Suicide Prevention Scotland.

Postvention & Incident Response

Local Suicide Prevention Planning and Implementation Toolkit

Local Suicide Prevention Planning and Implementation Toolkit

What will this document support you to do?

- Understand the types of activities which often happen following a suicide related incident and which you may undertake as part of your response. These include information sharing, support for those affected, locations of concern, clusters, memorials, suicide reviews and communications.
- Locate relevant guidance, information and resources to support you to develop your response or to support others in their response.
- Consider postvention and incident response in relation to communities, staff and colleagues, and children and young people.

When might this document be most helpful?

- When you are developing or reviewing local suicide related incident response protocols, action plans and procedures.
- When you are considering your response following a suicide related incident in your local area or service.
- When you receive a query from an external partner or organisation following a death by suicide or suicide attempt.

Contents

Suicide Prevention Scotland.

Introduction

What is Postvention?

Postvention is the word we use to describe our response to, and the care and support offered to those affected by, a suicide related incident. Postvention helps to support recovery and reduce the risk of suicide in those affected or exposed and is a key part of suicide prevention activity. Having carefully considered postvention responses and protocols in place can help support timely and effective responses.

It is important to note that many of the examples and resources provided in this toolkit are specific to responses following a death by suicide, however postvention is important following all incidents of suicidal behaviour, including suicide attempts.

This document introduces some of the main areas of postvention and incident response work and provides links to further information and guidance to support you as you plan and take action locally.

Postvention and suicide incident related actions might involve:

- Having an agreed action plan in place to enable effective responses.
- Information sharing between relevant organisations to ensure that support can be offered and responses can be mobilised.
- Ensuring that people bereaved by suicide are offered information and support to cope with their loss.
- Ensuring that a person who has attempted suicide, as well as their family or friends, are offered support.
- Ensuring that staff are sensitively informed about the suicide of a patient or service user and that appropriate support is available when needed.
- Providing information and support to a person who has been witness to a suicide of someone they didn't know to allow them to process their experience.
- Taking action to reduce the risk of further suicides amongst individuals or communities who might be more at risk of suicide..

Postvention work can be emotionally demanding. Even if you are not directly involved in providing support to those affected, repeated exposure to information on deaths by suicide and suicide incidents can have an impact. It is important that staff involved in this work pay special attention to self care, seek support from colleagues and line managers, and are alert to signs that work may be having a negative impact on wellbeing.

Public Health Scotland and Suicide Prevention Scotland have developed a short podcast series called 'You First' which explores the impact of emotionally demanding work such as suicide prevention can have on us as staff, and provides insights and suggestions to support us to look after our wellbeing.

Why do we need to prioritise planning for postvention and incident response?

How we respond following a suicide or suicide attempt really matters, not only because of the devastation experienced by individuals, families and communities. It is an important part of suicide prevention work primarily because we know that exposure to suicide can increase the risk of suicide, particularly in vulnerable individuals. Studies from **2015** and **2016** have demonstrated that exposure to the suicide of a loved one is associated with subsequent increases in the risk for suicidal thoughts or actions.

Suicide contagion describes when one person's suicide, due to its circumstances and the publicity around it, triggers the risk of suicidal ideation, suicide attempts and/or deaths by suicide in others who are already vulnerable to suicidal thoughts or behaviours. Postvention efforts can often be focused on reducing the likelihood of contagion occurring, by supporting those affected and preventing or responding to unhelpful discussion or media coverage of suicide. There is more information around the concept of suicide contagion in the **national clusters guidance.**

Having well planned and agreed postvention plans or protocols which include arrangements around information sharing following suicide related incidents can ensure that when they occur, local partners are able to respond quickly and effectively. Ensuring that people understand their role following an incident can reduce duplication and ensure that affected people receive a smooth response.

Reflection

Does your local area or organisation have a process in place for how suicide-related incidents should be responded to?

What is your role, or that of your organisation in local postvention response, and how do you connect with others to ensure a coordinated response?

Would the response look different for specific groups or circumstances? For example the death of a prominent community member or the death of someone who lived on their own with a limited social circle? Would the response be different following the suicide attempt of a child compared to an adult?

Practice example

Suicide Response Workshop, Public Health Scotland

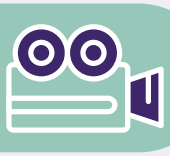
The Suicide Response Workshop was developed by Public Health Scotland for use in local areas should they wish to test their preparedness to respond to suicides in their communities and settings. It uses an unfolding scenario to support the identification of improvement actions to ensure local areas are adopting best practice approaches for responding to suicide. When delivered with a multiagency partner group it also supports a shared understanding of roles and responsibilities for suicide postvention.

The scenario facilitates a discussion of practice around areas such as information sharing, support for those affected by suicide, cluster response, locations of concerns and communications. It is delivered as a one-off facilitated session worked through stage by stage to identify current practice and processes and areas where action or improvements may be needed. A bank of scenarios has been created to support differing local contexts.

Materials are available to support the delivery of the workshop including:

- an overview document
- facilitator guide
- participant handouts
- alternative scenarios.

You can also watch this video to find out more about the Suicide Response Workshop and how it was developed.



For more information on the workshop contact phs.suicidepreventionteam@phs.scot

Information sharing after a suicide incident

In order for postvention and incident response activity to occur, information on suspected suicide or suicide attempts will need to be shared with the relevant people locally. Different partners will have access to different types of information, with information on deaths by suicide often more easily obtained than information on suicide attempts or crisis presentations. It can be helpful to make connections with the different agencies who may hold relevant data and explore how this can be shared in order to enable postvention responses to occur. It's also fairly common to find out about a suicide through local community connections, and following this up with agencies who can provide confirmation is helpful before action is taken.

Once we have this information we can identify which individuals or groups may need information or support or be at heightened risk of suicide. It helps inform decisions around where we should focus postvention efforts.

