"I actually have no idea what's available. […] I would guess that there is very little support for those who are bereaved by suicide, but I don't know."
– Stakeholder interviewee

**Figure 3: Do Edmontonians who have been bereaved by suicide have adequate access to the services or supports they need in the period immediately following the death?**




Source: Service provider survey QG4a (n=115). 'Prefer not to answer' responses excluded.

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This aligned with data from the service providers, who overwhelmingly (97%) did not know if clients bereaved by suicide had adequate access to the services they needed in the period immediately following a death by suicide (Figure 3).

Lived experience interviewees also identified that there were gaps in service availability for those bereaved by suicide. Among interviewees with lived experience of suicide bereavement, it took time to choose to access services and, when they did, their success in accessing services was varied. Some reported finding, accessing and continuing to access, supports, while others reported finding supports but being unable to access them due to cost or long wait lists.

Lack of service access also occurred because stigma surrounding suicide prevented bereaved individuals from seeking out suicide-specific bereavement supports. However, one interviewee explained that an outcome of attending a non-targeted bereavement support group was that they realized they were 'not alone', as other members of the group had also suffered a loss from death by suicide.

"The biggest thing [I] learned is that [I am] not alone. Approximately eight to ten people in the group had lost someone to suicide. Even though [the circumstances were] all different, there were similarities."
– Lived experience of suicide interviewee

### 2.4. What types of services should be available to individuals bereaved by suicide?

The key message from those with lived experience was that services for those bereaved by suicide must be targeted, with information made available about how services can be accessed when the individual chooses to do so. Those bereaved by suicide reported being overwhelmed immediately following the death, with one interviewee describing it as 'chaos'; deaths by suicide often involve the presence of emergency response services, which can add to the chaotic load borne by those experiencing a sudden death. Additional supports might therefore be better-timed once the funeral is passed and fewer people are 'dropping by'.

> "There's so much to do immediately right after: phoning family, planning a funeral... when you're in that crisis, it's hard to locate [services]. You're already in an overwhelmed state, so even what they're telling you you're not absorbing. What would be helpful is for someone to say 'people to be in touch with you, maybe once the funeral is over. We'll set up a time with you'."
>
> – Lived experience of suicide interviewee

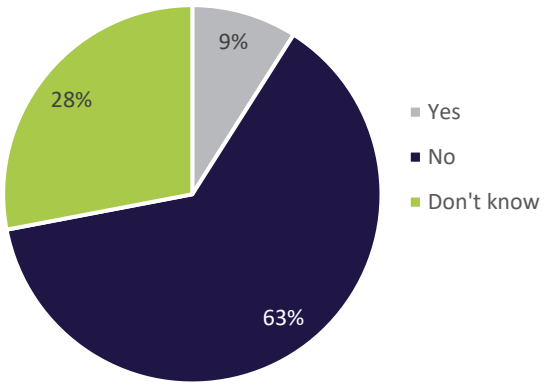
There was a general sense among interviewees bereaved by suicide that messaging such as 'someone will be in touch with you following the funeral' would be helpful. That way, bereaved individuals know that someone is going to contact them and that the onus of trying to figure out where and what supports are available is not on them.

An additional challenge faced by those bereaving a death by suicide is that the death can impact a broad cross-section of people, not only the immediate family. Interviewees with lived experience identified two issues created by this challenge. The first issue is that different community members may want or need differing types of services; there might thus be varying experiences of the same traumatic event, requiring different forms of support. For example, the parent of someone who died by suicide sought out a range of individual services (including a psychologist), while a sibling of the same deceased individual refused to visit a psychologist. Instead, the deceased's siblings elected to hold a party to which they invited friends and the deceased individual's school colleagues organized a suicide awareness day. The second, interconnected, issue is that services are typically only offered to the immediate family. For example, one interviewee stated that they would have appreciated hearing from support services but that they were never contacted since they were not the closest next of kin, despite being the deceased's (adult) child.

Fewer than 10% of service provider survey respondents reported awareness of best practices that aimed to support those bereaved by suicide in the initial period following the death (Figure 4). Among the few who felt able to identify best practices, they noted suicide bereavement supports should be:

- Specifically targeting those bereaved by suicide;
- Supported by staff specifically training in suicide bereavement;
- Person-centered;
- Open and responsive;
- Recovery-oriented;
- Provided in group settings;
- Underpinned by peer support; and
- Accessible (including no cost).