Careful consideration needs to be given about **what** information should be shared, with **who** and **for what purpose.** Sometimes information is shared on a more informal basis, however this process can fall down if someone moves role. Formalising appropriate information sharing agreements ensures this process is sustainable, is done safely and lawfully.

Further information to support you to consider inter-agency data and information sharing locally can also be found in the **Data and Information section of this toolkit.**

Practice example

Police Scotland

Police Scotland hold data on suspected deaths by suicide and can provide this to designated local partners. In most areas this is shared as close to real time as possible, and usually within 24-72hrs depending on the local arrangement. It includes identifiable information such as name, date of birth, postcode of residence and locus, method and suspected contributory factors. This data sharing allows local Suicide Prevention Leads and multi agency suicide prevention groups to activate postvention responses, and can inform preventative activity.

Reflection

Who receives the information locally when someone dies by or attempts suicide?

Who else is this information shared with and for what purpose?

Do current local information sharing arrangements allow for timely postvention responses?

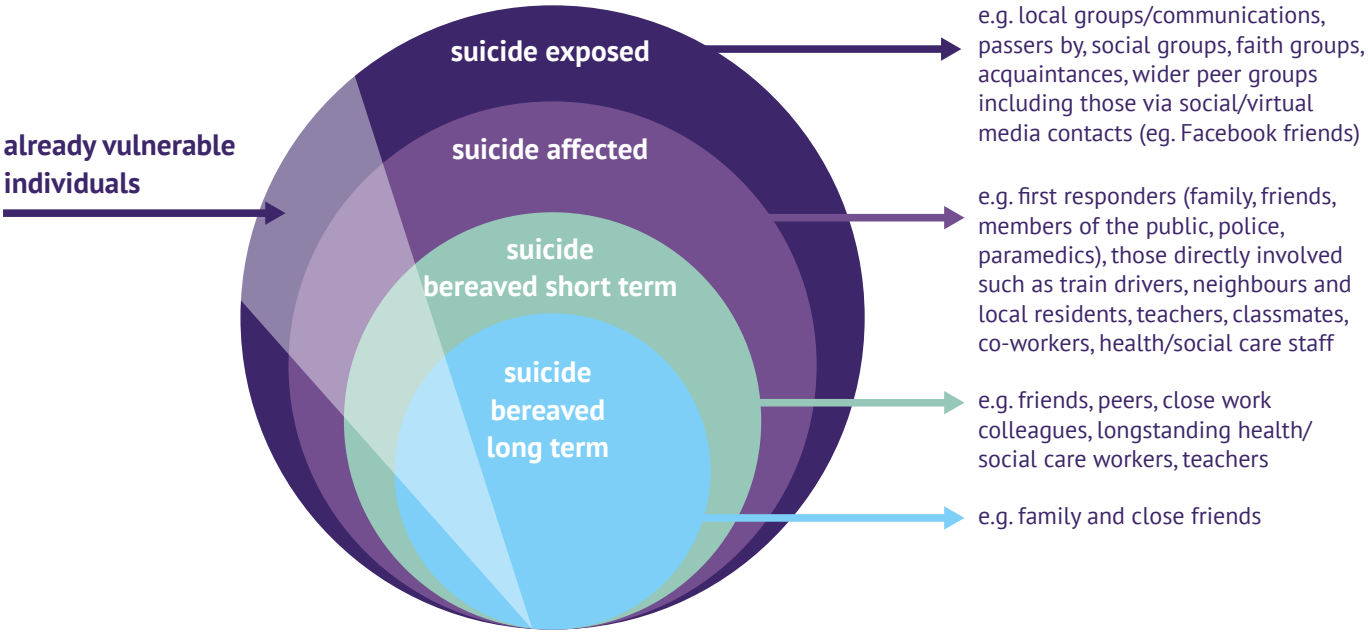
Are appropriate information sharing agreements in place?

Support for people affected

The Ripples of Suicide

Understanding the different people who may be impacted by an individual suicide can help us consider what information or support may be needed. **Research** has shown that for every death by suicide, up to 135 individuals can be affected. **Further research** has suggested a significantly larger vulnerable population affected per death particularly due to media exposure and social media use.

The model below represents the different ways that individuals and groups of people may be impacted when someone dies by suicide. It is important to remember that the unique circumstances of each suicide will mean that who is impacted and how will differ for each incident. Similarly, following a suicide attempt there may be a range of individuals and groups affected in different ways.



The **clusters guidance** has more information on the circles of vulnerability and the **suicide response workshop** (see page 6) includes an exercise which supports a mapping of individuals and groups affected by a suicide related incident, and allows local areas to consider what support is currently offered and how, and address any gaps in local processes.

When a suicide or attempt involves a young person there is a **higher risk of contagion**, and so particular attention should be paid to postvention activities. Recognising the importance of pre planning in this area, the response workshop process, developed to support local areas to consider their response following a suicide, includes scenario examples which involve the suicide of a young person and a child.

What happens following a death by suspected suicide?

There are a number of processes which take place following a suspected suicide. It can be useful to understand these in order to better inform and support people affected.

The Police will:

- Confirm the identity of the person who has died.
- Investigate the circumstances of a person's death to ensure no criminality has been involved.
- Search the body of the deceased and surrounding area.
- Ask questions about the person who has died, including about how they had been acting in the days and weeks before their death, and any circumstances which may have contributed to their suicide for example medical conditions and financial issues.
- Sometimes remove items from the person, location of death or home address, which may be relevant to an investigation. These items will normally be returned to next of kin at the end of any investigation following approval from the Procurator Fiscal's office.
- Provide the Procurator Fiscal a 'Sudden Death Report' which details the full details of the deceased and circumstances of death.

If a death is unexpected, suspicious or unexplained, the Procurator Fiscal's office will:

- Become involved and a death certificate may be issued after an investigation and possible postmortem.
- Release the body of the person who has died to the nearest relative once the investigation is complete.
- Release any property that has been seized of the person who has died to the identified next of kin once the investigation is complete.
- Contact the nearest relatives to keep them updated and answer questions throughout the process

This process and the delay it can cause can be very distressing for families, especially where there are **religious or cultural traditions** that means the funeral and burial or cremation should occur as soon as possible. Receiving the death certificate can also be an upsetting time for families because the certificate will detail the method of death but won't mention suicide.

In addition to the legal processes described above, in some circumstances a review of the circumstances leading up to a suicide can take place. You can read more about suicide reviews on page 21 of this toolkit.

Bereavement by Suicide

Almost anyone can be affected by suicide, but the intensity of the bereavement can be different depending on the relationship someone had with the person who has died. People most likely to experience bereavement following a suicide are those who have a close personal relationship or relationship history with the person who has died. This can include family members, friends, colleagues, peers or staff who have supported the person in some way for long periods of time, but may include others for whom the relationship was less defined or more complicated and who may experience disenfranchised grief as a result. **Disenfranchised grief** can occur when a loss and the associated grief is not openly acknowledged, socially validated, or publicly mourned.

Suicide bereavement is a completely different experience of loss when compared with other forms of bereavement for a number of reasons which include:

- The circumstances of the death
- Intense and complicated emotions such as guilt, shame, anger and fear
- Unanswered questions
- Stigma
- Isolation
- Community and media attention
- Ongoing legal proceedings
- Long term physical and mental health impacts on the bereaved

Research also tells us that being bereaved by suicide can increase an individual's risk of dying by suicide. Ensuring that bereaved people are offered compassionate support around their loss is a key feature of suicide prevention work.

Bereaved by Suicide Focused Podcasts: Public Health Scotland as part of Suicide Prevention Scotland have recorded a **podcast episode** which explores bereavement by suicide. Guests on the podcast discuss why bereavement by suicide can differ from other types of bereavement, the impact of stigma and discrimination, the impacts on children and older people, and what kind of support can be helpful.

You may also be interested in listening to a podcast series called **Speaking of Suicide** from Highlands based organisation Mikeyline. It hears from people who have been impacted by suicide in a series of powerful interviews.

There are lots of useful resources which can help you to increase your understanding of suicide bereavement and improve your local response. These include:

Suicide Prevention Scotland provides information a page focused on supporting people bereaved by suicide.

Wave After Wave is suicide bereavement focused training developed in Glasgow and being utilised across Scotland to support people who may come into contact with people bereaved by suicide to respond with increased understanding, sensitivity and compassion.

Support After Suicide includes a repository of guides and resources around suicide bereavement and well as a searchable service directory.

After a Suicide This booklet from SAMH is often provided to people bereaved by suicide. It includes information on the practical issues associated with a death by suicide as well as information on grief and available support.

Survivors of Bereavement By Suicide provide information for professionals which including supporting people bereaved by suicide.

From Grief to Hope is the report on a research study which explored the experiences of people bereaved by suicide.

Finding the Words is a guide on how to support someone bereaved by suicide.

Diverse Experiences of Suicide Bereavement

For some people, particularly those from communities who face additional barriers, stigma and marginalisation, experiences of suicide bereavement can be complex and may need a tailored response. There are a number of useful guides which can increase your understanding around the needs of these groups.

Neurodivergence Support After Suicide Partnership (SASP) have produced a guide to supporting people bereaved by suicide who are neurodivergent.

Gypsy Travellers Support After Suicide have a support guide for understanding Gypsy Roma Traveller communities who have been bereaved by suicide.

LGBTQ+ This report outlines the findings of a study which looked at the experiences of suicide bereavement among people who identify as LGBTQ+.

Armed Forces Suicide Bereavement UK produced guides for those bereaved by suicide in the armed forces community.

Racialised Groups & Communities – A guide for support services and professionals supporting people from racialised groups and communities who have been bereaved by suicide.

Gambling Harms A guide on how best to support people who have suffered a bereavement by suicide and are affected by gambling harms.

Older Adults This research paper is useful to support understanding and responses to suicide bereavement in older adults.

Faith and Religion A site with suicide prevention and postvention information to support faith-informed conversations.

Children and Young People – We have included a specific section about children and young people on page 16.

Reflection

What do you understand about peoples' experience of bereavement by suicide?

How important is that for your role / organisation?

What more would you like to know and what can you access to support this learning?

Support for People Bereaved by Suicide

People who are bereaved by suicide may need support to help them deal with their loss. This support can take different forms and what's right for an individual will depend on their personal preferences, needs and circumstances. It is important not to make assumptions about what an individual will need:

- There is no one service which can meet everyone's needs, and not everyone who is bereaved will need support from a service.
- Individuals who seek support may do so immediately, or in the weeks and months after a death.
- For some, years can pass before they look for help and some may never seek or need support from a service.
- Some may need support for a short time only, and for others for long periods of time.
- Some may feel the need of additional support around specific events or anniversaries.

It is important that people bereaved by suicide are made aware of the support that is available to them. There are a number of ways in which bereaved individuals are offered information and support. These include:

- Written information on what to expect and support available
- One to one grief counselling
- Emotional or practical support
- Group support, often led by people with their own experience of suicide loss

Practice example

Creating Hope with Peer Support Resource (Scottish Recovery Network)

The development of this resource and practice guides brought together a range of people already delivering peer support for those affected by suicide. Many people bereaved by suicide, who are in crisis, or have survived their own attempt share that spending time with others who have similar experiences offer them validation, understanding, and support through their own mental health recovery. The resource from Scottish Recovery Network aims to support and build the confidence and skills of those delivering these kinds of groups and projects. It uses the **Creating Hope with Peer Support Pathway** to outline four key stages of the peer support relationship and journey: **Connect, Explore, Hope and Support**. While it is intended for peer workers and volunteers, the peer approach can be applied in other roles to encourage a more person-centred and empowering approach to supporting others.

Reflection

What information are people bereaved by suicide given in your area?

What services are available for people bereaved by suicide and how are they made aware of them?

Do the services available offer flexibility and choice for bereaved people?