**Figure 4: Are you aware of any best practices, including from other jurisdictions, that aim to support those bereaved by suicide in the initial period following the death?**




Source: Service provider survey QG3a (n=114). 'Prefer not to answer' responses excluded.

### 2.5. What are the barriers, if any, to accessing services for those bereaved by suicide?

According to service providers, there are barriers prohibiting those bereaved by suicide from obtaining services. The most frequently identified barrier was a lack of awareness of available services or supports (91%), followed by perceived stigma or shame (80%), cost (74%), and that available services either do not target the unique needs of those bereaved by suicide (54%) or are over-subscribed in Edmonton (51%) (Table 5).

**Table 5: Barriers to Services as Identified by Service Providers**

| | % |
|---|---|
| Individuals are not aware of available services or supports | 91% |
| Perceived stigma or shame associated with accessing such services | 80% |
| Individuals cannot afford services or supports | 74% |
| Services and/or supports are too generalized/not relevant/not targeted | 54% |
| Services and/or supports are over-subscribed in Edmonton | 51% |
| Fear of being treated without dignity or respect | 49% |
| Individuals are aware of available services or supports, but do not know how, or are unable, to access them | 40% |
| Services and/or supports do not exist in Edmonton | 31% |

Source: Service provider survey G4b (n=35). Percentages do not sum to 100% due to multiple responses.

Findings from the stakeholder interviews aligned directly with findings from the services provider data; specifically, stakeholders identified personal, awareness, capacity and financial barriers that those bereaved by suicide might, or were likely to, encounter (Table 6).

**Table 6: Barriers to Services as Identified by Stakeholders**

| Barrier type | Examples | Data excerpts (Stakeholder interviewees) |
|---|---|---|
| Personal | • Stigma<br>• Feelings of guilt or shame<br>• Cultural barriers | "I think the barriers again, would be personal from the point of view of feeling so guilty."<br>"If these services aren't culturally sensitive to the way in which suicide is understood and engaged, […] then that would prevent people from accessing supports and services." |
| Awareness | • Lack of information about services<br>• Lack of knowledge of how to access | "I would say there is a general lack of awareness. 'Where are these services offered?' 'How do I act?' 'Do I qualify?' 'Do they serve my particular population?'."<br>"I think the barriers are to have the skill and the ability to actually go looking for [services] for yourself." |
| Capacity | • Over-subscribed services<br>• Lack of appropriate services | "Lack of capacity, lack of staff to be able to engage in these conversations."<br>"I think one barrier is that services only come to the immediate family. But research suggests that, for every suicide death, over one hundred people are affected. Where are those people? They're not all in the home, right?" |
| Financial | • Cost of accessing services | "I think [there are] financial barriers. You know, counseling services and therapeutic services can be very costly."<br>"If you are wanting individual support, cost is a barrier for sure." |

Source: Year 3 Stakeholder interviews.

## 3. Summary

There are key differences between the experiences of those bereaved by suicide when compared to those bereaved by other causes, including heightened or acute feelings of guilt, shame, shock, trauma, confusion, disbelief and anger. In addition, those bereaved by suicide typically experienced stigma exacerbated by other people either adopting avoidance behaviours or, conversely, asking inappropriately-intrusive questions.

Lines of evidence suggest there is minimal knowledge of what postvention supports or services are available for those bereaved by suicide in Edmonton. This directly aligns with the view that there are no services in Edmonton that meet the unique needs of someone bereaved by suicide which, in turn, suggests that those in need do not have adequate access to appropriate services following a death by suicide. When services are identified, such as private or group counselling sessions, access is often limited by factors such as prohibitively high costs or long wait lists.

Postvention support services for those bereaved by suicide must be targeted, with information made available about how services can be accessed when the individual elects to do so. This may be some time following the death, such as once the funeral is over. Information provided to those bereaved by suicide in the immediate aftermath of the death should be limited to raising awareness that services exist and that those bereaved by the death will be contacted at a later date. In addition, the recognition that deaths by suicide impact different populations within communities suggests that services in Edmonton should aim to target more than immediate family or next of kin only.

Postvention services should be designed to overcome suicide-specific barriers to access. Services or supports provided to those bereaved by suicide should thus be: targeted, person-centred, open, responsive, recovery-oriented, accessible and supported by appropriately-trained staff.