Evidence based responses

In 2020 the Mental Health Foundation published the findings of a study commissioned by Scotland's National Suicide Prevention Leadership Group to inform the development of potential support models for people bereaved by suicide. The study comprised a literature review, mapping exercise and primary research with people who had experience of suicide bereavement.

Their research study **Support for those Bereaved by Suicide** explores the defining features of current models of support, reasons why people sought support, barriers and facilitators to accessing support, their experiences of the support they received and views about what ideal support should look like.

This report informed the development of the Scottish Government funded Suicide Bereavement Support Service, the **evaluation** of which provides a useful summary of elements which may be important to ensure that the best support is available to people bereaved by suicide. Suggestions include:

- Clear and sensitive referral processes.
- Timely access to assessment and support.
- Person-centred, flexible support which aligns with service user need and where parameters are made clear at the start.
- Ensure support is accessible and appropriate for diverse communities including faith groups, LGBTQ+ individuals and gypsy/traveller communities.
- Support which is delivered by a trained and supported staff team.
- Consideration of how people will be supported to exit from or transition to other forms of support.

The **Support for those bereaved by suicide research report** and **the full evaluation report** are useful resources for those planning and delivering suicide bereavement support services.

Additionally Support After Suicide Partnership have developed a set of **Core Standards** for people developing or commissioning suicide bereavement support services. They aim to ensure that services delivering postvention support to people bereaved or affected by suicide, are delivering high quality services, achieving consistency and supporting their staff to provide support to those bereaved or affected by suicide. While they were developed to support bereavement support services being commissioned as part of the delivery of the NHS Long Term Plan in England, they provide a helpful resource for anyone working to deliver suicide bereavement support in any capacity.

Practice example

Glasgow Bereavement Website (Glasgow City HSCP & Police Scotland)

As a result of local scoping work on support for people bereaved by suicide, the bereavement subgroup of the Glasgow City Suicide Prevention Partnership Group identified a gap in information about what people bereaved by suicide could expect following their loss and available support. Staff from the Health Improvement team worked with partners from Police Scotland to develop a **bereavement focused website** which contains a section on suicide bereavement. A **Support after a bereavement leaflet** was also developed so that it could be provided by Police staff to people bereaved by suicide, this leaflet included a link to the website.

Practice example

Suicide Bereavement Support Service (NHS Highland/NHS Ayrshire & Arran)

The Suicide Bereavement Support Service is delivered by Change Mental Health and Penumbra and draws on learning from the pilot progressed under the previous national suicide prevention action plan, Every Life Matters. It offers free, confidential, one-to-one support for anyone who has been impacted by a death by suicide in the Highlands, Argyll & Bute, and Ayrshire & Arran. The support given helps to reduce distress, stigma, and risk of suicide. Support can be face to face or over the phone, and is available for as long as it's needed. This service is only one example of suicide bereavement support that takes place in communities across Scotland.

Find out more about the **Change Mental Health Suicide Bereavement Service** and Penumbra's Ayrshire & Arran **Suicide Bereavement Support Service.**

The Suicide Bereavement Support Service featured as a **Time Space Compassion Practice Story.** The **final evaluation of service.** It includes a number of recommended elements which may be important to ensure that the best support is available to people bereaved by suicide and may be helpful for those developing and delivering support.

Practice example

Peer support for people bereaved by Suicide (East Ayrshire)

In East Ayrshire the **Creating Hope Together Peer Led Bereaved by Suicide Support Group** is a 7 week peer support group for people bereaved by suicide, developed after a gap in peer support provision in the local area was identified. Delivered by a peer facilitator with the support of the Auchinleck Community Development Initiative (ACDI) and Penumbra, the group follows a simple 7 week structure to open up conversations about suicide loss. At the first and last sessions a member of staff from the Suicide Bereavement Support Service attends to let the group know about the one to one support they can offer, and a Bereavement Café model has been developed to facilitate ongoing support.

Practice example

Wave After Wave (Glasgow City HSCP)

Following identification of a need for multi-agency training on suicide bereavement, Glasgow HSCP, on behalf of the Glasgow City Suicide Prevention Partnership, commissioned the development of suicide bereavement training using a co-production approach. The aim of the training is to equip staff and volunteers from across organisations and communities with the knowledge and confidence to offer a compassionate helpful response to people bereaved by suicide. The **training materials** are available for use across Scotland. A **short video** produced by Suicide Prevention Scotland explores how the public and charity sectors are working together in Glasgow and the surrounding areas. You can also read about the process in this **extended practice example.**

You can find out more about the process to develop the training **here**

Support for Children and Young People

Special consideration needs to be made when children and young people are affected by a suicide or suicide attempt of a peer or an adult in their lives. Understandably, adults may wish to protect children from the truth around a death by suicide, however children are much more able to deal with difficult events if they are given open and factual information.

There are many places you can go to find out more about suicide bereavement support for children and young people or around bereavement in childhood more generally.

Suicide Prevention Scotland has information on supporting children and young people bereaved by suicide.

Winston's Wish supports bereaved children, young people, their families and the professionals who support them. This website includes information about how to speak to a child or young person about suicide.

Beyond the Rough Rock is a purchasable booklet developed by Winston's Wish for adults supporting a child bereaved by suicide.

Child Bereavement UK have lots of guidance and training to support those supporting children bereaved by suicide.

The Compassionate Friends offers support for families bereaved after the death of a child or children

Hope Again provides youth bereavement information

Safe Harbour is an illustrated storybook from Ireland for children bereaved by suicide. It was developed by bereavement experts - including professionals and people with lived experience – to help a child with their grief by encouraging conversation and developing their understanding of death and suicide. The storybook comes with a guide that will help parents and carers to read Safe Harbour with their child and empower them to have these important conversations. To support this book, further resources are available including an audiobook, podcast series and activities for children.

Papyrus provides some useful information about how to support a young person after a suicide attempt, which was commissioned as part of the delivery of the NHS Long Term Plan in England.

Practice example

The National Childhood Bereavement Project (Includem)

The National Childhood Bereavement Project was created in March 2020 to improve support for those who are bereaved during their childhood. Although the project did not look at bereavement by suicide specifically, the findings are useful when considering the needs of bereaved children and young people. The Project ran for 3 years and worked to understand the experiences of infants, children, young people and young adults who have been bereaved under the age of 26 in Scotland. In total, the Project listened to 100 people with lived experience of childhood bereavement and over 250 people with a role in supporting bereaved children and young people, through their personal life as parents, carers or friends or through their work as charity workers or teachers. The report recommended improved bereavement support, increased awareness of childhood bereavement, improved sector coordination, the development of accessible advice for children and young people, grief aware workplaces and learning establishments and the establishment of a bereavement grant. In September 2022, the Project concluded by publishing its final report **'Growing Up Grieving'** and submitting seven recommendations for change to the Scottish Government.

Practice example

A Whole School Approach to Loss and Bereavement (Glasgow City HSCP)

Recognising the school setting as a vital setting for bereavement support for children and their families, Glasgow City HSCP developed a whole school approach to loss and bereavement. **The resource** which was developed aims to support school staff to feel more confident and equipped when helping a child through an experience of loss or bereavement. It includes specific information about supporting a child who has experienced bereavement through suicide or another type of traumatic death.

Practice example

Step By Step (Samaritans)

The **Step by Step service** by Samaritans provides support and resources for school communities to respond to and recover from a suspected suicide or a suicide attempt. The service offers practical advice, emotional support, and resources for staff, students, and parents, including support to plan responses to future suicide events and reduce the risk of further suicides. For more information email: **stepbystep@samaritans.org**

Staff Support

When staff in a workplace are impacted by the suicide of a colleague or client, it is important that organisations respond in compassionate, supportive and appropriate ways. Staff may also require support if they are looking at distressing data relating to suicide attempts or deaths, or supporting people bereaved by suicide.

Ideally, organisations should have clear policies and procedures in place to support the response following a suicide. Having clear roles and responsibilities can help people know they are playing their part.

Policies or procedures might include things like:

- How the response will be coordinated and led, including roles and responsibilities.
- Procedure for informing staff sensitively of the death while respecting the privacy of the deceased and their family.
- Responsibilities for communicating with the family of the person who has died.
- What support is available for those affected both in the aftermath and in the longer term, and how this will be communicated.
- How the organisation will respond to any media enquiries about the death.

Reflection

How do workplaces and organisations find out when there has been the suicide of a member of staff, client or service user?

There are a number of resources which can help you or your partners to consider the approach that should be taken. We have listed some of these below.

Postvention guidance: Supporting NHS staff after the death by suicide. This comprehensive guidance was developed following a research project which explored the needs of staff bereaved by suicide.

Samaritans have produced a toolkit to support postvention for NHS Employees

The Firefighter Charity have produced Senior Leaders and Managers guides to suicide prevention and postvention in the workplace.

First Hand is a website for people affected by the suicide of someone they don't know. It includes a section on suicide at work and includes helpful suggestions from people who have experiences suicide loss.

Crisis Management in the Event of a Suicide: A Postvention Toolkit for Employers: This toolkit was designed to support employers in their response to the suicide of an employee, at work or outside the workplace.

Practice example

Support for Workplaces in the Aftermath of Suicide (Cruse Scotland)

Following a recognition that many employers felt unprepared and without the funding needed to provide timely support for their staff following a suicide, Cruse Scotland was funded by the Scottish Government to provide **free support for any workplace who have been affected by a suicide**. This has included frontline services, and many private and public sector organisations. Soon after contacting the service Cruse Scotland will talk with workplace managers to learn more about the circumstances, and agree what support would be most helpful. The support is then tailored and delivered in person, or online if preferred, by skilled and experienced bereavement specialists, usually within a group setting, though often there are opportunities for follow up one to one discussions.

Practice example

Fire Service Bereavement Videos (Fife HSCP/Cruse Scotland)

Scottish Fire & Rescue Service reached out to health promotion staff for workforce support following the death by suicide of a colleague. It was felt important that the support offered should be accessible to staff across a number of locations, cover the immediate and longer term needs of those affected, and be provided in a discrete way to allow for confidentiality around access. A series of videos were developed utilising local and national expertise which provided immediate signposting, information and resources in relation to bereavement following a suicide. **The Evaluation** showed the videos were viewed in large numbers and feedback from staff and managers was positive.

Witness support

People who have witnessed a suicide, suicide attempt or discovered the body of someone who has taken their own life, may be in need of information or support to help them process their experience.

First Hand is an online resource developed in England which is aimed at people who have been affected by being at the scene of a suicide of a person they did not know or those who may be supporting them. This could include people who have witnessed a death or staff who have attended the scene. It provides advice and supportive information about common reactions, what to expect and self care.

Practice example

Witness Support Leaflet (NHS Fife & NHS Forth Valley)

NHS Fife and NHS Forth Valley identified a gap in information for those who may have witnessed a suicide. These local Health Boards have each developed leaflets which are being distributed by relevant partner organisations including Police Scotland. The leaflets contain supportive information about what the person may be experiencing, self care and coping strategies, and links to digital information and resources and other sources of support.

Support After a Suicide Attempt

While much of the focus of postvention activity is responding and ensuring support following a death by suicide, it is important to consider what can be offered to support those who have attempted suicide and those who are caring for them or affected by the attempt.. One of the common challenges for those caring for someone who has attempted suicide is around confidentiality in relation to details about the specific suicide attempt and finding out what support has been provided to the person they care for.

We have included a couple of practice examples which may help as you consider the needs of the people you work with locally. There is also useful information on the **Mind website** and on the **Papyrus website** for specifics around children and young people.

Practice example

Resources for Carers (Glasgow Association for Mental Health/Glasgow City HSCP)

After identifying a gap for information and support for people looking after someone at risk of suicide, including those who have made suicide attempts, Glasgow City HSCP commissioned GAMH to work with people with lived experience of caring to develop a specific resource. The resource **Being there for someone at risk of suicide – a guide to taking care of yourself and others** brings together useful information from various organisations and enhances it with suggestions and tips for how carers can both look after themselves and their loved one.

Practice example

Living Warriors Project (Edinburgh City)

Living Warriors Project is a peer support group for adults (age 18+) who have survived a suicide attempt which is run by people with lived experience. Sessions include open discussion, reflection and creative activities and provides a safe and non-judgemental space where people's journeys are understood and respected. The group can be accessed via self referral. For more information email **hello@livingwarriorsproject.com**

Suicide reviews

When someone dies by suicide a review process may take place to better understand the circumstances that might have contributed to the death, and where there might be learning or service improvements that could help to prevent future suicides. While undertaking reviews of deaths by suicide is not a statutory requirement in all cases, it is important to better understand the circumstances that might lead to someone attempting to take their own life or dying by suicide.

Depending on the process, a suicide review may:

- Involve multiple agencies or be single agency focused
- Involve a small or wider number of partners who may have engaged with the individual (mental health services, social work, Police, GPs, and in some circumstances the third sector)
- Involve the family or people with lived and living experience
- Consider the circumstances and risk factors that might have made them more at risk of suicidal behaviour (such as adverse events, medical conditions, social circumstances)
- Be focused around specific operational service improvements or take a broader approach to look at risk factors
- May be voluntary or statutory

The suicide review may be processed in different ways depending on the local area and the circumstances of the death. In some circumstances more than one review will take place, although where possible a single review process that meets all reporting requirements around the death is preferred. In other circumstances no review will take place.

Below is a list of potential reviews that may take place following a suspected suicide, this list is not exhaustive and there are likely to be other reviews that take place in specific settings e.g. in a university if a student dies by suicide.

Type of review	Description
Local multi-agency suicide review process	Around 1/3 of local areas in Scotland currently have a multi-agency suicide review process in place. This usually covers all deaths by suspected suicide of residents in a local area. The approach varies depending on the local area.
Adverse event review (AER) and Serious adverse event reviews (SAER)	When someone has been in contact with mental health services in the 12 months prior to their death an Adverse Event Review or Serious Adverse Event Review will be taken forward.
Child death reviews	Death of a young person aged up to age 18, or 26 if care experienced. For those in continuing care up to age 26, or in receipt of after care up to this age there is also a requirement to submit notification to the Care Inspectorate.

Adult Protection Learning Review	Formerly initial or significant case review for public bodies to learn lessons around protection of adults at risk of harm.
Drugs death reviews	Takes place where illict drugs or alcohol were thought to have been a contributory factor in the immediate cause of death, whether or not the person who died was in recent contact with specialist treatment service.
DIPLAR for deaths in prison	Scottish Prison Service (SPS) process for reviewing all deaths in prison custody or when an individual in SPS care dies in hospital or any other location external to the prison.
Police Investigations and Review Commissioner (PIRC)	Deaths of a person in police custody or following contact with the Police.
Fatal Accident Inquiry (FAI)	If someone dies in legal custody or accident at work, or in other circumstances if it is decided that it is in the public interest.
Morbidity and Mortality Review	A systematic approach that provides members of a healthcare team with the opportunity for peer review of adverse events, complications or mortality to reflect, learn and improve patient care.
Mental Welfare Commission (MWC)	The death of any individual who is subject to compulsory treatment either the Mental Health (Care and Treatment) (Scotland) Act 2003 or Criminal Procedure (Scotland) Act 1995 at the time of death, or who died within one month of cease of detention under the above Acts, or where a patient died as a result of actual or suspected suicide as an inpatient or within one month of discharge from hospital based care.
Domestic abuse homicide and suicide reviews	Domestic homicide and domestic abuse related suicide reviews aim to learn lessons following a death where abuse is known or suspected. Development of a review model supported by legislation is a commitment under the Equally Safe Strategy.

Practice example

Multi-Agency Suicide Review Group (NHS Tayside)

The **Tayside Multi-Agency Suicide Review Group (TMASRG)** was established in 2016 and is jointly funded by NHS Tayside, Angus, Dundee and Perth & Kinross Health & Social Care Partnerships. The TMASRG involves key partners from across Tayside and works as closely as possible with other review processes across Tayside in order to improve the efficiency and effectiveness of reviews and support implementation of actions.

The scope of the TMASRG is to:

- Provide timeous co-ordination and communication of local information on suicide deaths, including alerts to any potential clusters for individual's resident in Tayside at the time of death
- Collate information around the individual circumstances and service contacts
- Provide an annual report and regular updates to the Tayside Suicide Prevention Coordinating Group and local suicide prevention groups
- Review each death, identifying areas for intervention or service improvement, including implementation of immediate improvement actions where possible

Support for Suicide Reviews

QES Electronic Recording and Reporting System

The **Creating Hope Together action plan** outlines a commitment to rollout multi-agency reviews and learning system. This drew on the learning from suicide review pilots taken forward under the **Every Life Matters suicide prevention action plan**. To support implementation a learning review system called QES (Quality Education Solutions Ltd) was procured nationally by Public Health Scotland and offered to each local area for individual use in surveillance and case management. As of October 2025, nine local areas are actively using the system to support the suicide review process. The system allows local areas to log initial case data received from Police Scotland, monitor the data for trends and to support the suicide review process by capturing information from different partners and pull together learning plans. This allows for streamlining of a suicide review system and for partners to more easily identify what needs to change to avoid future deaths by suicide. Public Health Scotland are supporting local areas to access and implement the QES system with the intention for more areas to use this system over time.

At a national level, Public Health Scotland plans to pull together a more expansive national picture of suicide deaths by drawing on the QES local data and combining this with **ScotSID** datasets.

For more information on the QES system, contact **PHS.SuicidePreventionTeam@phs.scot**

Locations of concern

Specific considerations or actions may need to be taken when a suicide has occurred in a public space or at a location of concern.

A **location of concern** can be broadly defined as a specific, usually public, site that is used as a location for suicide and that provides either means or opportunity for suicide. One or more incidents of suicidal behaviour at a particular location suggests that action should be considered to address the site in question. Suicidal behaviour can include people presenting at a location in distress and experiencing suicidal thoughts, people attempting suicide, or deaths by suicide.

There is strong evidence which suggests that reducing access to the means for suicide, including restricting access to locations which provide opportunity for suicide, is an effective method of suicide prevention. A **recent paper** published in the Lancet suggested that restricting access to the means for suicide is effective because:

- It can delay a person carrying out an act during a crisis and allow them to take a different course of action (including, potentially, seeking help)
- It can provide the opportunity for others to intervene with the person
- they might choose an alternative method with less potential to be fatal.

The evidence for effectiveness of interventions beyond interventions which restrict access, such as fencing and barriers, is still emerging. This was highlighted in the recent **review of evidence** conducted by Health and Care Research Wales Evidence Centre. As such the need to collect evidence of impact of interventions is important.

Work around suicide at locations of concern has been a key feature of local suicide prevention activity for many years, but due to the risks and sensitivities around drawing attention to locations or methods for suicide it is often not spoken about or shared more widely. It is important that all partners involved in this work have the knowledge and sensitivities required to take it forward. There are several supporting resources which can support you and your partners to develop your knowledge and practice in this area listed below.

Public Health Scotland has developed **guidance** to support prevention and action on suicides at locations of concern.

Practice example

Locations of Concern Stakeholder Workshop (Public Health Scotland)

The Suicide Prevention Implementation Leads at Public Health Scotland have developed a customisable Locations of Concern focused workshop which includes full facilitator notes. It was developed for use by local suicide prevention leads to increase knowledge and understanding of locations of concerns work and the concept of suicide contagion among local partners. The workshop was tested with a multiagency group of stakeholders in West Lothian with positive feedback and has supported partnership working in the local area.

Resources to support the delivery of the workshop include an **overview for facilitators**, **workshop slides** with facilitators notes and a **participant handout**.

Practice example

Engagement with Shopping Centre

Following a suicide incident at a shopping centre location, a multiagency suicide prevention steering group organised the delivery of suicide awareness training to shopping centre staff including security and cleaning staff. In addition, some management attended suicide intervention skills training.

After discussions around options with centre management, modifications to the location were made including the addition of non-weight bearing safety netting, screening and fencing. A member of security staff was also stationed at the site during centre opening hours. Anecdotal evidence of staff intervening in crisis situations has been received. The shopping centre has since supported local efforts through offering space for public suicide awareness raising activities.

Supporting Resources

National guidance to support action on suicides at locations of concern

Rapid literature review in reducing suicides at locations of concern

A rapid review of interventions to reduce suicide ideation, attempts, and deaths at public locations **which includes executive summary, full report and useful infographic**

Reducing Suicide at Locations of Concern This document is a helpful summary of the suggested areas for action around suicide at locations of concern.

Practice examples: Multi-intervention approaches to addressing suicide at locations of concern in Scotland
Two practice examples of local approaches to locations of concern work:

Practice example 1

Practice example 2

Practice example

Safer Public Spaces Network

The Safer Public Spaces Network is a UK wide network of people and organisations working to reduce suicide at public locations. It meets monthly online and offers useful opportunities for learning and practice sharing for anyone involved in action to reduce suicide in public spaces.

Suicide clusters

A **suicide cluster** describes a situation in which more deaths by suicide occur than is normally expected in terms of time, place or both. It usually includes three or more deaths, but two suicides occurring in a specific community or at a specific location or setting, especially over a short period of time, should also be given attention in terms of potential impact and any possible connections. It should also be noted that suicide attempts may also indicate a potential cluster.

One or more incident of suicidal behaviour at a particular public location suggests that action should be considered to address the site in question. It is important to note there do not have to be clear connections for multiple deaths by suicide to constitute a cluster. A suicide cluster or perceived suicide cluster can cause serious distress within communities.

It is also important to remember that consistent and well planned postvention responses following every death by suicide could be considered suicide cluster prevention. Often the activities which form a response to a suicide cluster are the same things we would consider a good postvention response – one which involves a number of partners, pays specific attention to the various groups who may be affected and has an eye to increased vulnerability to suicide.

Supporting Resources

National Clusters Guidance: Public Health Scotland have developed guidance for identifying and responding to a suicide cluster. It will help you consider how you will plan for and respond to an emerging suicide cluster in your area.

Social Media Guide for Communities: Orygen, a child and youth mental health focused organisation in Australia have developed helpful guidance for communities around social media use following a suicide in order to reduce the risk of suicide clusters. Headspace's **Communication following a suicide incident** leaflet

Reflection

Who has the information needed to determine if suicides in a local area could be a suicide cluster?

Who has the responsibility locally for declaring a suicide cluster?

What additional action might be required where you are responding to multiple suicides?

Memorials

Finding a way to remember and celebrate the life of a person who has died is a common reaction to loss by suicide. Memorials and memorial events can help those bereaved and their family and friends by supporting them through their grieving process, bringing people together, and providing a place or space for them to talk about the person they have lost.

There are certain risks associated with memorials following a suicide. These include:

- the impact memorials might have on the bereaved family
- the impact on other vulnerable people, especially those at risk of suicide
- the risk of drawing attention to a particular location that may offer means or opportunity for suicide
- drawing media attention to the death

Supporting Resources

National memorials guidance: provides information on managing the risks of public memorials after a probable suicide to support local multi agency steering groups to respond.

Samaritans Social Media and Online Memorials: information around the potential risks of using the internet and social networking sites to help deal with a suicide.

Step By Step memorials guidance: produced by Samaritans Step by Step service provides guidance around memorials in the school setting

Practice example

The Clootie Tree (NHS Borders)

The Clootie Tree within the grounds of Haining House in the Scottish Borders is a dedicated tree to people who have died by suicide. This is a place where people bereaved by suicide can come together, reflect and share their experience. An annual memorial event is held where people can tie a ribbon to the tree in memory of someone who has died by suicide. This film, **Healing the Loss**, features the Clootie Tree and was produced by people in the Borders bereaved by suicide and explores places of special meaning where people remember their loved ones who have died by suicide.

Communications following a suicide incident

Suicide Contagion

There is good **evidence** that unhelpful coverage of suicide and suicidal behaviour in the media can increase the risk of suicide for already vulnerable people. This phenomenon is usually referred to as contagion.

Suicide contagion is more likely when:

- Methods or locations are specified
- Lethality of method or location is highlighted
- The death is described as "quick" or "painless"
- Locations are highlighted by a memorial at the site
- Suicide is glamourised or romanticised
- Suicide being presented as a positive outcome for a person
- When people identify with or are close to the person who has died

Conversely there is also **evidence** to suggest that careful and positive reporting, particularly stories of hope, help seeking, support and recovery can have a protective impact and can lead to reduced incidences of suicide.

The Media and Suicide Reporting

We have known about the dangers of unhelpful media reporting for some time and so guidelines have been developed to encourage responsible media reporting about suicide by the **WHO** and in the UK by **Samaritans**. These can be used to support local decision making and efforts to tackle unhelpful media coverage. Ensuring that local partners are aware of the guidance to inform their communications strategies and responses is a helpful step to take.

Good Practice

The Samaritans Media Guidelines & Communication Guide

The **Samaritans media guidelines** were developed to support journalists and media outlets to report responsibly on suicide reducing the risk of suicide contagion, balancing the need to report matters of public interest with a responsibility to avoid causing further harm. They are a helpful source of information for individuals and organisations keen to understand how they can communicate positively and safely about suicide online.

Samaritans have also developed a **Suicide Prevention Communications Guide** which covers useful tips for developing safe and informed suicide prevention messages for those communicating about the issue, raising awareness or campaigning for change. They also host an **Online Excellence Hub** which contains useful information for those working in the online space.

In recent years we have seen huge changes in how news and information are reported and shared, driven by the rise in social media use and other digital platforms and the decline in traditional print media. This change is relevant as we consider media coverage of suicide for many reasons including:

- Information about a suicide can be shared quickly, spread widely and updated rapidly.
- Stories about suicide can be created and shared by anyone.
- People can access information about suicides anywhere and at any time.
- The information being reported and shared may be misleading or inaccurate.
- Online news stories and social media posts usually include the ability for others to like, share and comment.
- People may be exposed to information or news unexpectedly due to algorithms.
- There can be less privacy for those affected and, due to information which may be available through social media accounts, stories about the person who dies may be shared without permission.
- Media stories change and evolve and can be updated quickly with new information.

As a result the way in which people are exposed to stories and information about suicide has become more complex and dynamic, and our prevention and postvention activities also have to adapt.

Social Media After A Suicide

Tackling unhelpful media stories and social media posts and comments in relation to suicide can be challenging. Different sites and groups have different content moderation rules and procedures, and the time it can take to have a post removed can be considerable. Organisational policies around social media can mean that staff are only able to view or respond to coverage using personal accounts, which is risky and unsafe. As an emerging area of practice, there can often be a lack of clarity around organisational responsibilities for responding to social media posts. Additionally, responses or interventions from certain organisations or from corporate accounts may not be welcomed, may be met with hostility or may unintentionally inflame the discussion.

Responding to social media is an emerging area of practice, and while we can draw from the principles of existing media guidelines, there is a need to build evidence around effective strategies. Given the prevalence of social media use, it should form a key part of local communications strategies.

Researchers at the University of Hull have examined social media and suicide, and have made a number of suggestions which it may be helpful as you consider your own protocols and responses.

- Work with partners to develop an approach to monitoring and regulating suicide related content. This approach should include the proactive amplification of protective content such as stories of hope and survival, particularly when there have been incidences of unhelpful or dangerous coverage, or following a high profile suicide incident.
- Develop template social media posts which can be used to respond to posts. These can be shared with partners.
- Consider ways to educate the public on safe social media practices in relation to suicide. Consider if this can be incorporated into suicide prevention awareness activities.
- Establish mechanisms to monitor social media and media responses – this may be a dedicated person or team within an organisation, or a wider partnership approach.
- As individuals and organisations we can remove or report harmful content.
- Offer support to families to develop press releases and statements for the media, how to deal with social media, and how/if to memorialise their loved one online – this could be incorporated into any bereavement information which is offered.

There are some useful **guidance and recommendations** for managing risks and responding safely to social media use in the aftermath of a suicide including policy briefs and advice for:

- **Organisations**
- **Colleges, universities and student unions**
- **Schools**
- **Community groups, youth clubs and charities**

Samaritans have also developed a **social media toolkit** designed to be used to call on other univer to learn about internet safety around suicide and self-harm. This may be useful if you are keen to improve practice locally amongst colleagues / partner organisations.

Good Practice

Orygen Chat Safe Guidelines

Orygen are the National Centre of Excellence in Youth Mental Health in Australia. As part of a wider programme of work they have developed helpful guidance for children and young people on how to communicate safely about suicide online. The **guidelines** and this **video** provide a really helpful introduction.

Orygen have also developed **guidance and tools** for communities on the use of social media for suicide prevention and postvention. One of the tools developed is a useful Postvention social media communications protocol which supports organisations to plan for online responses following a suicide incident.

Resources and support

Throughout this document there are a number of additional resources that are linked to from each section.

Further information, resources and practice examples are available on the **Suicide Prevention Scotland website**.

For any questions about postvention and incident response you can also contact the Suicide Prevention Implementation Leads at Public Health Scotland on **phs.suicidepreventionteam@phs.scot**